



# Health Policy Brief

JUNE 13, 2012

## Care for Dual Eligibles. Efforts are afoot to improve care and lower costs for roughly 9 million people enrolled in both Medicare and Medicaid.

### WHAT'S THE ISSUE?

Medicare and Medicaid are the main government programs that provide health insurance to a range of individuals, including the elderly, people with low incomes, and those with certain disabilities. The programs have different funding sources, covered benefits, and management systems.

People who qualify for benefits under both programs, some nine million beneficiaries, are commonly referred to as “dual eligibles.” They frequently have multiple chronic conditions and more than half have cognitive or mental impairments. Yet because of the separate nature of Medicare and Medicaid, care provided to the “duals” is often poorly managed.

The Affordable Care Act created a new Medicare-Medicaid Coordination Office within the Centers for Medicare and Medicaid Services (CMS) in an attempt to make the two programs work together more effectively. The office is testing various approaches to doing so. This brief describes those efforts and the debate over how they should be structured and how likely they will be to lower costs.

### WHAT'S THE BACKGROUND?

Medicare and Medicaid were established to meet the unique needs of different populations. Medicare is a federal health care program that provides benefits to the elderly and

to certain people with disabilities, regardless of income. Medicare covers acute care services, such as hospital stays; postacute services, such as home health services and skilled nursing facility stays; and physician visits and prescription drugs. It does not provide coverage for long-term services and supports.

In contrast, Medicaid is a federal and state program that provides coverage to people with low income and limited resources, who also fall into certain eligibility groups, such as children, pregnant women, or aged or disabled adults. Medicaid covers both acute and long-term care services (institutional and community services), but benefits vary by state. The program is funded by a combination of federal and state dollars with no or minimal cost sharing for beneficiaries.

**DUAL ELIGIBLES:** Inevitably, a number of Americans are eligible for both programs, and over the years Congress created additional ways to connect the two programs for the benefit of other individuals.

Of the nine million Americans who are covered by both Medicare and Medicaid, two-thirds are people age 65 or older and the rest are under 65 and disabled. In some cases, individuals with low incomes on Medicaid age into coverage on Medicare, becoming eligible for both programs when they reach 65. In other cases, a Medicare beneficiary may qualify for Medicaid because of a change in financial resources, including incurring substantial

health care expenses, often referred to as a “spend down.” Those already receiving Medicaid benefits may fulfill the two-year waiting period to become eligible for Medicare based on disability status or could age into the program.

In 2008 dual eligibles constituted 20 percent of Medicare beneficiaries and accounted for 31 percent of Medicare spending. Dual eligibles account for just 15 percent of Medicaid beneficiaries but 39 percent of Medicaid spending (Exhibit 1).

# 9 million

## “Dual eligibles”

The number of people who qualify for benefits under both Medicare and Medicaid.

Dual eligibles are much poorer and have greater health needs than other Medicare beneficiaries. More than half have annual incomes of less than \$10,000, while only 8 percent of all other Medicare beneficiaries are as poor. Dual eligibles are also more likely to be disabled; live in an institution, such as a nursing home; and report poor health status. Dual eligibles are considerably more likely than other Medicare beneficiaries to suffer from chronic health conditions, such as diabetes, chronic lung disease, and Alzheimer’s disease.

Roughly a quarter of dual eligibles receive help from Medicaid only in paying their Medicare premiums, and sometimes cost sharing. They do not receive additional services under Medicaid. The rest, who are so called full-benefit duals, qualify to receive full Medicaid benefits, such as nursing home and other institutional care, home care, dental care, mental health services, eye care, and transportation to and from providers. Medicaid also covers these enrollees’ Medicare cost sharing. Medicare is the primary payer for most acute care services received by these patients, but Medicaid may cover additional services after Medicare coverage has been exhausted—for example, if the Medicare limit on inpatient days has been exceeded.

**LACK OF COORDINATION:** Qualifying for both Medicare and Medicaid benefits helps lower the financial barriers that patients face in receiving needed care but also introduces complexity. For example, a physician with a primarily Medicare practice may not be familiar with home or community-based services available under Medicaid. And patients may be confused when transitions from one care setting to another, such as from the hospital to a nursing facility, shift program coverage and requirements.

In addition, providers may have an incentive to shift costs from one program to the other, which can lead to greater fragmentation in care. Patients, for example, may be shifted from a nursing home, where Medicaid is paying the benefits, to a hospital, where Medicare pays, mainly to maximize provider reimbursement.

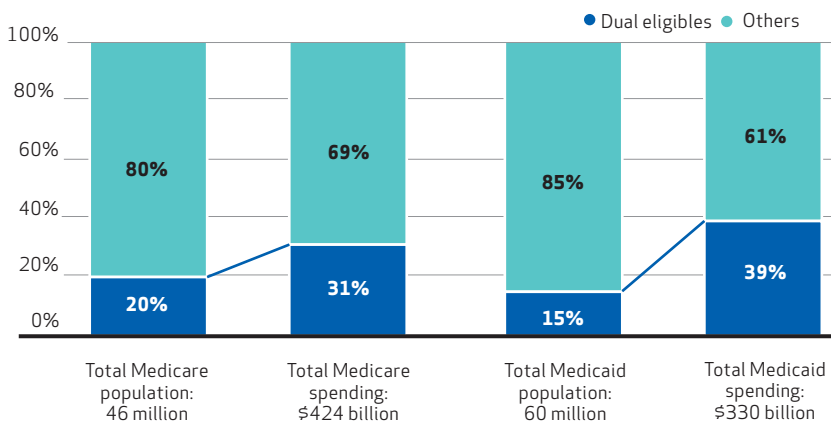
In the best case scenario, care would be coordinated such that patient needs and preferences were understood, and different providers treating the same patient would share information. This would reduce the risk of medication interactions, avoid duplication of services, and avert unnecessary hospitalizations.

Better coordinated care may improve health outcomes and satisfaction with care for dual-eligible beneficiaries, and result in lower costs to federal and state governments. The most likely direct benefit of better coordinated care would be a reduction in the need for acute care services, primarily hospitalizations, by providing treatment earlier and in lower-cost settings. CMS estimates that 45 percent of hospitalizations of dual eligibles from either Medicare skilled nursing facilities or Medicaid nursing facilities in 2005 could have been avoided.

**MANY CHALLENGES:** However, improving care coordination is administratively challenging. For example, care coordination may increase costs under one program—such as by increasing use of home and community-based support services under Medicaid—while saving money under another, such as reducing Medicare financed hospitalizations. There is

### EXHIBIT 1

#### Dual-Eligible Beneficiaries: Enrollment and Spending in Medicare and Medicaid, 2008



**SOURCES** Kaiser Family Foundation analysis of the Centers for Medicare and Medicaid Services (CMS) Medicare Current Beneficiary Survey Cost and Use File, 2008; Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from fiscal year 2008 Medicaid Statistical Information System and CMS Form 64.

# 45%

## Hospitalizations potentially avoided

CMS estimates 45 percent of dual-eligible hospitalizations could have been avoided in 2005 if care had been better coordinated.

**“Dual eligibles are much poorer and have greater health needs than other Medicare beneficiaries.”**

little incentive for states to invest in initiatives that produce savings primarily to the federal government.

Currently, fewer than 100,000 beneficiaries are in plans that coordinate care across the two programs. Some Medicare managed care plans, called “special needs plans,” are directed to groups of people who have specific chronic conditions or who are institutionalized. The most common type is directed to dual eligibles; more than 80 percent of beneficiaries enrolled in a special-needs plan are also eligible for Medicaid benefits. Beginning in 2013 special-needs plans offering Medicare benefits to dual eligibles will be required to also contract with the state to provide Medicaid benefits. (See the [Health Policy Brief](#) published June 15, 2011, for more information on Medicare managed care plans, known as Medicare Advantage.)

### WHAT'S UNDER WAY?

Medicare and Medicaid policies have traditionally been developed by separate groups within CMS. The new Medicare-Medicaid Coordination Office created by the Affordable Care Act is now working closely with another new group within CMS, the Center for Medicare and Medicaid Innovation, to develop new approaches to improving care for dual eligibles.

The new office has also identified opportunities to reduce conflicting requirements between the two programs, including reducing or eliminating differences under Medicare and Medicaid in coverage of durable medical equipment, home health services, and behavioral health care, as well as creating common enrollment and appeals processes and other requirements. CMS has invited public comment on these opportunities and requested ideas for future improvements.

The Medicare-Medicaid Coordination Office and Center for Medicare and Medicaid Innovation have three initiatives under way to develop or test new approaches to care coordination. In the first initiative, 15 states received grants of up to \$1 million to design new models for coordinating care for dual eligibles, and CMS will work with states to implement the models with the most promise.

In the second initiative, called the Financial Alignment Demonstration, CMS will test two models to better integrate primary, acute, behavioral health, and long-term services and

allow states to share in savings from these improvements. Twenty-six states, including the fifteen states awarded demonstration design contracts, have developed proposals for this demonstration. These two models are as follows:

- **Blended rate.** One model pays select health plans a prospective blended rate to provide both Medicare and Medicaid benefits to dual eligibles. The payment rate is expected to be below what the state and federal governments would otherwise have paid for the beneficiary's care, resulting in savings to both levels of government.

- **State coordination.** The second model allows states to take responsibility for coordinating the beneficiary's care, which will continue to be paid for by Medicare and Medicaid on a fee-for-service basis. Under this model, states could qualify for performance payments if quality and Medicare savings targets are met.

The third initiative aims to reduce avoidable hospitalizations among nursing facility residents. CMS will partner with physician practices and care management organizations to implement evidence-based interventions that reduce hospitalizations, such as improved processes to identify and respond to changes in patient health status.

### WHAT'S THE DEBATE?

There are several areas of concern over how best to proceed. For example, should all dual eligibles be enrolled in managed care plans? Which program—Medicare or Medicaid—should take the lead? How uniform should the approaches be for all duals? And how realistic will the actual cost savings be?

**MANAGED CARE:** Some observers see managed care plans as having the best potential to coordinate care for dual eligibles. America's Health Insurance Plans, a trade association, emphasizes the experience that managed care plans have with key elements of improved care, such as patient education, medication monitoring and adherence, and transitions between care settings, such as from a hospital back to a patient's home. The National Commission on Fiscal Responsibility and Reform (the Bowles-Simpson Commission) estimated that enrolling dual eligibles in Medicaid managed care plans would save \$12 billion through 2020.

# <100,000

## Beneficiaries under coordinated care

Currently, fewer than 100,000 dual-eligible beneficiaries are in plans that coordinate care across the two programs.

**“Qualifying for both Medicare and Medicaid benefits helps lower the financial barriers that patients face in receiving needed care but also introduces complexity.”**

Budget pressures are leading many states to embrace managed care approaches. For example, Texas and California will require some or all dual-eligible beneficiaries to enroll in managed care plans for their Medicaid benefits. On the Medicare side, current law prohibits mandated enrollment in managed care programs.

Some point out that few health plans have experience caring for the complex needs of the dual-eligible population. Historically, dual eligibles have been less likely than other Medicare beneficiaries to enroll in Medicare Advantage plans, perhaps finding these plans less appealing because they already received help from Medicaid with Medicare cost sharing and coverage gaps. Furthermore, health plans may not market to dual eligibles because their care delivery systems are not focused on serving individuals with complex medical needs, who may require the services of specialized providers.

Beneficiary advocates question whether Medicaid or Medicare plans have the expertise to fully coordinate the complex care and diverse needs of the dual-eligible beneficiaries and to achieve savings comparable to those seen for other patient groups. Despite high Medicaid managed care enrollment, most of these enrollees are children or younger adults who have less intense health care needs than the dual-eligible population. For example, 73 percent of children receiving Medicaid reported being in excellent or very good health, compared to 16 percent of older Medicaid beneficiaries.

**TAKING THE LEAD:** The three initiatives described above focus on creating incentives for state Medicaid programs to improve care coordination. Some experts recommend the opposite approach, which is having Medicare take the lead. Doing so would recognize the fact that the federal government is the primary payer of services for dual eligibles and could lead to a consistent national approach to improving care for this vulnerable population, they say.

Policies to improve care coordination could differ depending on which program is leading the initiative. A recent analysis by the Kaiser Family Foundation and Urban Institute highlights differences in use of services by groups of dual eligibles. The beneficiaries most costly to Medicaid are those who are institutionalized. Those most costly to Medicare are those using substantial acute care services because

of chronic conditions. Thus, efforts to improve care coordination for high-cost Medicaid beneficiaries might be directed at nursing homes, while care coordination for high-cost Medicare beneficiaries would be better directed to keeping patients healthier and out of the hospital.

**CHALLENGE OF COST SAVINGS:** The amount of money that can be saved through care coordination remains to be seen. An analysis by Randall S. Brown and colleagues at Mathematica Policy Research examined 4 of 11 programs that were part of the Medicare Coordinated Care Demonstration that ran from 2002 to 2008. Their analysis found that these programs succeeded in reducing hospitalizations among high-risk enrollees through such interventions as meeting frequently with patients or speaking with them by telephone, and providing strong medication management and comprehensive care to transition patients back home after being discharged from hospitals. If organizations could find cost-effective ways to deliver these interventions, Brown and colleagues found the approaches could save money overall for Medicare.

A study by the Congressional Budget Office (CBO) illustrates just how difficult it is to achieve cost savings under the Medicare fee-for-service program when treating beneficiaries with complex medical needs similar to those of dual eligibles. CBO analyzed results from six demonstration projects, testing various forms of disease management or care coordination. It found that although the interventions reduced hospitalizations, the resulting savings were less than the cost of providing the additional services.

## WHAT'S NEXT?

States had until May 31, 2012, to submit proposals under the Financial Alignment Demonstration. As part of the review process, CMS is putting each proposal out for a 30-day comment period. CMS expects the demonstration to start January 1, 2013, although states may request different start dates. States interested in participating in the demonstration beginning January 1, 2014, will be expected to notify CMS of their intention in the fall of 2012.

More than 300 organizations indicated that they intended to apply for the initiative to reduce hospitalizations among nursing facility residents. Selected projects are expected to begin in August 2012 and run for four years. ■

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