Integrated Care Organizations: Medicare Financing for Care at Home

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ABSTRACT

OBJECTIVES: As the boomer population ages, there is a growing need for integrated care organizations (ICOs) that can integrate both medical care and long-term services and supports in the home. This paper presents a policy proposal to support the creation of ICOs, redesign care, and provide financing for home- and community-based services (HCBS), with the goal of enhancing financial protection for beneficiaries, coordinating care, and preventing costly hospital and nursing home use.

METHODS: This study used the 2012 Medicare Current Beneficiary Survey (MCBS) Cost and Use File, inflated to 2016 figures, to describe the characteristics of Medicare beneficiaries and their healthcare utilization and spending. The costs of covering up to 20 hours of personal care services a week were estimated using MCBS population counts, participation assumptions based on the literature, and financing design parameters.

RESULTS: A targeted HCBS benefit could be added to Medicare and financed with income-related cost sharing ranging from 5% to 50%, a premium paid by Medicare beneficiaries of approximately $42 a month, and payroll taxes estimated at around 0.4% of earnings on employers and employees.

CONCLUSIONS: Adoption of an HCBS benefit in Medicare would improve financial protection for beneficiaries with physical and/or cognitive impairment and provide the financing for health organizations to better integrate medical and social services. ICOs and delivery models of care emphasizing care at home would improve accessibility of care and avoid costly institutionalization; additionally, it would also reduce beneficiary reliance on Medicaid.

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As the boomer generation ages, a growing number of Medicare beneficiaries will experience difficulty functioning without assistance. The Medicare benefit package was originally aimed at covering acute care, including the cost of hospitalization and short-term postacute care following hospitalization[1]; however, beneficiaries are becoming increasingly in need of long-term services and supports to enable them to maintain independent living. Medicare does not pay for this, nor does it coordinate care across acute and long-term services and supports, and sites of care. Further, it does not provide training and support to care partners, whose assistance is often critical to good health outcomes, adherence to medications and recommended care, and beneficiary functioning.[2]

To address these issues, this commentary presents a policy proposal to finance Medicare home and community-based care, create integrated care organizations (ICOs), and redesign care to deliver both medical and long-term services and supports (LTSS) in the home. Financing home- and community-based care under Medicare and creating ICOs to be accountable for LTSS would provide the incentive and means to coordinate care, support family care partners, and better meet beneficiary preferences for independent living and care at home. Providing Medicare coverage of home and community-based care would reduce beneficiary reliance on Medicaid's safety net coverage.

Beneficiaries With Physical and/or Cognitive Impairment

Based on the Medicare Current Beneficiary Survey for 2012 with population and cost figures inflated to 2016 levels,[3,4] almost one-fourth of the community-dwelling (noninstitutionalized) Medicare beneficiary population has physical and/or cognitive impairment, representing 12 million noninstitutionalized individuals living in the community. **Table 1** describes the demographic, socioeconomic, and health status characteristics of the community-dwelling Medicare population with and without physical and/or cognitive impairment. The population with physical and/or cognitive impairment has disproportionately lower income; 64% have incomes

below 200% of the federal poverty level, with 29% on Medicaid and 35% not on Medicaid. The latter is the group most at risk of not being able to afford care not covered by Medicare.

The overwhelming majority of individuals with physical and/or cognitive impairment have multiple health problems in addition to functional impairment. More than three-fourths of the population with physical and/or cognitive impairment has 3 or more chronic conditions compared with half of the population without physical or cognitive impairment. More than half (53%) of the group with physical and/or cognitive impairment rates their health as fair or poor compared with 17% of beneficiaries without such functional limitations.

TAKE-AWAY POINTS

This paper presents a policy proposal to finance Medicare home- and community-based care, create integrated care organizations (ICOs), and redesign care to deliver both medical and long-term services and supports (LTSS) in the home.

- Financing home- and community-based care under Medicare and creating ICOs to be accountable for LTSS would provide the incentive and means to coordinate care, support family care partners, and better meet beneficiary preferences for independent living and care at home.
- Providing Medicare coverage of home- and community-based care would reduce beneficiary reliance on Medicaid's safety net coverage.

"Medicare Help at Home" Policy Proposal

The policy option we call "Medicare Help at Home" could be offered as a supplement to Medicare, and with financing, it would share the costs across all ages.[5] The policy has 3 elements: 1) a Medicare home and community-based benefit for those with 2 or more functional limitations or dementia, covering up to 20 hours a week of personal care services or an equivalent dollar amount for a range of home and community-based care; 2) creation of new ICOs accountable for the delivery and coordination of both acute and long-term services and supports that meet quality standards, honor beneficiary preferences, and support care partners; and 3) innovative models of healthcare delivery, including a team approach to care in the home, building on models of service delivery that improve patient outcomes, reduce emergency department (ED) use, prevent avoidable hospitalizations, and delay or reduce long-term institutional care.

Medicare Home and Community-Based Benefits

Those eligible include Medicare beneficiaries with serious physical and/or cognitive impairment, such as limitations in 2 or more activities of daily living or a diagnosis of Alzheimer's disease or other forms of dementia. Beneficiary functional limitation would be assessed by organizations designated by Medicare and individualized care plans developed based on beneficiary preferences (or those of a legal guardian) and the degree and nature of functional limitations. All enrollees would complete an advance directive indicating preferences regarding end-of-life care.

Under this proposal, Medicare's current home health and hospice benefits would continue. The new home- and community-based benefit, however, would not have the restrictions that apply to home health services, such as being limited to homebound beneficiaries who require skilled nursing care, physical therapy, occupational therapy, speech-language pathology services, or hospice services that require giving up treatment for the beneficiary's terminal condition (other than pain and symptom management). Instead, the home- and community-based services benefit would permit palliative care in the home and personal care services that help beneficiaries maintain independent living.

For modeling purposes, we assume that 60% of eligible beneficiaries would receive the maximum benefit (full year, 20 hours per week) of personal services and 40% would receive partial benefit for care (either partial year or partial support, averaging 10 hours a week).[6] The cost is estimated at $15 per hour, plus an additional 33% allowance for fringe benefits and overhead. For the maximum benefit of 20 hours per week, the cost amounts to $400 per week, or $20,800 a year. Beneficiaries (or their legal guardians) could, however, elect to use a portion or all of their allowance on other approved home and community services. Beneficiaries could select their own paid personal attendant ("consumer-directed care"), including family members other than their legal guardian.

Beneficiary Financial Responsibility

Coinsurance based on income would range from 5% for beneficiaries with incomes below 150% of the federal poverty level (FPL) to 15% for incomes between 150% to 199% of the FPL, 25% between 200% to 399% of the FPL, and 50% for incomes 400% of the FPL or greater.

Estimated Cost and Financing

Based on take-up rates in other programs, such as Medicaid and Medicare Part B, it is estimated that 75% of those eligible for the home care benefit who are not already on Medicaid would participate each year—6.3 million of a total eligible population of 8.5 million.[7] Beneficiary coinsurance, which varies with income (as outlined above), would cover an average of 20% of the total cost of the benefit. As illustrated in **Table 2**, we estimated that the total program costs with these participation assumptions—net of beneficiary cost-sharing payments—would be around $82 billion a year.

Financing through a combination of Medicare beneficiary premiums (25%) and payroll taxes (75%) is suggested to share the costs over the life span and across Medicare beneficiaries with and without physical and/or cognitive impairment. The required premium to cover one-fourth of the cost would amount to about $42 a month. The remaining 75% of the cost of the benefit—$61

TABLE 1. Characteristics of Community Dwelling Medicare Beneficiaries by Physical and/or Cognitive Impairment

Medicare Community Dwelling Beneficiaries	Without PCI	With PCI	Total
Overall	77%	23%	100%
Overall number (millions)	41.5	12.4	53.9
Characteristics			
Age, years			
<65	13%	28%	17%
65-74	52%	27%	46%
75-84	26%	25%	26%
≥85	9%	20%	11%
Income relative to poverty			
<100%	15%	25%	17%
100%-149%	15%	23%	17%
150%-199%	13%	15%	14%
200%-399%	34%	26%	32%
≥400%	23%	10%	20%
<200% FPL not on Medicaid	30%	35%	31%
Insurance coverage			
Medicare only	9%	10%	9%
Medicaid	14%	31%	18%
Medigap	14%	11%	13%
Medicare Advantage	26%	23%	25%
Employer	37%	26%	34%
Chronic conditions			
0	8%	2%	7%
1-2	42%	20%	37%
3-5	44%	56%	47%
≥6	6%	22%	9%
Self-reported health status			
Excellent	21%	5%	17%
Very good	33%	14%	29%
Good	29%	27%	29%
Fair	13%	32%	17%
Poor	4%	21%	8%
Living arrangement			
Alone	29%	29%	29%
Spouse	53%	42%	50%
Children/family	9%	16%	11%
Other	9%	13%	10%

FPL indicates federal poverty level; PCI, physical and/or cognitive impairment. Source: Medicare Current Beneficiary Survey cost and use file 2012[4] inflated to 2016 population, nursing home residents excluded.

billion—could be financed through an increase in the payroll tax. This could be split evenly on employers and employees, with each contributing 0.4% of earnings.[8]

Integrated Care Organizations

ICOs that both meet the current requirements for accountable care organizations (ACOs) and agree to be accountable for the delivery and coordination of medical care and LTSS, would be authorized under the Help at Home proposal. Beneficiaries would receive reduced cost sharing on their Medicare Help at Home benefit if they enrolled in an ICO, and ICOs would receive financial incentives for reduced long-term institutional placement subject to meeting quality targets and reporting on quality and other performance metrics. ICOs would be responsible for supporting family care partners, including training, respite, and other support services (eg, mental health services).

Care Delivery Innovation

ICOs would be encouraged to incorporate promising models of care using a team approach to care found to improve patient outcomes, as well as reduce the use of EDs, hospitalizations, and long-term institutionalization.[9] This could include, for example, Independence at Home, a model of home-based primary care using home-based primary care teams directed by physicians and advanced practice nurses.[10] The Hospital at Home program provides hospital services within the patient's home to avoid the necessity of admission for patients presenting at the ED or ambulatory clinic with pneumonia, exacerbations of chronic heart failure, chronic obstructive pulmonary disease, or cellulitis.[11]

ICOs would also be encouraged to adopt innovative models of care delivery that help maintain independent living. For example, CAPABLE (The Community Aging in Place, Advancing Better Living for Elders), which uses an interdisciplinary team consisting of a nurse, occupational therapist, and a handyman, has been shown to improve functioning as defined by activities of daily living.[12] MIND (Maximizing Independence for Dementia patients) at Home, which uses memory care coordinators supervised by a geriatric psychiatrist and nurse, has been found to enable participants to safely stay in their homes.[13]

Impact on Beneficiaries

The proposal would benefit Medicare beneficiaries who face the challenge of serious physical or cognitive functioning. It could improve access to home and community long-term services and supports, reduce the financial burden of out-of-pocket costs, and assist family care partners. Beneficiaries with physical and/or cognitive impairment now face serious financial burdens. As shown in **Table 3**, twice as many Medicare beneficiaries with physical and/or cognitive impairment spent over 10% of their income on out-of-pocket spending for medical services compared with those

TABLE 2. Medicare Help at Home Cost/Impact Estimates by Beneficiary Income[a]

	Community Dwelling, PCI Not on Medicaid					
	<100%	100%-149%	150%-199%	200%-399%	≥400%	Non-Medicaid
Beneficiaries with PCI (thousands)	922	1693	1601	3051	1191	8457
Assume 75% participate	691	1269	1201	2288	893	6343
Maximum annual benefit	$20,800	$20,800	$20,800	$20,800	$20,800	$20,800
(Assume 60% full benefit; 40% half benefit)						
Total cost ($M)	$11,215	$20,595	$19,480	$37,123	$14,495	$102,908
PCI coinsurance	0.05	0.05	0.15	0.25	0.5	
Beneficiary payments ($M)	$561	$1030	$2922	$9281	$7247	$21,041
Medicare payments ($M)	$10,655	$19,565	$16,558	$27,842	$7247	$81,867
Financing						
Premium 25% ($M)	$16,373					
Premium monthly	$41.60	Assumes 75% of all beneficiaries purchase benefit				
Payroll tax financed 75% ($M)	$61,400					
Employer and employee contribution	0.40%	Estimate based on CBO estimates that 1% payroll tax in 2016 would generate $77 billion				

$M indicates dollars in millions; CBO, Congressional Budget Office; PCI, physical and/or cognitive impairment.
[a]Population estimates have been inflated to 2016 levels of enrollment according to the National Health Expenditure figures provided by CMS.[3] CBO payroll tax estimate CBO options.[8]
Source: Authors' estimates based on PCI beneficiary and poverty counts from the Medicare Current Beneficiary Survey, 2012.[4]

without physical and/or cognitive impairment (33% vs 18%). In particular, the proposal could be expected to reduce the high out-of-pocket costs Medicare beneficiaries now spend on long-term services and supports.

Medicaid does not cover two-thirds of those with physical and/or cognitive impairment. As a result, the cost of such services poses barriers to care access and represents a major financial burden on beneficiaries with modest incomes. By intervening before beneficiaries become impoverished by the purchase of home and community services, and moving to long-term nursing facilities, this proposal could achieve savings by reducing the number of Medicaid enrollees. The innovative delivery options that would be adopted by ICOs can be expected to yield significant savings in reduced hospitalizations and ED use.

Caveats and Limitations

Several important caveats should be noted. First, the numbers of Medicare beneficiaries will grow over time, including those with physical and/or cognitive limitations, subsequently increasing the cost of care over time. Some Medicaid beneficiaries may opt for coverage under Medicare rather than Medicaid given serious restrictions on eligibility and home- and community-based benefits in many states. Further, there may be adverse risk selection with beneficiaries at greater risk of requiring LTSS being more likely to participate than those with lower risk. Low-income individuals with lower cost sharing are also more likely to participate than high-income beneficiaries who are required to pay 50% of the cost of services. However, the fact that there is a severe penalty for

TABLE 3. Utilization and Spending Among Medicare Beneficiaries With and Without Physical and/or Cognitive Impairment[a]

	Non-PCI	PCI
≥10% of income on OOP	18%	33%
≥20% of income on OOP	8%	17%
Average total OOP	$2010	$3576
Average total spending	$12,267	$25,954
Utilization (% using services)		
SNF	2%	8%
Home health	11%	43%
Facility	1%	4%
Average number of events[b]		
SNF stays	1.3	1.5
Home health days	72	125
Facility stays	1.2	1.1
OOP spending[b]		
SNF OOP	$787	$1118
Home health OOP	$40	$941
Facility OOP	$14,076	$8995
Total spending[b]		
SNF	$15,380	$18,012
Home health	$1200	$2562
Facility	$34,462	$36,209

OOP, out-of-pocket; PCI, physical and/or cognitive impairment; SNF, skilled nursing facility.
[a]Population figures[4] are inflated to reflect 2016 population. Income has been inflated using the Consumer Price Index. Medical spending has been inflated to 2016 dollars using the National Health Expenditure tables provided by CMS.[3]
[b]Of those who had an event.
Source: Medicare Current Beneficiary Survey cost and use file, 2012.

failing to enroll at the time of Medicare eligibility, and the substantial financing provided by payroll taxes are likely to be significant deterrents to forgoing the benefit, as has been the experience with Part B of Medicare.

Conclusions

ACOs will increasingly grapple with the need for LTSS among their aging patients. Financing home- and community-based services under Medicare and expanding ACOs to be accountable for LTSS would provide the incentive and means to coordinate care, support family care partners, and better meet beneficiary preferences for independent living and care at home. It would also reduce beneficiary reliance on Medicaid's safety net coverage of institutional care. This policy proposal is worthy of serious consideration as the nation grapples with the need for Medicare redesign to meet the needs of an aging population. It could serve as an important first step toward more far-reaching Medicare benefit redesign proposals to improve the affordability of services. Unlike Medicare's original focus on inpatient hospital care, it recognizes that many services can be provided in noninstitutional settings, including the home, and realigns benefits to provide care in a way that meets beneficiary preferences. ■

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