6 | Dual Eligible Beneficiaries

Overview

Low-income older adults and people with complex needs who are eligible for both Medicare and Medicaid are sometimes referred to as "dual eligible." An estimated 12 million dually eligible beneficiaries were enrolled in Medicare and Medicaid in 2019. Dually eligible individuals are typically low-income individuals over 65, or those diagnosed with End-Stage Renal Disease (ESRD) or another disability. They often experience socioeconomic vulnerability and have various complex care needs, such as multiple chronic conditions, functional limitations, and behavioral health conditions. This group typically represents the highest need, and highest cost beneficiaries within both programs. Therefore, policies directed at this population should in theory have a high impact in reducing costs and improving care, but in reality are very complicated to design and implement; any policy change would involve altering two very large government programs.

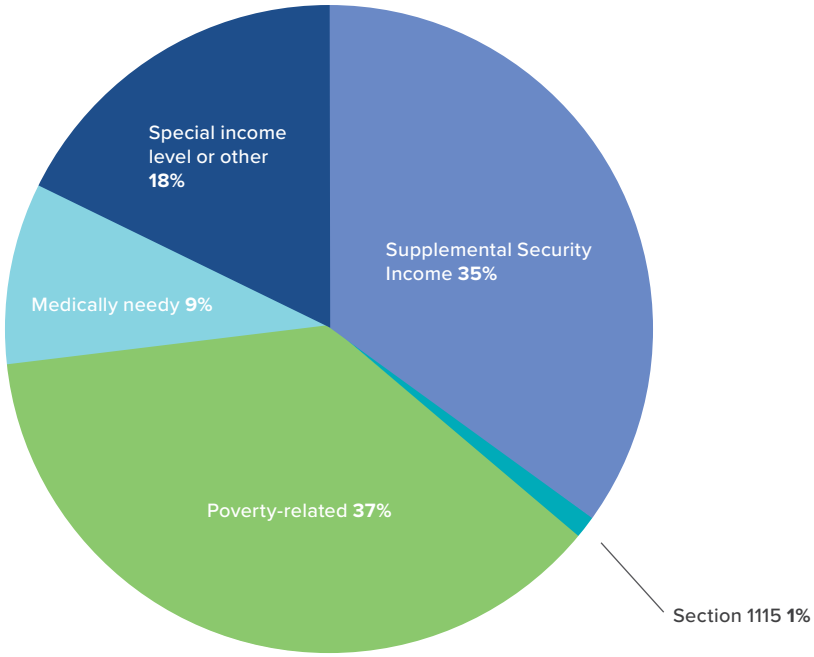
Generally, Medicare covers medical services for dual-eligible beneficiaries, and Medicaid covers certain services not provided by Medicare, including long-term services and supports (LTSS) and some

behavioral health benefits. Medicaid also offers financial assistance to these low-income beneficiaries to pay Medicare premiums and cost-sharing. Federal and state policymakers have long grappled with strengthening coordination between Medicare and Medicaid to improve quality and outcomes for dual-eligible beneficiaries and reduce both programs' costs. That said, there is significant diversity within the duals population. Further, because meaningful change in this area requires policymakers to make changes to both Medicare and Medicaid, dual eligible-focused policies require careful consideration of both programs as well as the populations' characteristics. *See Chapter 2 of this Handbook for more information on Medicare and Medicaid programs and the basics of health care coverage.*

Eligibility

For an individual to be dually eligible for both Medicare and Medicaid, they must meet the statutory criteria for both programs. Medicaid eligibility varies by state, which means a Medicare beneficiary might be dually eligible in one state, but not in another. There are two broad dual eligibility groups. *Partial benefit dual eligible individuals* are those only eligible for assistance paying for some of their Medicare premiums and cost-sharing. *Full benefit dual eligible individuals* qualify for help paying for all Medicare cost-sharing and premiums, as well as for the full range of Medicaid benefits. The partial benefit eligibility category is further broken out by the level

Fig 6.1 Share of Dually Eligible Population by Medicaid Eligibility Pathways



Source: "Eligibility." Medicaid and CHIP Payment and Access Commission. 2018. Available at http://allh.us/k4Ug.

of cost-sharing and premium assistance people are eligible for. The federal government sets income and asset floors for each of these categories; however, states have the flexibility to provide support above these levels, and many do.

Individuals become eligible for the Medicare program through one of three pathways: Age, ESRD, or disability. Medicare provides health insurance coverage to nearly all adults over age 65 and younger individuals who qualify through other conditions. To be eligible for Medicare based on a disability, an individual must have a history of contributing to the Medicare program through payroll tax, and a qualifying medical condition. Individuals with disabilities may qualify for Medicare based on their own work history or based on a spouse's or parent's work history. Roughly 42% of dual eligibles qualify for Medicare through the disability criteria.

Individuals become eligible for the Medicaid program based on federal requirements that states must follow (mandatory eligibility categories), or based upon additional requirements that states may choose to cover (optional eligibility categories) (See Fig 6.1).

Benefits

Medicare benefits include inpatient hospital care, skilled nursing facility care, home health care and hospice care (Part A), physician and other ancillary services in an outpatient setting (Part B), and coverage of prescription drugs (Part D). Medicare Part A and B benefits are offered through traditional fee-for-service or private managed care plans (Part C Medicare Advantage), and Part D is administered through managed care plans. The benefits may include service limitations and a requirement for individual financial participation through premiums, copays, and deductibles.

The Medicaid program provides additional services not covered by Medicare, including long-term stays in a nursing home. The Medicaid program may provide extra benefits at the discretion of each state, such as home and community-based services (HCBS) or transportation services, that Medicare does not cover. The Medicaid program also provides additional financial support for Medicare premiums, copays, and deductibles of individuals dually eligible for both programs.

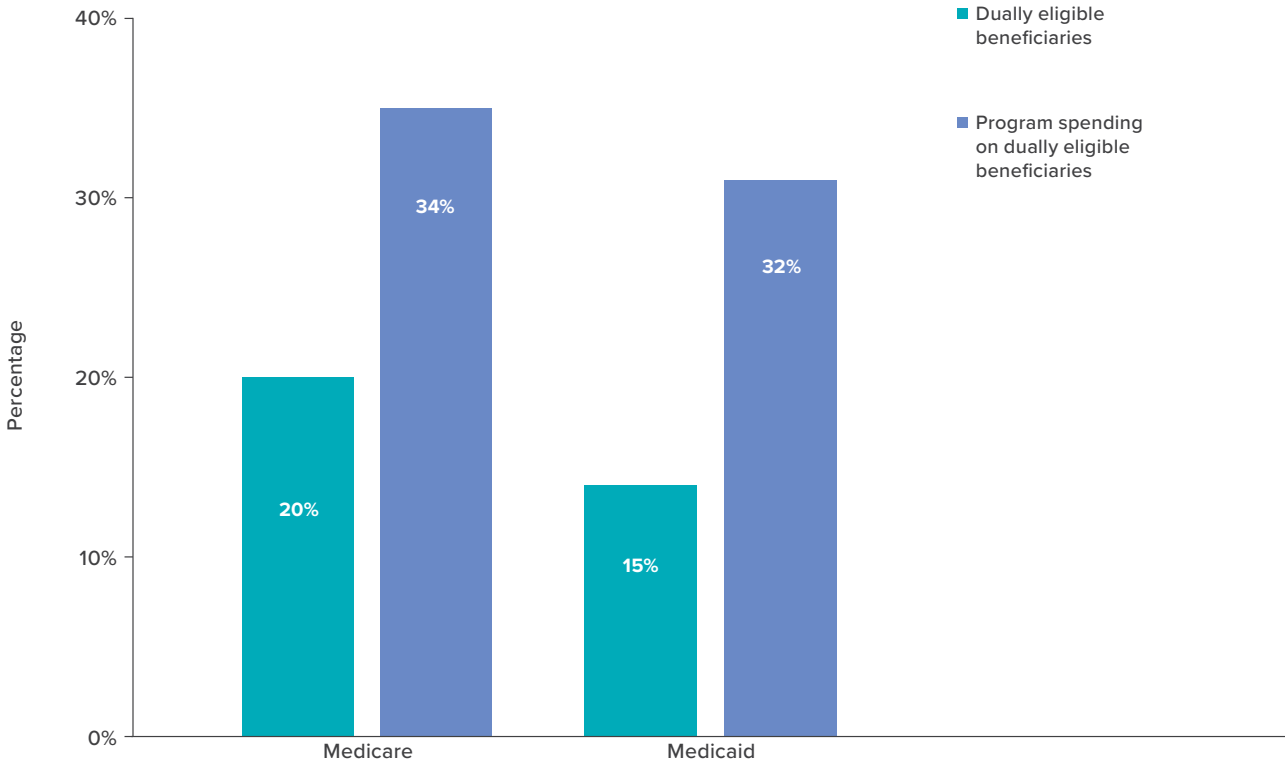
Divisions between the two programs may compromise patient care by complicating coordination across providers. For example, a patient's acute care provider paid by Medicare may have difficulty accounting for or following up on their patient's chronic or non-medical needs, covered by Medicaid. This disconnect is particularly challenging in periods of care transition, such as, for example, when a patient has a hospital stay (Medicare) before being discharged to their home or institution where they may need LTSS (Medicaid).

Additionally, different program rules can create stress, administrative burden, and waste for beneficiaries around the coordination of benefits. Cost-shifting across the two programs – and the different levels of government that take the lead on each program – is a persistent issue. Appeals processes also differ between the two programs, as do care coordination and coverage for services that allow beneficiaries to transition back to the community after an inpatient stay. The lack of program alignment and fragmented coverage also means that one program may not take actions that would result in savings in the other program – and there can be incentives to cost shift. Last, cost-sharing policies differ across states, with studies indicating that beneficiaries in states with higher cost-sharing face access issues. Finding ways to provide more integrated benefits and services to these individuals in a more cost-effective manner is a perennial challenge for policymakers.

The Demographics and Economics of the Dually Eligible

In 2019, 12.3 million individuals were enrolled in Medicare and Medicaid. Dually eligible individuals have several demographic characteristics that distinguish them from non-dual Medicare beneficiaries. Dually eligible individuals are more likely to be female and persons of color, be in poor health, experience more activity of daily living (ADL) limitations, and are more likely to be

Fig 6.2 Dually Eligible Beneficiaries as a Share of All Medicare and Medicaid Beneficiaries and Spending by Program (2013)



Source: "Integrating Care for Dually Eligible Beneficiaries: Background and Context." The Medicaid and CHIP Payment and Access Commission. June 2020. Available at http://allh.us/wk9e.

living alone or in a facility. They are also prone to have social risk factors that lead to poor health outcomes, including homelessness, food insecurity, lack of transportation, and low health literacy levels.

Individuals dually eligible for Medicare and Medicaid account for a disproportionate amount of the spending in those programs (See Fig. 6.2). In the calendar year 2013 (which is "the most recent year of comprehensive data for both programs" according to MACPAC, as data completeness and accuracy are a perennial issue), combined spending on dually eligible individuals was $312.4 billion (See Fig. 6.3). Of that total, 62% was from the Medicare program.

Beyond some of the characteristics outlined above and the eligibility pathways that all dual beneficiaries must meet, there is significant diversity within the population that limits simplistic policy solutions. A dually eligible individual may be a person under 65 with a disability living in the community who only needs a limited amount of HCBS, or a relatively healthy low-income senior who needs additional financial assistance provided by the Medicaid program to pay for Medicare coverage. An individual who is dually eligible may be under 65, profoundly disabled, and living in a facility, or a frail elder with numerous health conditions requiring significant attention.

The Challenge of Two Programs Serving One Population

For federal and state policymakers facing budgetary challenges, the disproportionate cost of dually eligible individuals will continue to drive efforts to address the challenges of providing efficient, quality care to those individuals. This is of increased importance to state policymakers as the Medicaid program will have many individuals who similarly utilize extensive services but are not dually eligible. The focus of policy solutions continues to be on integrating care across the services provided by both programs (particularly acute care and LTSS) as well as ones that will have the highest impact in reducing costs and improving care to the most medically needy, high cost individuals.

The Impact of Long-Term Services and Supports

Long-Term Services and Supports (LTSS) differs from both acute and post-acute care services and can range from a home health aide assisting someone with activities of daily living for a couple of hours a day (an example of HCBS) to intensive nursing care for persons needing 24-hour supervision (an example of institutional care).

The Medicare program provides a 100-day benefit for LTSS. The provision of LTSS for both dually eligible individuals and Medicaid beneficiaries without Medicare falls mainly to the states and the Medicaid program. The expense of the LTSS benefit is significant for state Medicaid programs. Nationwide, the LTSS benefit accounts for 32% of Medicaid spending. In Iowa, New Hampshire, and North Dakota, the LTSS benefit accounts for more than half of all Medicaid spending in each state. These spending trends drive states to seek creative solutions to provide HCBS and potentially delay the use of the more expensive institutional benefit.

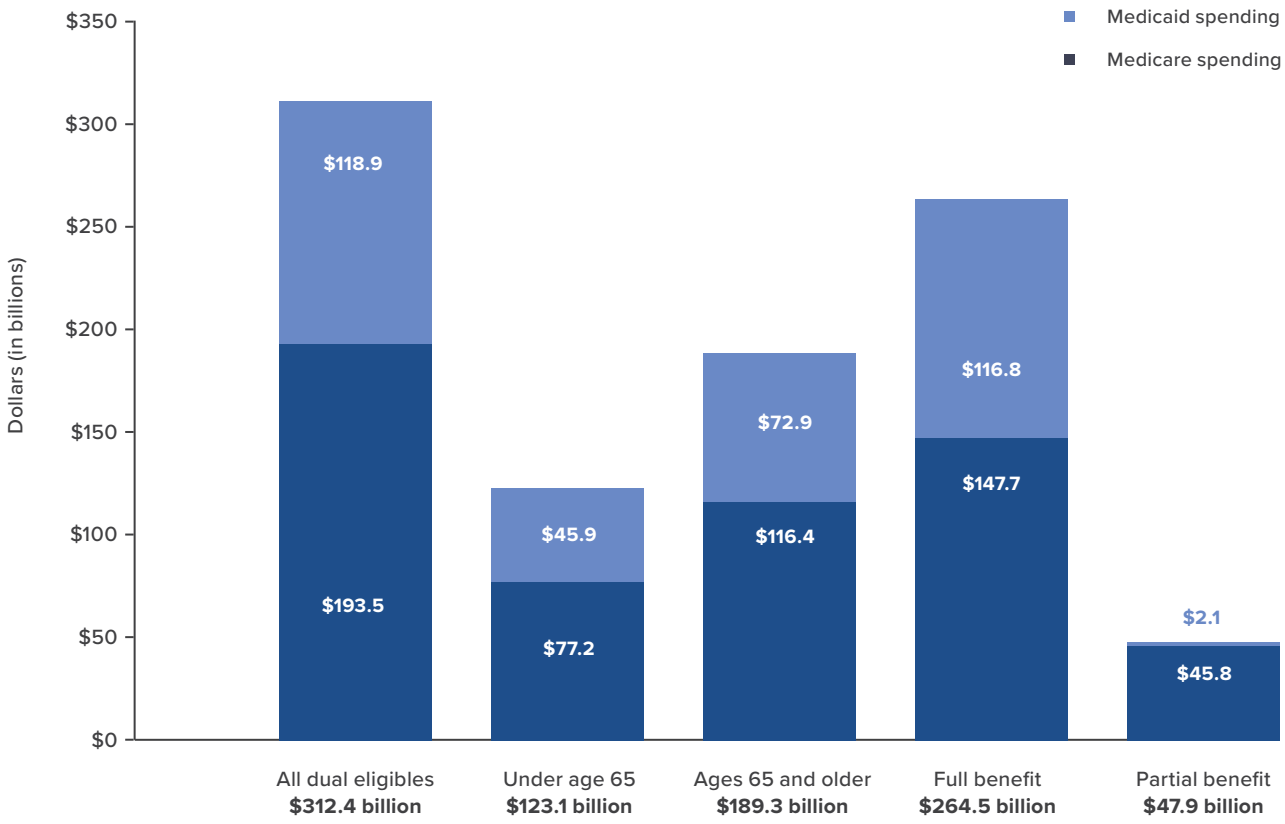
The Challenge of Behavioral Health Integration

An additional challenge faced by states in treating the dually eligible population is the simultaneous need for behavioral health services (including mental health and substance use care). Medicare beneficiaries age 65 and over are increasingly likely to report having a behavioral health disorder, and Medicare beneficiaries under 65 are significantly more likely to need behavioral health services.

Those patients needing behavioral health services are also more likely to need treatment for a chronic physical condition. Medicare spending for individuals needing

There is significant diversity within the population that limits simplistic policy solutions.

Fig 6.3 Medicare and Medicaid Spending on Dual-Eligible Beneficiaries (2013)



Source: "Databook: Beneficiaries Dually Eligible for Medicare and Medicaid." Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission. January 2018. Available at http://allh.us/xaJN.

behavioral health services is roughly two times greater than spending for the average Medicare beneficiary.

Efforts at Integration

A significant problem in providing care for the more expensive dually eligible individuals is the complicated nature of the interactions between two separated programs with their own complex set of rules. Much of the work over the last decade has focused on creating mechanisms to better integrate Medicare and Medicaid programs for dually eligible individuals.

In 2010, the Affordable Care Act (ACA) authorized an office within the Centers for Medicare and Medicaid Services (CMS), now known as the Federal Coordinated Health Care Office, or **Medicare-Medicaid Coordination Office** (MMCO). To date, there are three types of integrated models: Financial Alignment Initiative, Dual Eligible Special Needs Plans, and Program of All-inclusive Care for the Elderly.

The **Financial Alignment Initiative** (FAI), a demonstration authorized in the ACA, is testing a capitated Medicare-Medicaid Plans (MMPs) model and a Managed Fee-for-Service (MFFS) model in several states. Early

analyses indicated that the FAI is associated with lower emergency department (ED) use and hospitalizations, but has had mixed impacts on the use of other services, such as nursing facility admissions, and beneficiary experience. Beneficiaries reported varying experiences with care coordinators. In some cases, beneficiaries had not been actively connected to a care coordinator and were not aware they had one. Effects on spending are also unclear, with some studies findings savings to Medicare, but no information on Medicaid. Eleven states are participating in the FAI, and while results have been mixed, there may be discussion in Congress and at CMS about building on the lessons learned from this effort.

Another integration approach has been Medicare Advantage **Dual Eligible Special Needs Plans** (D-SNPs), permanently authorized by Congress in 2018. These managed-care plans target individuals who are dually eligible for both programs and attempt to better coordinate and integrate services. These plans work with both the federal and state government to provide seamless integration of benefits to the beneficiary. An estimated 2.6 million beneficiaries are enrolled in D-SNPs – or 20% of all dual beneficiaries. As a result, there is growing interest in their effectiveness at coordinating benefits and care. Research indicates they are associated with lower rates of hospitalization and readmission. Still, results are mixed on the use of ED and LTSS services – and most studies cannot assess the impact on Medicaid spending.

One approach states take is to implement managed LTSS (MLTSS) programs, a type of managed care plan, and connect it with these D-SNPs to assist with coordination across the two programs. There is limited data on the success of MLTSS, but a growing number of states are employing this strategy.

Program of All-inclusive Care for the Elderly (PACE), permanently established in 1997, is another means of providing comprehensive and integrated care for dually eligible people. PACE offers medical and social services to older adults living in the community (non-institutional). Unfortunately, PACE programs only serve 49,000 beneficiaries or less than 1% of duals in 31 states.

Medicare beneficiaries age 65 and over are increasingly likely to report having a behavioral health disorder.

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GLOSSARY OF TERMS

Activities of Daily Living (ADL): Basic self-care activities that persons must perform on a day-to-day basis to live independently, including eating, bathing, using the toilet, and dressing. The inability to accomplish essential activities of daily living may lead to unsafe conditions and poor quality of life.

Long-Term Services and Supports (LTSS): Range of health and health-related services (including support with ADL) for individuals who lack the capacity due to a physical, cognitive, and/or mental disability or condition.

Multiple Chronic Conditions (MCC): People who live with two or more physical or behavioral conditions that last one year or more and require ongoing care. Common chronic conditions include high blood pressure, asthma and/or COPD, heart disease, and diabetes. MCCs exacerbate symptoms, complicate care plans, and are costly to address. Over 25% of Americans have MCCs, and over 75% of the duals population experience MCCs.

Home and Community-Based Services (HCBS): Care delivery model that allows patients to receive health services in their home or a local setting rather than a typically higher-cost institutional setting. Offerings include intensive, round-the-clock care through more wrap-around services such as caregiver support, home-delivered meals, and employment supports.

RESOURCES

Chapter 6: Dual Eligible Beneficiaries

Listed by the order in which they appear in Chapter 6.

OVERVIEW

People Dually Eligible for Medicare and Medicaid. http://allh.us/RCQv

MACPAC: Dually Eligible Beneficiaries. http://allh.us/73Vn

End-Stage Renal Disease (ESRD). http://allh.us/W4x8

Care Needs for Dual-Eligible Beneficiaries. http://allh.us/VPA7

Overview of Long-Term Services and Supports. http://allh.us/VQuF

Who is the Dual-Eligible Population and Why is Change Needed? http://allh.us/EpXR

ELIGIBILITY

Dually Eligible Individuals – Categories. http://allh.us/4tkw

Who is Eligible for Medicare? http://allh.us/kM3g

MACPAC: Eligibility. http://allh.us/k4Ug

BENEFITS

MACPAC: Home and Community-Based Services. http://allh.us/fy4e

MACPAC: Third Party Liability. http://allh.us/QjXE

Integrating Care for Dually Eligible Beneficiaries: Background and Context. http://allh.us/wk9e

THE DEMOGRAPHICS AND ECONOMICS OF THE DUALLY ELIGIBLE

MACPAC: Dually Eligible Beneficiaries. http://allh.us/73Vn

Data Book: Beneficiaries Dually Eligible for Medicare And Medicaid. http://allh.us/7xyu

Integrating Care for Dually Eligible Beneficiaries: Background and Context. http://allh.us/wk9e

Data Book: Beneficiaries Dually Eligible for Medicare And Medicaid. http://allh.us/7xyu

Medicaid: Data Completeness and Accuracy Have Improved, Though Not All Standards Have Been Met. http://allh.us/hgEN

MACPAC: Dually Eligible Beneficiaries. http://allh.us/73Vn

Duals Demystified: Actions to Drive Quality, Outcomes, and Value for the Dual Eligible Population. http://allh.us/yYWP

Faces of Dually Eligible Beneficiaries: Profiles of People with Medicare and Medicaid Coverage. http://allh.us/4w9a

THE CHALLENGE OF TWO PROGRAMS SERVING ONE POPULATION

MACPAC: Medicaid Spending in Context. http://allh.us/qQC9

THE IMPACT OF LONG-TERM SERVICES AND SUPPORTS

Long-Term Services and Supports Expenditures on Home & Community-Based Services. http://allh.us/TkVU

Who Pays for Long-Term Services and Supports? http://allh.us/g4eF

MACPAC: Long-Term Services and Supports. http://allh.us/kvqr

An Overview of Long-Term Services and Supports and Medicaid: Final Report. http://allh.us/NF3X

Long-Term Services and Supports Rebalancing Toolkit. http://allh.us/PkXM

THE CHALLENGE OF BEHAVIORAL HEALTH INTEGRATION

Behavioral Health in the Medicaid Program – People, Use, and Expenditures. http://allh.us/nuCY

Behavioral Health Care and the Medicare Program. http://allh.us/TjJF

EFFORTS IN INTEGRATION

About the Medicare-Medicaid Coordination Office. http://allh.us/6FGB

Financial Alignment Initiative (FAI). http://allh.us/c9vm

Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps. http://allh.us/ypJc

Integrating Care Through Dual Eligible Special Needs Plans (D-SNPs): Opportunities and Challenges. http://allh.us/fgAk

Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps. http://allh.us/ypJc

Integrating Care for Dually Eligible Beneficiaries: Background and Context. http://allh.us/wk9e

Managed Long Term Services and Supports. http://allh.us/ht6A

Managed Long-Term Services and Supports: Status of State Adoption and Areas of Program Evolution. http://allh.us/YKJe

MACPAC: Managed Long-Term Services and Supports. http://allh.us/evaN

Programs of All-Inclusive Care for the Elderly Benefits. http://allh.us/FnE9

Integrating Care for Dually Eligible Beneficiaries: Background and Context. http://allh.us/wk9e

Box: Glossary of Terms

Overview of Long-Term Services and Supports. http://allh.us/VQuF

Multiple Chronic Conditions Research Network. http://allh.us/rXfC

MACPAC: Home and Community-Based Services. http://allh.us/fy4e

Implications of Inflation Limits. http://allh.us/hBdt