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CARE COORDINATION FOR DUALY ELIGIBLE BENEFICIARIES

KATIE M. DEAN* AND DAVID C. GRABOWSKI**

I. INTRODUCTION

Care coordination has been identified as a potential method of achieving the triple aim in health care—improving outcomes and care quality while reducing costs. Well-designed, targeted care coordination entails comprehensive coverage of services across a coordinated provider team working together to provide high-quality, patient-centered care. This model, however, faces significant challenges at both the payment and delivery levels. Health care payment is traditionally “silo-based,” with payers reimbursing individual providers for specific services without consideration of other services.¹ The fee-for-service (FFS) model does not incent care coordination among providers and may even serve as a deterrent, because a reduction in utilization resulting from better and more coordinated care would mean a reduction in reimbursement for certain providers. The care coordination challenge extends to health care delivery, where again, coordination is discouraged as it typically requires costly infrastructure investments from providers with no promise of future savings or reimbursement from payers.

The care coordination problem is quite evident in the fragmented care received by the sickest and frailest members of society, those who are dually eligible for Medicare and Medicaid (duals). This population is typically dealing with multiple chronic illnesses as well as functional limitations that require long-term care. Because of their health profiles, the duals tend to have multiple providers and require services that are covered by Medicare and Medicaid.

Approximately 9,200,000 individuals in the United States are dually eligible for both Medicare and Medicaid coverage.² They qualify for Medicaid due to their low income and assets. Roughly sixty percent are elderly duals

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1. Barbara Gage, *Building a Long-Term Services and Supports Delivery System that Works*, 24 PUB. POL’Y & AGING REP. 56, 57 (2014).

2. KATHERINE YOUNG ET AL., KAISER COMM’N ON MEDICAID & THE UNINSURED, PUB. NO. 7846-04, MEDICAID’S ROLE FOR DUAL ELIGIBLE BENEFICIARIES 1 (2013).

who meet the age requirement for Medicare, while the remaining forty percent of duals qualify for Medicare because of their Social Security Disability Insurance (SSDI) eligibility.³ The dual eligible population includes some of the sickest, frailest, and most vulnerable individuals covered by either program. Duals are more likely than other Medicare beneficiaries to have multiple chronic illnesses, functional limitations requiring assistance with activities of daily living (ADLs) and a significant mental illness (SMI) or substance use disorder (SUD).

The duals comprise about twenty percent of Medicare beneficiaries and fifteen percent of Medicaid beneficiaries, yet they account for roughly thirty-one percent of Medicare spending and thirty-nine percent of Medicaid spending annually.⁴ Medicare covers acute services for the duals, including hospital procedures, physician visits, prescription drugs, and post-acute care, while Medicaid covers Medicare premiums and cost-sharing and long-term care services.⁵

Due to their poor health statuses, the duals use a range of health care services, which vary between the elderly and the young duals. Elderly duals are more likely than younger dual beneficiaries to utilize institutional long-term care services and skilled nursing facilities for post-acute care. Young duals are more likely to use outpatient hospital services and physician services, and both groups are similarly likely to require inpatient hospitalizations.⁶ Because the duals are likely to require assistance with ADLs or to suffer from an SMI or SUD, they are also far more likely to live in an institution, with seventeen percent of the dually eligible population currently institutionalized.⁷

The high levels of service utilization among duals, combined with their tendency to receive care from multiple providers and the dual-payer reimbursement model, have contributed to an epidemic of poor care

3. *Id.* at 10.

4. GRETCHEN JACOBSON ET AL., KAISER FAMILY FOUND., PUB. NO. 8138-02, MEDICARE'S ROLE FOR DUAL ELIGIBLE BENEFICIARIES 2 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8138-02.pdf>.

5. KAISER COMM'N ON MEDICAID & THE UNINSURED, THE DIVERSITY OF DUAL ELIGIBLE BENEFICIARIES: AN EXAMINATION OF SERVICES AND SPENDING FOR PEOPLE ELIGIBLE FOR BOTH MEDICAID AND MEDICARE 1 (2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7895-02.pdf> [hereinafter DIVERSITY OF DUAL ELIGIBLES]. See also MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: NEW APPROACHES IN MEDICARE 72 (2004).

6. See DIVERSITY OF DUAL ELIGIBLES, *supra* note 5, at 1, 4.

7. *Dual Eligibles – Health Services Utilization*, THE SCAN FOUNDATION (2011), http://www.thescanfoundation.org/sites/default/files/1pg_DataBrief_No10.pdf; *Medicare Beneficiaries With Severe Mental Illness and Hospitalization Rates*, THE SCAN FOUNDATION (2013), http://www.thescanfoundation.org/sites/thescanfoundation.org/files/1pgdatabrief_no36_medicare_beneficiaries_with_severe_mental_illness_and_hospitalization_rates.pdf.

coordination, low-quality care and difficulty accessing appropriate care.⁸ Medicare and Medicaid are both large public programs with frequently misaligned incentives that can discourage care coordination. One important result of the uncoordinated care experienced by most duals is a high rate of avoidable hospitalizations.⁹ Spector and colleagues identified sixty percent of hospitalizations among long-term nursing home residents as potentially avoidable.¹⁰ Similarly, the Centers for Medicare and Medicaid Services (CMS) found that forty-five percent of hospitalizations of Medicare beneficiaries for either short-stay or long-stay nursing home residents could have been avoided.¹¹ Not only are these hospitalizations costly for Medicare, they are disruptive and potentially harmful for the elderly patients experiencing this type of unnecessary care.

The purpose of this paper is to examine the barriers to care coordination for dually eligible individuals. Care is currently fragmented at both the payment and the delivery level. Thus, a key takeaway from our article is that in order to introduce system-level coordination of care, policymakers need to reform both the payment and delivery of services for dually eligible individuals. Efforts to fix either the payment or delivery system in isolation will not lead to sustainable, comprehensive reform.

We begin the paper by presenting two representative patient vignettes to illustrate the coordination of care problems faced by dually eligible beneficiaries. We then use these patient vignettes to discuss the implications of various care coordination issues for representative elderly and young duals.

II. PATIENT VIGNETTES

The duals are a heterogeneous group along a number of dimensions, but in order to illustrate the consequences of poor care coordination, we consider a scenario that could be experienced by a “representative” older dual living in a nursing home and a “representative” younger dual living in the community.

8. See generally TA Coughlin et al., *Among Dual Eligibles, Identifying The Highest-Cost Individuals Could Help In Crafting More Targeted And Effective Responses*, 31 HEALTH AFF. 889, 1083 (2012).

9. MISHA SEGAL, CTR. FOR STRATEGIC PLANNING, CTRS. FOR MEDICARE & MEDICAID SERVS., DUAL ELIGIBLE BENEFICIARIES AND POTENTIALLY AVOIDABLE HOSPITALIZATIONS 1, 2, 6 (2011). See generally A. Wysocki et al., *The Association between Long-Term Care Setting and Potentially Preventable Hospitalizations among Older Dual Eligibles*, 49 HEALTH SERVS. RESEARCH 778 (2014).

10. William D. Spector et al., *Potentially Avoidable Hospitalizations for Elderly Long-Stay Residents in Nursing Homes*, 51 MED. CARE 673, 673 (2013).

11. *Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://innovation.cms.gov/initiatives/rahnfr/> (last visited Sept. 22, 2014).

“Ms. B” is a ninety year-old woman living in a nursing home. She suffers from moderately advanced Alzheimer’s disease, congestive heart failure with severe left-ventricular dysfunction and chronic pain from degenerative joint disease. Under the traditional payment and delivery model, Ms. B has three ID cards—Medicare, prescription drugs, and Medicaid—and three different sets of benefits. She is treated by multiple providers who rarely communicate.

Now imagine Ms. B develops a nonproductive cough and fever of 100.4°F. Although Ms. B’s symptoms are treatable in the nursing home, in a typical scenario she will be sent to the emergency room and likely admitted for an inpatient hospital stay. Why? Because under the current payment system, nursing homes are able to receive reimbursement from Medicaid for holding Ms. B’s bed while she undergoes treatment in the hospital, and then to receive reimbursement from Medicare when Ms. B returns to the nursing home for what is considered post-acute treatment after her hospital stay.¹² Medicaid pays for the nursing home care but does not share in any Medicare savings associated with reduced hospitalizations. Nursing homes can invest in the infrastructure to safely prevent a hospitalization, but because they do not share in the savings from reduced hospitalizations, they are discouraged from making this investment.

Ms. B is representative of an elderly dual; but the young duals, those under sixty-five who qualify for Medicare through SSDI eligibility, present different care coordination issues than their elderly counterparts.

“Mr. C” is a forty-year-old dual with schizophrenia, an SUD, and multiple chronic illnesses. Mr. C resides in the community and receives assistance with finding and maintaining housing and employment, along with some community-based Medicaid case management. When Mr. C’s medication was changed to a generic formulation, his Medicare Part D prescription coverage required a prior authorization of the drug, resulting in a lapse in Mr. C’s access to medication. During this period, Mr. C had a psychiatric event and was brought to the emergency department for treatment. Because Medicaid does not cover Mr. C’s prescription drugs, his Medicaid case manager had no knowledge of the lapse in his treatment, and Mr. C had deteriorated enough as to be unable to relay the information. The case manager was only privy to the psychiatric symptoms of Mr. C’s medication disruption, and so she did not intervene when he was brought to the Emergency Department (ED) for acute treatment. However, once Mr. C entered the ED, Medicare took over coverage, and the Medicaid case manager did not follow Mr. C through his acute treatment and subsequent Skilled Nursing Facility (SNF) assignment.

Mr. C’s episode and adjustment to new medication were disorienting, so the hospital released him to a SNF for post-acute treatment. The Medicaid case

12. DAVID C. GRABOWSKI, *MEDICARE AND MEDICAID: CONFLICTING INCENTIVES FOR LONG-TERM CARE* 10 (2007).

manager is typically not responsible for enrollees when an acute care episode results in hospitalization or entry into a SNF. This lack of coordination increases the likelihood that Mr. C will not return to the community following an acute care episode.¹³

In both of these cases, the dually eligible individual is provided lower quality services in a higher cost setting because no incentive exists for care alignment among Medicare, Medicaid and the various providers. In this paper, we will provide an overview of the care coordination problem and suggest possible delivery and payment levels to improve care quality, improve health outcomes, and reduce the cost of care for dual eligibles such as Ms. B and Mr. C.

III. IMPLICATIONS OF THE CARE COORDINATION PROBLEM

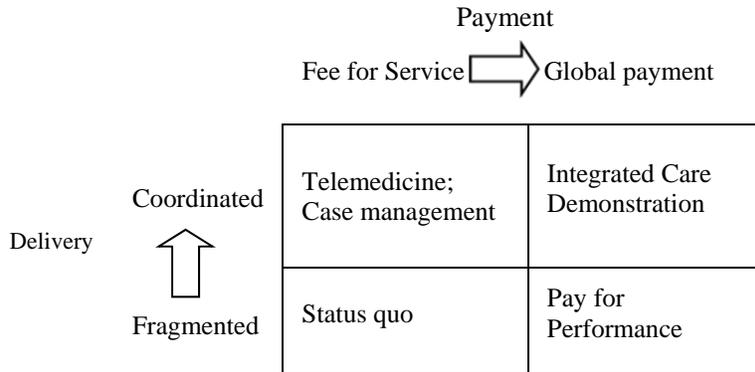
The poor coordination of Medicare and Medicaid financing and delivery of services has been a long-standing problem in the care of the dually eligible population.¹⁴ As suggested by the two patient vignettes, the fragmented coverage of acute and long-term care services often contributes to higher costs and worse patient outcomes. Given the bifurcated coverage introduced by Medicare and Medicaid, neither program has an incentive to internalize the risks and benefits of its actions as they pertain to the other program.¹⁵ Thus, each program has the narrow interest in limiting its share of costs, and neither program has an incentive to take responsibility for overall care management or quality of care. This fragmentation flows down to the providers in that long-term care providers often lack the incentive to invest in the expertise and infrastructure to treat patients in place. The interrelationship between payment and delivery of care for the duals is represented in Exhibit One. Historically, we have had FFS payment and fragmented delivery of care, represented by the “status quo” in the lower left quadrant.

13. *Id.* at 12.

14. JENNIFER RYAN & NORA SUPER, NATIONAL HEALTH POLICY FORUM, ISSUE BRIEF NO. 794, DUALY ELIGIBLE FOR MEDICARE AND MEDICAID: TWO FOR ONE OR DOUBLE JEOPARDY? 4, 11 (2003).

15. Grabowski, *supra* note 12, at 11.

EXHIBIT ONE: DELIVERY AND PAYMENT LEVEL REFORMS



One common outcome of this “status quo” is the high rate of potentially avoidable hospitalizations for both elderly and young duals. In 2005, potentially avoidable hospitalizations of nursing home residents cost \$1.9 billion, with an avoidable hospitalization rate of 338 per 1000 person-years.¹⁶ If Ms. B experiences a health issue, her nursing home does not have appropriate staffing or infrastructure to care for her in place, so she is sent to the hospital for treatment. Ms. B’s nursing home lacks the financial incentive to invest in the infrastructure necessary to care for its residents onsite, and so the ED is likely to remain the primary care setting for nursing home patients with a flare-up of a chronic condition and other non-life-threatening medical issues. Due to her age and frailty, Ms. B leaves the hospital disoriented and more vulnerable than she had been previously, directly increasing the likelihood that she will be re-hospitalized in the next thirty days.

The hospitalization of the community-dwelling duals is also a significant issue. In 2005, potentially avoidable hospitalizations of Medicaid Home and Community-Based Services (HCBS) clients cost \$463 million, with an avoidable hospitalization rate of 250 per 1000 person-years.¹⁷ Although Mr. C has a Medicaid case manager, some aspects of his care are still uncoordinated, so his case manager has no role in his medication change, hospitalization, or the decision to send him to a SNF for recovery. As with Ms. B, Mr. C finds his hospitalization disorienting and has arrived at the SNF in a weaker and more vulnerable state.

Despite the differences in their patient profiles and living arrangements, Ms. B and Mr. C find themselves similarly susceptible to unnecessary, dangerous, and avoidable hospitalizations due to the fragmented state of their

16. Edith G. Walsh et al., *Potentially Avoidable Hospitalizations of Dually Eligible Medicare and Medicaid Beneficiaries from Nursing Facility and Home-and Community-Based Services Waiver Programs*, 60 J. AM. GERIATRICS SOC. 821, 825-26 (2012).

17. *Id.* at 824, 825-27.

care. The FFS payment structure of reimbursement for care provided to duals encourages this type of health cycle, in which the health outcomes of patients diminish due to an inability to access proper care in both long-term care institutions and in the community.

The experiences of Ms. B and Mr. C are representative of issues and outcomes of both elderly and young duals and make it clear that the current FFS model is not working for this population. Although attempts at integrated care for the dually eligible have so far failed to improve outcomes while reducing costs, several evidence-based delivery and payment innovations show promise toward achieving the triple aim. In the next two sections below, we discuss how we might better address care at the delivery level and then the payment level. We ultimately conclude that meaningful system-level change requires reforms at both the payment and delivery levels.

IV. DELIVERY REFORM ALONE IS NOT SUSTAINABLE

The care coordination problems experienced by Ms. B and Mr. C can be broken down into failures at both the delivery and payment levels. A common delivery failure, and one experienced by Ms. B. above, is a failure of nursing homes and other providers to invest in infrastructure and expertise to treat residents safely in a nursing home setting. The preponderance of nursing homes lack the tools and staffing to treat ailments such as urinary tract infections and minor falls on-premises. The lack of onsite clinical expertise results in residents being sent to the hospital to receive expensive care in an unnecessarily acute setting.¹⁸ For example, during off-hours, if a resident becomes ill, the on-call physician has the option of going to the nursing home for a consultation or recommending that the resident be sent to the hospital for care; the latter of the two options is the most common.

One potential way to mitigate the increasing rates of unnecessary hospitalizations of nursing home residents is through telehealth. Telehealth can include any type of health care service provided in a non-face-to-face setting, but it is most commonly used to refer to a teleconference taking the place of an in-person consultation.¹⁹ In the nursing home setting, a physician could videoconference with a resident and her family in real-time to potentially avoid a costly trip to the emergency room and possible hospital admission. Grabowski and O'Malley conducted a randomized study of telehealth in a

18. David C. Grabowski, *Predictors of Nursing Home Hospitalization: A Review of the Literature*, 65 MED. CARE. RES. & REV. 2, 4, 24 (2008).

19. *What is Telemedicine?* AM. TELEMEDICINE ASS'N, <http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VE5sii5dU00> (last visited Oct. 27, 2014).

Massachusetts nursing home chain.²⁰ The nursing homes in the treatment group experienced fewer hospitalizations and generated roughly \$100,000 in Medicare savings annually in prevented hospital transfers.²¹ The telehealth infrastructure cost \$30,000 per nursing home annually.²² Although the study findings suggested that the hospital savings exceeded the costs of the technology, the nursing home chain did not fully implement the intervention because of the disconnect in the return on the investment. As long as Medicare reaps the savings of reduced hospitalizations while nursing homes foot the bill for new technologies, nursing homes will not pay for expensive infrastructure modifications despite potential improvements to resident health outcomes. Using the framework for Exhibit One (upper left quadrant), telemedicine addresses the fragmentation in delivery, but it is still based on the underlying FFS model.

Another potential delivery-level intervention to alleviate the reliance on acute care is an integrated case manager. In the abovementioned scenario, Mr. C has a case manager who is paid for by Medicaid and, therefore, is not responsible for Mr. C's Medicare-funded care. This fragmentation led to the case manager being unaware of Mr. C's lapse in medication and to his being released from the hospital into a SNF rather than back into the community. Although Medicaid HCBS case management has the potential to generate positive outcomes for community-dwelling duals, these programs often introduce negative outcomes because of the broader disconnect with the Medicare program. For example, an evaluation of Florida HCBS programs found evidence of cost shifting to Medicare through increased inpatient hospital days for dually eligible enrollees.²³ In the Florida programs, the Medicaid HCBS contractor is responsible for paying only the Medicare deductibles and copayments when a dually eligible enrollee is hospitalized, with Medicare paying the bulk of the hospital expenditures.²⁴ If the dually eligible enrollee is not hospitalized, the HCBS contractor must pay the full cost of services, such as respite care. Thus, the contractor has the unintended incentive to shift costs to Medicare by hospitalizing clients. Once again, we have an example of a reform that offers a strong delivery intervention without any broader change or alignment in payment.

20. David C. Grabowski & A. James O'Malley, *Use Of Telemedicine Can Reduce Hospitalizations Of Nursing Homes Residents And Generate Savings For Medicare*, 33 HEALTH AFF. 244, 245 (2014).

21. *Id.* at 247.

22. *Id.*

23. Glenn Mitchell, II et al., *The Relative Benefits and Costs of Medicaid Home-and Community-Based Services in Florida*, 46 GERONTOLOGIST 483, 488 (2006).

24. *Id.* at 485.

V. PAYMENT REFORM IS NECESSARY BUT NOT SUFFICIENT

Beyond delivery-level issues, elderly and non-elderly duals also experience care coordination failures at the payment level. The primary payment-level issues at play in covering the dually eligible population are the conflicting financial incentives between Medicare and Medicaid, two large-scale, public programs that were not designed to work together. In Ms. B's case, her nursing home shifted costs to the federal government instead of developing the infrastructure and staffing to treat Ms. B on-premises. The nursing home was not incentivized to invest in improving its scope of care, because Medicaid would not reimburse it for the costly changes, and it would not receive a share of any potential cost savings from reduced hospitalizations, which would only go to Medicare. Similarly, Mr. C's case management benefits only applied to his Medicaid-funded services, so when he was sent to the hospital, he received no guidance and was released to a SNF, a Medicare-funded treatment setting. Mr. C's disruption in case management services and resulting release to a SNF greatly decreases the likelihood that Mr. C will ever return to living in the community.

To improve the quality of care and address the payment-based issues hindering quality improvements in nursing homes, CMS initiated the Nursing Home Value-Based Payment Demonstration (NHVBP) in July of 2009.²⁵ The voluntary program ran from 2009 through 2012 and included thirty-eight nursing homes in Arizona, seventy-two in New York and sixty-one in Wisconsin.²⁶ The demonstration evaluated participating nursing homes using four performance domains: staffing, survey inspections, quality measures and hospitalizations.²⁷ Top-performing nursing homes were to receive a reward payment based on the cost savings they generated for Medicare.

The demonstration resulted in little pre/post change in performance across the treatment and control nursing homes and mixed or negative results on savings.²⁸ In Year One, both Arizona and Wisconsin achieved savings.²⁹ In Year Two, only Wisconsin realized savings, and in Year Three, none of the states generated any Medicare cost savings.³⁰ Qualitative interviews with nursing home leadership suggested that the facilities did not make major investments toward preventing hospitalizations in spite of the potential

25. LISA GREEN, L&M POLICY RESEARCH, EVALUATION OF THE NURSING HOME VALUE-BASED PURCHASING DEMONSTRATION 1 (2013), *available at* http://innovation.cms.gov/Files/reports/NursingHomeVBP_EvalReport.pdf.

26. *Id.*

27. *Id.* at 2.

28. *Id.* at 3.

29. *Id.* at 2.

30. *Id.*

financial rewards.³¹ The NHVBP results align with the broader economics literature suggesting financial incentives alone are not likely to succeed in the context of complicated tasks such as preventing hospitalizations. For example, education research on the use of financial incentives to encourage student performance has indicated that these incentives do increase student attendance, but they have had little impact on more complicated outcomes such as graduation rates or student achievement.³² We argue that payment reform is necessary but not sufficient to improve care quality and reduce costs. In Exhibit One (lower right quadrant), the NHVBP pay-for-performance offers a global payment but does not offer any reform to the delivery system.

VI. SYSTEM-LEVEL REFORM UNDER THE AFFORDABLE CARE ACT

Based on the abovementioned delivery-level and payment-level approaches to improving care coordination for duals, it is clear that what is needed is an integrated program that combines reforms to the delivery and payment systems currently in place. Under the Affordable Care Act, twenty-six states received funding and approval to develop new models to coordinate care for duals.³³ Variation exists across the states in the proposed models, but all include reforms at the payment and delivery levels (upper right quadrant in Exhibit One).

On the delivery side, a number of states are considering using or developing state-specific service delivery infrastructure, such as the Tulsa Health Innovation Zone or the Wisconsin Family Care Program.³⁴ Despite their unique attributes, the states can be categorized at a higher level by whether they propose to build on existing capitated managed care programs, expand FFS initiatives such as patient-centered medical homes and health homes, or do both. A range of accountable entities have been proposed, including health

31. Grabowski & O'Malley, *supra* note 20, at 248.

32. Robert E. Slavin, *Can Financial Incentives Enhance Educational Outcomes? Evidence from International Experiments*, 5 EDUC. RES. REV. 69, 78 (2010).

33. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2601, 124 Stat. 314-5 (2010) (codified in scattered sections of 26 U.S.C.); KAISER COMM'N ON MEDICAID & THE UNINSURED, PUB. NO. 8369, STATE DEMONSTRATIONS TO INTEGRATE CARE AND ALIGN FINANCING FOR DUAL ELIGIBLE BENEFICIARIES: A REVIEW OF THE 26 PROPOSALS SUBMITTED TO CMS 4 (2012) available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8369.pdf>; see also MARYBETH MUSUMEGLI, KAISER COMM'N ON MEDICAID & THE UNINSURED, FINANCIAL AND ADMINISTRATIVE ALIGNMENT DEMONSTRATIONS FOR DUAL ELIGIBLE BENEFICIARIES COMPARED: STATES WITH MEMORANDA OF UNDERSTANDING APPROVED BY CMS 1 (2014) (providing a state-by-state overview of state participation in demonstrations).

34. NAT'L ASS'N OF STATES UNITED FOR AGING & DISABILITIES, STATE MEDICAID INTEGRATION TRACKER 51, 66 (2014), [hereinafter TRACKER] available at http://nasuad.org/documentation/nasuad_materials/Medicaid%20Tracker/September%202013%20Integration%20Tracker.pdf.

plans, emerging accountable care organizations, regional provider collaboratives, and state agencies themselves, acting as managed care organizations. At least four states (California, Minnesota, New York, and Washington) expect to use different service delivery approaches in different parts of their states.³⁵

The states' approaches to payment map their service delivery approaches, with the managed care states proposing capitated or global payments to accountable entities, and the other states proposing to introduce new incentives in a FFS payment context, such as measuring FFS reimbursement against global budgets with the opportunity for gain-sharing.³⁶

All of the states seek to restructure the federal-state relationship in regard to Medicare. Several have proposed to take Medicare financial risk by receiving a risk-adjusted Medicare capitation from CMS and unifying Medicare and Medicaid at the state level.³⁷ Others have proposed gain-sharing arrangements with CMS without taking on the full Medicare financial downside risk.³⁸ States are also pushing the policy envelope on Medicare enrollment policy.³⁹ At least one state (Oregon) has proposed mandatory enrollment for all dually eligible beneficiaries.⁴⁰ Several others propose passive enrollment with the ability to opt out.⁴¹

Most of the states are seeking to fully integrate all Medicare and Medicaid services, including prescription drugs, long-term services and supports, and behavioral health services, but some important exceptions will challenge the notion of fully integrated care. California, Colorado, Connecticut, Oregon, and Tennessee are all proposing that one or more key service area (e.g., long-term services and supports, behavioral health, Part D) will be coordinated with but remain separate from their Medicare-Medicaid initiative, at least initially.⁴²

Most of the states propose large, statewide initiatives for all full-benefit dually eligible beneficiaries, but a few are targeting subsets, including

35. *Id.* at 7, 23, 32, 45.

36. *Id.* at 23, 25.

37. Ellen Breslin et al., *Risky Business: Capitated Financing in the Dual Eligible Demonstration Projects*, COMMUNITY CATALYST 1, 6 (2013), <http://www.communitycatalyst.org/doc-store/publications/State-and-health-readinessFINAL.pdf>.

38. KAISER COMM'N ON MEDICAID & THE UNINSURED, STATE DEMONSTRATIONS TO INTEGRATE CARE AND ALIGN FINANCING FOR DUAL ELIGIBLE BENEFICIARIES: A REVIEW OF THE 26 PROPOSALS SUBMITTED TO CMS 9-10 (2012), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8369.pdf>.

39. *Id.* at 8.

40. *Id.* at 26.

41. TRACKER, *supra* note 34, at 15.

42. KAISER COMM'N ON MEDICAID & THE UNINSURED, PROPOSED MODELS TO INTEGRATE MEDICARE AND MEDICAID BENEFITS FOR DUAL ELIGIBLE: A LOOK AT 15 STATE DESIGN CONTRACTS FUNDED BY CMS 9-10 (2011), *available at* <http://kff.org/health-reform/issue-brief/proposed-models-to-integrate-medicare-and-medicaid>.

Connecticut, which proposes to begin with older persons; Massachusetts, which is targeting adults under sixty-five years; and South Carolina, which is focusing on persons with behavioral health needs.⁴³

Despite all the variation in design features, the states have many goals in common. Most states, for example, want to decrease utilization of preventable hospital, nursing home and other high-cost services, and nearly all states have articulated goals concerning unification or streamlining of the administrative processing of the Medicare and Medicaid programs.

VII. CONCLUSION

The health and long-term care of the dually eligible population historically have been characterized by high spending and low quality. A major explanation for this inefficiency has been the lack of care coordination in the payment and delivery of health and long-term care services. As we argued above, in order to ensure meaningful system change, we need to coordinate services at both the payment and the delivery level. In returning to the patient vignettes, imagine Ms. B and Mr. C under an integrated care program that coordinates both the payment and delivery of services. Both beneficiaries would have one insurance card, comprehensive benefits, a coordinated provider team with a dedicated case manager, and a comprehensive, individualized care plan. Most importantly, all of the decisions about their health care and treatment would be made with their needs and preferences in mind. This type of care is achievable for all dually eligible individuals but only with comprehensive reform that addresses the fragmented payment and delivery models currently present in our system. Moving forward, it will be important to track spending and outcomes under the integrated care demonstration and other similar initiatives designed to reform the payment and delivery system for dually eligible individuals.

43. *Id.* at 8.