Modernizing Medicare’s Benefits to Meet the Needs of Beneficiaries - Especially Low-Income, Complexly Ill Beneficiaries

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APPAM Fall Research Conference: Medicare’s Future Panel
Saturday Nov. 14, 2015 8:30 AM
Miami, Florida

10/6/2015

Abstract:

Medicare was originally designed based on 1965 private health insurance benefits to protect beneficiaries from the financial burdens of acute episodes of care. Now outdated, Medicare’s core benefits have high cost-sharing with no limit on out-of-pocket costs. Although prescription drugs were finally added in 2006, this requires purchase of a separate private plan as well as purchase of private coverage to fill-in Medicare cost sharing. The resulting coverage of acute care services is fragmented and complex. Moreover, although substantial shares of Medicare beneficiaries have long-term cognitive and physical impairment, Medicare does not provide supportive services to live at home or in community settings. Low-income beneficiaries not eligible for Medicaid are particularly at risk for not being able to afford care when needed or to navigate complex care system and insurance restrictions. Looking to strengthen Medicare’s future, this paper presents several options that would modernize Medicare benefits and potentially provide a foundation for spurring and supporting innovations in the healthcare insurance and delivery systems.

OVERVIEW

For 50 years, Medicare has provided a stable, trusted source of health insurance that provides basic access and financial protection for elderly and disabled beneficiaries.¹ The program has directly contributed to sharp declines in mortality and longer life expectancy for those 65 and older. Medicare has also enhanced quality of life by providing rapid access to treatment and relief from pain for acute care conditions. Yet, Medicare’s core benefit design remains modeled on private health insurance as of 1965 with separate hospital and medical care benefits and no limit on out-of-pocket costs. Moreover, Medicare benefits focus on acute care episodes despite the fact that as lifespans have expanded there are growing numbers of beneficiaries with significant chronic conditions, cognitive and physical impairments.

Today 54 million people – 17 percent of the population - rely on Medicare with the projection that Medicare will grow to cover one-fifth of the population by 2024 as the population ages and baby boomers become eligible.² An estimated 20 million Medicare beneficiaries live on income below 200 percent of poverty with, at best, limited assets to last their lifetimes. Yet, current low-income provisions are limited, fragmented and complex, and fall far short of provisions now in place for under-65 low-income individuals and families with the Affordable Care Act.
This paper focuses on the need to modernize Medicare’s benefit design and low income provisions to improve access, care and financial protection. As background, we first describe current Medicare policies and present data on financial burdens for health expenses by poverty groups, documenting the need for to modernize benefits and expand current low-income policies. Looking beyond the current scope of benefits, we profile the estimated 9 million beneficiaries with cognitive or physical impairments and discuss current barriers to affording, finding and coordinating longer-term services to support them at home or in their communities.

We then outline three illustrative policy options that together could modernize Medicare’s benefits provide a more secure foundation for the future that would enhance access and financial protections. The three options include:

- Offer a new Medicare sponsored plan choice that would provide an integrated set of benefits including prescription drugs, with reduced cost sharing and a new limit on out-of-pocket costs. The design could include positive incentives to choose high-value care by lowering cost-sharing for primary care and high-value provider networks. The new plan option would be available through Medicare for an extra premium, eliminating the need to purchase private supplemental coverage.

- Extend subsidies for Medicare’s premium and cost-sharing for beneficiaries with incomes up to 200 percent of poverty on a sliding scale that aligns with policies in place for the under-65 population with the Affordable Care Act.

- Implement a new benefit option for beneficiaries with complex care needs, including community services, care coordination, and enhanced support for family care-givers. Eligibility would be restricted to those severely impaired living in the community. The option could be piloted before opening to the target group.

We discuss how the illustrative policies could reinforce each other and position Medicare to be a stimulus for innovation in the broader health insurance and healthcare delivery system. As a companion payment reform paper points out, modernized Medicare benefits would also position Medicare to be a potential insurance option for the under-65 population through insurance marketplaces.

As the single largest purchaser of medical care in the country, Medicare plays a critical role not only for beneficiaries but also as a stimulus for change in insurance and delivery systems. Accounting for more than one-fifth of total national health expenditures and an even greater share of hospital revenue, Medicare’s benefit and payment decisions directly influence delivery systems across the country. Modernizing Medicare’s benefit policies thus offer the potential to benefit all families well as Medicare’s aging and disabled beneficiaries.

**BACKGROUND: THE NEED FOR BENEFIT AND LOW-INCOME REFORMS**

**Medicare’s Current Benefits**

Insurance coverage for Medicare beneficiaries is currently provided through a complex, fragmented combination of Parts A, B, and D for hospital care, physician services, and prescription drugs, and supplemental private insurance, or Part C for those opting for private plan...
coverage. As Exhibit 1 details, Part A includes a $1,216 deductible per hospital episode and cost-sharing for longer hospitalization or nursing home stays following hospital discharge. Part B has an annual premium that amounts to $1,259 per year per person (couples pay two premiums). Beneficiaries pay an annual Part B deductible and open-ended coinsurance of 20 percent for physician care (including doctors when hospitalized), physical therapy, outpatient care, and durable medical equipment (DME.) There is no limit on out-of-pocket costs for such cost sharing.

![1: Current Medicare Benefits, 2015](image)

Beneficiaries must buy a separate policy for prescription drug coverage. Known as Part D, this is supplied through private plans for a premium that averages $440 a year. The premium costs as well as drug formularies and cost-sharing designs vary widely, with use of cost-sharing tiers. Beneficiaries in need of specialty drugs or multiple medications can face substantial costs.

Supplemental coverage to fill in Medicare’s cost sharing, known as Medigap, is costly. Premiums average $2,000 a year per person just to pay for Part A and B cost-sharing – and Medigap premium costs are often higher. Despite high premiums, Medigap plans limit the scope of services to Medicare benefits, excluding dental, hearing aids, and long term care. Medigap coverage comes with high-overhead cost: administrative costs and profit margins absorb 20 percent of premiums on average. 4

Beneficiaries may also opt-out of traditional Medicare to enroll in a private Medicare Advantage (MA) plan. These plans must cover core Medicare benefits, but they can cover more. Some, for example, offer limited vision and hearing services. MA plans offer a more integrated design in return for restricted provider network choices. A decade ago, such plans offered much
lower-cost sharing than Medicare. However, in recent years cost-sharing in MA plans has increased substantially.\textsuperscript{5} Similar to Medigap plans, Medicare Advantage plans do not cover long-term care services and support.

**Low-income provisions and role of Medicaid**

The poorest Medicare beneficiaries may be eligible for full Medicaid in which Medicaid pays Medicare’s premium and cost-sharing and covers an expanded scope of benefits for dental, hearing, and long term care. Beneficiaries must have income below poverty in most states and assets of no more than $2,000 if single and $3,000 if a couple for full Medicaid (Exhibit 2). Beneficiaries at higher income levels may spend-down into Medicaid for full coverage if they incur high medical care expenses.

<table>
<thead>
<tr>
<th>2: Current Low-Income Policies for Medicare Beneficiaries: Complex and Fragmented</th>
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<tr>
<td>• Full Medicaid up to poverty varies by state</td>
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<tr>
<td>– Assets limit: $2,000 single; $3,000 couple</td>
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<tr>
<td>• Medicare savings programs</td>
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<td>– Administered by Medicaid</td>
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<td>– Asset limit: $7,160 individual; $12,750 couple</td>
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<td>– 100% poverty: Medicaid pays Medicare premium + cost sharing</td>
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<td>– 100 to 135% poverty: help with Part B premium only</td>
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<tr>
<td>• Medicare Part D sliding scale to 150% poverty - premium and benefits</td>
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<td>– Asset limit: $13,300 individual; $26,580 couple; lower for full premium subsidy</td>
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<td>– Administered by Medicare</td>
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Medicare beneficiaries may also have partial-Medicaid under provisions known as Medicare savings programs. For those with income up to poverty and assets of no more than $7,290 single or $10,930 if a couple, Medicaid will pay for Medicare’s Part B premium and cost sharing for Medicare benefits. Beneficiaries with incomes up to 135 percent of poverty ($1,345 a month single/$1,813 couple) and meeting the same asset test receive subsidies to pay the Medicare Part B premium but no help with cost sharing. To receive such help, beneficiaries must apply to state Medicaid programs. Including those with full Medicaid benefits, an estimated 9.6 million Medicare beneficiaries have “dual” coverage. The majority have full Medicaid – including long term care and other services beyond Medicare (Exhibit 3).
Low-income beneficiaries apply separately to Medicare for Part D subsidies. Part D provisions subsidize both premiums and cost-sharing on a sliding scale up to 150 percent of poverty. Eligibility is also limited to those with assets of no more than $13,300 if single and $26,580 if a couple.

These provisions are complex and fragmented. Low-income beneficiaries must apply separately to Medicaid for help with Medicare premiums and cost-sharing and to the federal government for Part D extra help. Separate administration of prescription drug benefits by private plans also undermines coordination of care and integration of information about care for beneficiaries seeing multiple providers for multiple conditions.

Notably, Medicare’s low-income provisions fall far short of reforms under the Affordable Care Act for the under-65 population. The ACA eliminates assets tests and provides substantial premium and cost-sharing subsidies up to 200 percent of poverty. And the ACA expands eligibility for Medicaid to 138 percent of poverty for participating states. 6

High Financial Burdens

The patchwork quilt of private supplemental coverage and fragmented, limited low-income provisions are confusing for beneficiaries and incur high administrative costs. Importantly, current low-income and benefit policies also fail to limit out-of-pocket costs and ensure adequate financial protection, especially for beneficiaries with low incomes and/or serious health problems.
Reflecting gaps in benefits, cost-sharing and premiums costs, an estimated one-in-four of all beneficiaries and 40 percent of beneficiaries with incomes below 200 percent of poverty spent 20 percent or more of their income on health care and premium costs in 2014. As Exhibit 4 illustrates, burdens were high for all poverty groups below twice the poverty level.

![Diagram](image)

Source: Analysis of 2010 MCBS updated to 2014.

Excluding premiums, 11 million beneficiaries (one in five) spent at least 10 percent of their annual incomes on medical care services despite having Medicare and often supplemental coverage (Exhibit 5). The risks of being underinsured were highest for those with low-incomes – one-third spent 10 percent or more of their income on medical care expenses, including groups within the income range of Medicare’s low-income provisions.
The medical care cost burdens reflect limits on the scope of Medicare coverage – not just Medicare’s cost-sharing. Only one third of low-income beneficiary out-of-pocket expenses were for Medicare Part A or B services and another 14% for prescription drugs. Nearly half was for long-term care services beyond Medicare’s benefits (Exhibit 6).
**Beneficiaries with Complex Care Needs**

Such burdens reflect Medicare’s historic focus on acute care and the limits of current Medicare benefit design for those with multiple chronic conditions and complex care needs requiring longer-term services and support to live independently. We estimate that 9 million Medicare beneficiaries living in the community have significant physical or cognitive impairment, indicating they require complex care including long-term services and supports to live at home or outside of an institution.

Roughly two-thirds of those with complex care needs have low or modest incomes. Although Medicaid covers home and community based services, less than a third of complex care beneficiaries are covered by Medicaid (Exhibit 7). One third with low incomes and complex care needs are not on Medicaid, leaving them at risk of being unable to pay for supportive care, exhausting their and family resources, and turning to nursing home care.

Not surprisingly, beneficiaries with complex care needs and low-income who are not on Medicaid are at high risk of spending a substantial share of their incomes on healthcare. Their average annual spending amounted to 39 percent of their incomes in 2010 compared to 7 percent of those with complex care needs who were dually eligible for Medicaid (Exhibit 8).
Even beneficiaries who can afford to pay for non-covered services can find it challenging to identify and coordinate care, with little support for family care-givers. To the extent such supports are available, physicians, nurses and other more traditional medical care providers may not know of or be able to make informed recommendations regarding community services such as senior day care centers, respite care or other personal care providers.

Complex care patients with cognitive or physical impairments frequently also have chronic conditions, often multiple conditions (Exhibit 9). Unless care is well coordinated with teams managing care across sites of care, there is a high probability of medical error or conflicting treatment care plans, including adverse drug-drug interactions.
Such complexly ill beneficiaries incur high acute care costs. Medicare, despite its limits on scope of benefits, spent more than twice as much on average for complex-need beneficiaries than for those without such limitations in 2010. As a group, these beneficiaries account for 32 percent of Medicare spending on community-dwelling beneficiaries although they represent just 17 percent of beneficiaries.

Current Medicare limits make it difficult to design care that best meets needs for acute much less longer-term care. Medicare does not cover social services that might be essential for independent functioning if the services are not deemed acute care and medical in nature. Further, Medicare does not enable substitution of home or community care for more costly medical care nor broadly support models that integrate home care and acute care such as the Hospital at Home model of care.

Across the care system, handoffs from one setting to another are often poor, with needs assessments repeated as medical records fail to move with patients. And multiple providers typically do not work with each other to develop care plans – leaving patients or their family members the task of making choices among potentially conflicting regimens and coordinating care. At the same time, there is little information about what services might be available.

As life spans lengthen, a significant share of beneficiaries is living with multiple chronic diseases in addition to physical or cognitive limitations. There is evidence that well-coordinated care spanning a range of services can prevent more costly institutional and specialized care.
Given the high costs for Medicare and Medicaid, cost burdens plus health risks for beneficiaries, developing a complex care benefit targeted on those most at risk has the potential to improve the performance on healthcare delivery system and to generate savings that could partly offset improved care for those at risk.

**ILLUSTRATIVE POLICY OPTIONS TO MODERNIZE MEDICARE BENEFITS AND LOW INCOME PROVISIONS**

The three illustrative policy options described below would separately improve core Medicare benefits to avoid the need for supplemental coverage, provide enhanced financial security for low and moderate income beneficiaries, and begin to address the complex care needs of those with significant health impairments to support living at home or in the community. If enacted together or phased as part of a broader strategy, the policies could modernize Medicare and provide a platform to spur improved care at lower costs.

**Medicare Essential: A New Integrated Benefit Option**

Modernizing Medicare’s core benefit design by offering an option sponsored by Medicare with integrated benefits and a limit on out-of-pocket costs for all covered services would avoid the need for supplemental coverage. Such an approach would reduce complexity for beneficiaries and lower administrative costs now incurred by private plans, generating premium savings for beneficiaries now buying supplemental coverage. Importantly, an integrated design would also enable Medicare to incorporate value-based incentives that reduce cost-sharing for beneficiaries selecting high-value services or receiving care from high-quality, lower-cost providers. Such benefit flexibility would complement payment policies to promote primary care, coordination and care system innovations.

Exhibit 10 displays an illustrative benefit design for what we call a ‘Medicare Essential’ option. The design would limit annual out-of-pocket expenses and have one deductible that exempted preventive care, primary care, and prescription drugs. There would be no cost-sharing for hospital care after the deductible. For physician care, patients would pay copayments for primary care, specialists, and emergency department use. Cost sharing for other Part B services would be reduced from Medicare’s current 20 percent to 10 percent. A new over-all limit on out-of-pocket costs for covered services would include prescription medications. The option we modelled set the limit at $3,400 and deductible at $250.
Beneficiaries selecting this option would pay an extra premium calculated to fully finance the enhanced benefits. The extra premium would be combined with Part B – with a single monthly payment covering Parts A, B and D benefits in an integrated insurance plan.

We estimate the extra premium for this new option, with drug benefits, would come to $85 a month in 2014 in addition to Part B. At this level, the option would offer a lower cost, simpler alternative to purchasing Medigap and Part D plans. Compared to Medigap plans with the greatest number of enrollees (plan F), beneficiaries would experience significant savings in premiums (about $1,500 a year) although with somewhat higher-cost sharing.

This option would likely have the greatest appeal to beneficiaries currently selecting Medigap plans, with incomes of 200 percent of poverty or higher. The option would also provide an integrated alternative and new competitor for Medicare Advantage plans.

**Expanding Protection for Low-Income Beneficiaries**

Those with low-incomes, who are not currently buying Medigap, however, would likely see the extra premium cost of Medicare Essential as beyond their budgets. For beneficiaries not fully eligible for Medicaid, expanding premium and cost-sharing subsidies to 150 or 200 percent of poverty would reach the population at risk due to health and income. If designed to align with protections under the ACA for people under 65, the expansion would also ease and simplify transitions as people age into Medicare.
An illustrative option would expand subsidies for Part B premiums up to 200 percent of poverty on a sliding scale using ACA premium subsidy thresholds as guides. At the same time, Medicare would institute a new out-of-pocket limit and lower cost-sharing for Medicare benefits for beneficiaries with incomes from 100 to 200 percent of poverty (Exhibit 11). Following the ACA, the policy would eliminate the asset test – simplifying the application process.¹⁰

In modeling a potential approach, we set the out-of-pocket limit to $2,000 and used the Medicare Essential design of coinsurance and cost-sharing. This approach would come close to the actuarial value for low-income benefits for those under 200 percent of poverty under the ACA.¹¹

To simplify the application process, Medicare would administer the expanded subsidies along with Part D subsidies. The policies could draw on existing federal administrative processes for determining income and avoid a separate application to Medicaid.

We estimate that if Medicare Essential and such low income provisions were enacted together, the combined impact would reduce the share of beneficiaries spending 20 percent or more of their income on premiums plus medical care costs from 25 to 15 percent. While low-income beneficiaries would see the most significant change, higher-income beneficiaries would also gain with the more integrated Medicare Essential option assuming those with Medigap switched coverage (Exhibit 12).
Developing a New Medicare Complex Care Benefit

Neither Medicare Essential nor the low-income expansion described above would expand the scope of Medicare’s current benefit package. Addressing the needs of older adults with complex care needs would require a new benefit that included essential non-covered services and enabled a flexible approach to care plans. Such a benefit would target beneficiaries with physical or cognitive impairment or multiple chronic conditions receiving care that spans acute and social services. The target group would also likely be those with incomes too high to qualify for full Medicaid (Exhibit 13).
Starting with a pilot program, Medicare could sponsor teams employed by complex care organizations with the authority to deliver a range of services including home care and to develop care plans and coordinate care. Such organizations could be paid, in part, with the new chronic care coordination fee Medicare began offering in January 2015. The complex care organizations could also be eligible to share in savings.

The scope of benefits would be flexible. Similar to what France does for chronically ill, the care plan would be tailored to individual needs. Authorized complex care organizations could waive certain provisions of Medicare that limit the mix of services. This could include waiving requirement of 3 days of hospitalization before nursing home care – when the patient needs a temporary respite from home but not hospital care. The organizations could also have greater flexibility in selecting home or hospital-based rehabilitative care.

A well-designed benefit and effective care team would provide enhanced support for independent living and could reduce duplication across sites of care. There is the potential that such a targeted benefit could generate savings for Medicare and Medicaid. One example is the Maximizing Independence at Home model serving people with various forms of dementia which has yielded savings by reducing and delaying nursing home placement.

To finance the new benefit, Medicare could assess a fee on a sliding scale relative to income. Higher income beneficiaries with complex care needs could pay most of the cost of extra benefits. Since any expansion of benefits, even if well targeted, could lead to higher Medicare costs there would likely be a need to pilot such a benefit. This would help determine
how to structure payments from higher-income families to cover the cost of their care while establishing sliding scale copayments for low and moderate income individuals. 14

CONCLUSION

Medicare’s current fragmented benefit design, inadequate subsidies for low-income beneficiaries, and acute care focus, make it difficult to meet the needs of sicker, frail beneficiaries for longer-term services, put beneficiaries at risk for high cost burdens, and undermine coordination of care. Risks are particularly high for those living on low or modest incomes and those afflicted with debilitating mental and physical impairments.

*Modernizing Medicare’s core benefit design*

Offering an integrated benefit option in traditional Medicare would simplify coverage, lower premium costs, and avoid the need for private supplements. An integrated benefit design would also allow Medicare to introduce positive incentives to select high-value care and care systems, aligning incentives with payment policies that encourage better care outcomes and lower costs. This would depend on the Medicare program being given the authority to incorporate lower-cost sharing based on the value of services as recommended by the Medicare Payment Advisory Commission (MedPAC) in a recent report.15 Enabling such a flexible benefit design would strengthen Medicare’s already significant role in providing a national platform to improve health system performance for the entire population. Such an integrated option would help traditional Medicare achieve savings and compete with Medicare Advantage plans. The dynamic could build on the comparative advantage of both public and private insurance, with healthy competition between the two.

In a companion paper on payment policies, we further discuss how such an integrated option could make it possible to offer Medicare as an option to the under-65 population on insurance exchanges. Such an option would increase choice, enhance the purchasing power of Medicare and streamline payment and reporting policies for providers.16 Medicare Essential would be a critical first step toward such marketplace integration across lifetimes and would expand choice.

*Expanding low-income protections and new complex care benefit*

Based on analysis by income group, expanding current premium and cost-sharing subsidies well beyond poverty will be necessary to ensure financial protection. Doing so would also ease transitions as under-65 adults with low-income age into Medicare or become eligible due to disability.

Currently, out-of-pocket expenses hit subgroups of Medicare beneficiaries particularly hard. A combination of more integrated core benefits, expanded low-income provisions and a new coordinated care benefit would lower out-of-pocket burdens and enhance access to care. By avoiding the need to buy supplemental private coverage and simplifying current administrative
processes there is the potential to reduce overhead costs and redirect spending toward needed care. For those with complex care needs, this would include supportive home care not covered by Medicare.

**Looking Forward**

The population is aging. In 2011 the oldest members of the boomer generation born after World War II became eligible for Medicare. By 2030 an estimated 20 percent of the U.S. population will be age 65 and older – up from 13 percent in 2010. And the share 85 and older will climb from 3.7 percent of the population in 2010 to 5.0 percent in 2030 and 7.4 percent in 2050. This in part reflects the fact that life expectancy today at age 65 is 5 years longer than it was before Medicare.

As the boomer generation reaches their mid-70s, we can expect an increasing prevalence of physical and cognitive limitations and that the issue of the adequacy of Medicare benefits for beneficiaries with complex care needs will become a central policy issue. Medicare beneficiaries and their families will become more familiar with the limited options for care of those who require assistance as a result of frailty, multiple chronic conditions, or need supervision as a result of cognitive impairment from Alzheimer’s or other causes, as well as the cost burden of paying for such services.

Dr. Atul Gawande’s book *Being Mortal* eloquently documents the gulf between the way in which Americans age and die and what they most prefer. We pour enormous sums of money into extending life by even a few days or a few months – with chemotherapy, surgery, and intensive care while at the same time declining to support families and friends trying to care for each other in their homes and communities – whether that is palliative care at home, personal care services for those no longer able to function without assistance, home modification or supportive housing that is easier to navigate, or support for caregivers to help those with complex needs be safe and cared for in a familiar setting while continuing independently to make the day-to-day decisions.

The way we finance health and long term services and supports undermines our ability to coordinate care or support those with complex needs to live at home or in the community. Modest and middle-income Medicare beneficiaries are not eligible for Medicaid. Even higher income individuals who would pay for such services often find it difficult to find and arrange for reliable, high quality personal care individualized to the needs of those with complex care needs.

The U.S. has the opportunity to learn from several other countries that have implemented more integrated social and acute care and innovative models of care teams. Medicare’s development and implementation of a targeted coordinated care benefit would stimulate the spread of care systems able to care for those with multiple conditions within the United States.
The aging of the boomer generation is likely to generate considerable public pressure for action by Congress and a new Administration in 2017 to modernize Medicare’s benefits with a more integrated creative core benefit and enhanced support for coordinated delivery of acute and long-term services and supports for beneficiaries with complex care needs. The three illustrative options described in this paper suggest a direction to move forward.

At a time when Medicare expenditures per beneficiary are growing more slowly, policy officials are likely to postpone fundamental changes to Medicare. This provides a window to test innovative approaches and assess an array of options with systematic analysis. By starting the discussion now to address future Medicare challenges, the policy debate will be better grounded, and informed on ways to build on rather than undermine the impressive record of accomplishments since Medicare’s enactment in 1965.20

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2 CMS, NHE Projects. Table 1 and 17, Updated June 2015
9 Analysis based on MCBS 2010 inflated to 2014.
11 G. Claxton and N. Panchal, *Cost Sharing Subsidies in Federal Marketplace Plans*, Kaiser Family Foundation, Feb 11 2015.  The ACA specifies low-income OOP limits can be no higher than $2,250 a year.  This brief finds limits are much lower – averaging $881 for the near –poor and $1,700 for those with incomes between 150 and 200% of poverty.  We used $2,000 for both groups for simplicity.
14 For a longer discussion of design issues see M. Moon et al. Serving Adults with Complex Care Needs, Commonwealth Fund July 2015.


