

Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?

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OVERVIEW — *This issue brief describes the characteristics of the population of individuals known as “dual eligibles,” who are eligible for health insurance coverage through both Medicare and Medicaid. It also looks at the differences between “full Medicaid” and “supplemental Medicaid” dual eligibles and the ongoing challenges associated with enrollment and eligibility, integration and coordination, and managed care. The paper presents several examples of integrated care programs designed to better serve the dual-eligible population, including the Program of All-Inclusive Care for the Elderly, Evercare, social health maintenance organizations, and state/federal initiatives such as the Wisconsin Partnership Program, Texas STAR+PLUS, and others. Finally, it considers the implications for dual eligibles of the House and Senate Medicare prescription drug proposals.*

Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?

The group of beneficiaries known as “dual eligibles”—individuals covered by both the Medicare and Medicaid programs—has come under increased scrutiny as the U.S. Congress debates a new Medicare prescription drug benefit and the governors consider options for Medicaid reform. Known for their high cost and complex health needs, dual eligibles have historically been a virtual hot potato in both programs, with neither Medicare nor Medicaid wanting to shoulder the full responsibility. Some efforts to better integrate and coordinate their care have been successful, but, for the most part, dual eligibles are still viewed as a liability to public and private insurers.

Whether the federally administered Medicare program or the state-administered Medicaid program should be responsible for the prescription drug costs of dual eligibles has emerged as an area of major disagreement between the two houses of Congress. The House of Representatives and the Senate each approved legislation in June to establish outpatient prescription drug coverage for Medicare beneficiaries. However, the Senate bill specifically excludes dual eligibles with full Medicaid coverage from the new Medicare drug benefit, leaving state Medicaid programs responsible for their prescription drug costs. Under the House bill, Medicare would become the primary payer for dual enrollees’ prescription drugs. The outcome of this debate has major implications for the federal government, states, and the beneficiaries they serve.

Who are these “dual eligibles” that have generated such controversy? Which of their benefits are covered by Medicare and which are covered by Medicaid? What have been the challenges in serving this population? What federal and state initiatives have been implemented to improve their benefit and care coordination? Finally, what would a Medicare prescription drug benefit mean for them?

BACKGROUND: WHO ARE THE DUAL ELIGIBLES?

The total number of individuals who are considered to be dual eligibles is estimated at about seven million and the group comprises 17 percent of all Medicare beneficiaries and 19 percent of all Medicaid enrollees.¹ In 1999, dually eligible beneficiaries accounted for about \$50 billion in Medicare expenditures (24 percent of total Medicare spending) and \$63 billion

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in Medicaid expenditures (35 percent of total Medicaid spending), making this group the most costly population being served by publicly funded health care programs.²

Health expenditures for the dually eligible population are more than double those of the non-dually eligible. In 1999, total annual health expenditures (including Medicare, Medicaid, private, and out-of-pocket spending) averaged \$16,278 for each dual eligible compared with \$7,396 on average for those who are not dually eligible.³

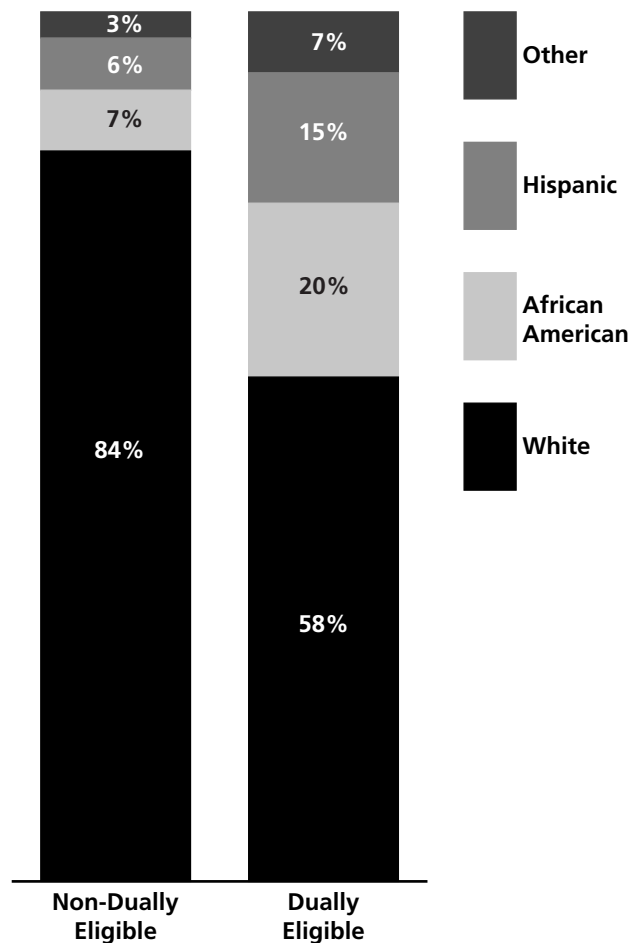
There are a number of characteristics that distinguish dual eligibles from other Medicare beneficiaries:

- The dually eligible population is more likely to be disabled and either younger (under 65) or older (over 85) than the majority of Medicare beneficiaries.
- Over half of the dually eligible population is in poor or fair health, while only one quarter of the non-dually eligible report their health as fair or poor.
- Dual eligibles are much more likely to be female and living alone.
- Dual eligibles are more likely to reside in a nursing facility or other long-term care facility, while the majority of non-dually eligible beneficiaries live at home with their spouses.
- Dual eligibles are more culturally diverse, with over 40 percent representing minority populations (Figure 1).
- Dual eligibles are more likely to suffer from chronic and serious health conditions such as diabetes, pulmonary disease, and stroke.
- Over 40 percent of dual eligibles have a cognitive or mental impairment, compared with 9 percent of non-dually eligible Medicare beneficiaries.⁴
- Dual eligibles tend to have lower education levels (63 percent had less than a high school education) than the overall Medicare population (29 percent) and to have lower incomes.⁵

Because many dual eligibles are in poor health and suffer from chronic conditions, they often use a disproportionately higher share of prescription drugs than other Medicare and Medicaid beneficiaries. While they represent only one in six Medicaid beneficiaries, dual eligibles accounted for nearly half of Medicaid's total spending on prescription drugs in 2002 (\$16 billion out of \$33 billion).⁶ Dual beneficiaries' drug costs average more than \$2,800 per year, while the annual figure for all Medicaid beneficiaries is \$1,240.

Most dual eligibles also have long-term care needs. More than 75 percent have some type of functional limitation, and more than 60 percent cannot

FIGURE 1
Race/Ethnicity of Medicare Beneficiaries, by Eligibility Status, 2000



Source: Centers for Medicare and Medicaid Services.

perform one or more activities of daily living, such as eating, dressing, or bathing. In addition to generating higher health care costs, dual eligibles' more serious and complex medical, social, and long-term care needs require them to navigate within a complicated series of providers and payers that can often hinder access to needed care.

GAPS IN MEDICARE COVERAGE

While the Medicare program serves an important purpose in providing health insurance for the nation's senior citizens, it was not designed as a comprehensive benefit and has failed to meet the range of health needs facing an aging population, especially those with low incomes.

Traditional Medicare consists of two parts. Part A helps pay for inpatient hospital, skilled nursing facility, hospice, and certain home health care services. Part B helps pay for physician services, outpatient services, home health care not covered under Part A, and other services, such as diagnostic tests, durable medical equipment, and some preventive services. In general, individuals age 65 and over and disabled individuals under 65 who are eligible to receive Social Security cash benefits are automatically entitled to Medicare Part A benefits. Participation in Part B is voluntary, but 95 percent of those eligible enroll.

While there is no premium for Part A coverage, beneficiaries are liable for required deductibles, coinsurance, and copayment amounts, which can be quite substantial.⁷ In 2003, beneficiaries must pay an \$840 deductible during the first 60 days for each inpatient hospitalization covered under Part A. For longer hospital stays, beneficiaries face steep daily copayments.⁸ For Part B-covered services, beneficiaries must pay a \$100 annual deductible and a monthly premium (\$57.80 in 2003), in addition to coinsurance of 20 percent for most services. Because Medicare has no stop-loss coverage (that is, no out-of-pocket limit), beneficiaries with chronic health care needs or high medical costs can be held responsible for major cost-sharing expenses.

Medicare provides no coverage for many services and products typically needed by beneficiaries, such as long-term nursing home care, most outpatient prescription drugs, eyeglasses, hearing aides, and routine dental care. The U.S. General Accounting Office estimates that the combination of the cost-sharing requirements and limited benefits leaves about 45 percent of Medicare beneficiaries' health care costs uncovered.⁹ As a result, about 80 percent of Medicare beneficiaries obtain some type of private supplemental coverage to limit their exposure; 11 percent receive this supplemental coverage through Medicaid.¹⁰ In addition, Medicare remains a highly "medical model" insurance program and, therefore, does not cover at-home care or other care (such as personal attendant care, homemaker services, and assisted living) that is provided by nonlicensed providers and is designed to help individuals maintain functioning and remain in the community.

Not designed as a comprehensive benefit, Medicare has failed to meet the needs of an aging population, especially those with low incomes.

SLICING THE PIE: ELIGIBILITY AND BENEFITS

Although this paper discusses the entire group of beneficiaries who are referred to as dual eligibles (also known as “duals”), it is important to note that the term actually encompasses two groups of individuals: (a) “full Medicaid” dual eligibles and (b) “supplemental Medicaid” duals. The majority of dual eligibles fall into the first group, which is made up of individuals who are categorically and financially eligible for both Medicare and Medicaid and therefore receive full benefits under each program. However, because Medicaid is by law the “payer of last resort,” Medicare serves as the primary payer for duplicate benefits. For these full Medicaid dual beneficiaries, Medicaid serves as a wrap-around plan, filling in gaps where Medicare coverage falls short and sometimes providing additional benefits as covered by the Medicaid state plan. An estimated 5.8 million of the nearly 7 million dual eligibles fall into this category.¹¹

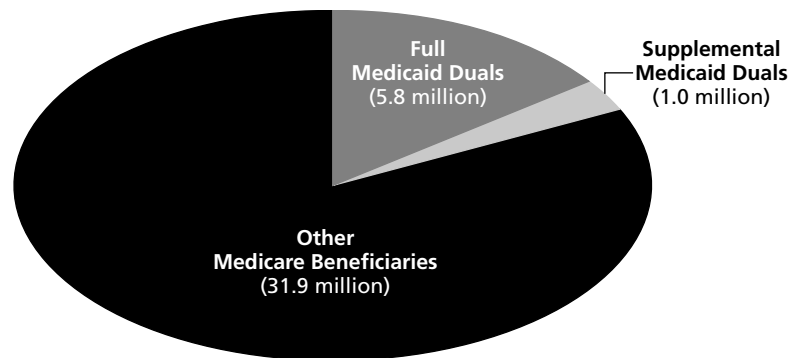
One million additional individuals receive assistance with Medicare premiums and cost sharing but do not receive the full range of Medicaid benefits. For this “supplemental Medicaid” dually eligible population, the Medicaid program supplements Medicare by paying the Part A and/or Part B coinsurance and deductibles on behalf of the beneficiary (in much the same manner as a private Medigap plan). (Figure 2)

“Full Medicaid” Duals

The vast majority of dual eligibles who qualify for full benefits under both the Medicare and Medicaid programs are the frailest population being served by the programs and are more likely to be institutionalized or in need of highly complex care. Consequently, they also constitute the largest share of Medicaid benefits spending as compared to all other Medicaid eligibility groups.

Because the Medicaid program is administered by the states within broad federal guidelines (and financed through a combination of state and federal funding), the eligibility and benefits structures vary significantly across the states. In order to receive federal matching funds, states must adhere to certain minimum standards for eligibility and benefits; they also have the option to provide coverage at higher income levels and offer a wide array of health care services through their Medicaid programs. Therefore, the scope of Medicaid coverage for the elderly and disabled depends on the state—with some states providing more comprehensive eligibility and benefits than others.

FIGURE 2
Medicaid Status of Medicare Beneficiaries, 2000



Source: Kaiser Commission on Medicaid and the Uninsured

Pathways to Eligibility — Medicare beneficiaries become enrolled in the Medicaid program through a variety of eligibility “pathways.”¹² For the elderly and those with disabilities, the two pathways most commonly used are through the Supplemental Security Income (SSI) and medically needy programs:

■ *Supplemental Security Income.* States are generally required to provide Medicaid coverage to elderly and disabled individuals who are receiving cash assistance through the SSI program.¹³ This eligibility pathway, despite its extremely strict income limits—federal minimums are set at 74 percent of the federal poverty level (\$552 per month for an individual, \$829 for a couple in 2003)—enables the lowest-income individuals to receive Medicaid coverage in addition to Medicare. SSI also serves as a crucial, albeit restrictive, connector to Medicaid for individuals with disabilities. Several initiatives are underway to provide flexibility to states in serving this population.

■ *Medically Needy.* Elderly individuals also commonly qualify for Medicaid following either an acute care event (such as a stroke that leads to permanent placement in a nursing facility) or the onset of chronic conditions (such as diabetes and dementia) that result in significant and overwhelming medical expenses. Many of these individuals whose incomes exceed the SSI eligibility limits become dual enrollees through the process of “spending down” to Medicaid eligibility. Thirty-nine states operate an optional eligibility category commonly referred to as a “medically needy” program. When calculating Medicaid eligibility, states take into account an individual’s incurred medical expenses in addition to any income and assets. This is the eligibility “pathway” that is often used for individuals who have extended hospital stays or are moved into a nursing facility or other institutional setting where expenses add up quickly.

Because eligibility for the medically needy program is dependent on incurred medical expenses, individuals who are medically needy may also be more likely to cycle on and off Medicaid. The income limits remain extremely low in most states, so in any given month in which medical expenses are not high, the individual may become ineligible and be disenrolled from the program until the next episode of illness. The complexity and administrative burden associated with this program is one of the many reasons that states have begun to advocate strongly for the federal government to take on more of the financial responsibility for the costs associated with serving dual eligibles.

Benefits — While Medicaid has some significant limitations, the flexible nature of the program has enabled states to adapt their benefits structures to try and meet the changing needs of the elderly and disabled populations. The Medicaid program acts as a wrap-around benefit for Medicare in many areas (Figure 3). Examples of key benefits that Medicaid can provide for low-income elderly and disabled Medicare beneficiaries include the following:

Individuals who are medically needy may be more likely to cycle on and off Medicaid.

FIGURE 3
Benefits Available to Dual Eligibles

MEDICARE	+	MEDICAID		
<ul style="list-style-type: none"> ■ Inpatient hospital ■ Skilled nursing facility care ■ Home health ■ Hospice care ■ Physician services 		Acute Care Services <ul style="list-style-type: none"> ■ Outpatient prescription drugs* ■ Transportation ■ Dental care* ■ Vision & hearing* ■ Medicare cost-sharing 	Long-Term Care <ul style="list-style-type: none"> ■ Custodial nursing facility care ■ Home- & community-based services* ■ Personal care services* 	Wrap-Around Services <ul style="list-style-type: none"> ■ Inpatient hospital ■ Skilled nursing facility care ■ Home health**

* Benefits that are provided at state option.

** Home health care services are mandatory for individuals who are entitled to nursing home care; the services are otherwise optional..

■ *Long-Term Care.* Medicaid generally covers the costs of needed services after Medicare benefits are exhausted. For example, because the Medicare program fully covers only 20 days of care in a skilled nursing facility, Medicaid supplements the cost of the following 80 days of care and takes over the costs entirely after 100 days. Medicare provides no coverage for long-term custodial care (such as help with bathing or dressing). As a result, the Medicaid program finances approximately 50 percent of all care provided in nursing homes.¹⁴ Similarly, Medicaid picks up where Medicare leaves off for inpatient hospital care and home health care. The program also exclusively finances the increasingly popular personal care services and care provided to individuals at home or in the community through home- and community-based services (HCBS) waivers.

■ *Prescription Drugs.* Medicaid covers the costs of virtually all outpatient prescription drugs for dual eligibles.¹⁵ Although prescription drug coverage is an optional benefit under Medicaid, all states currently provide it, at great cost. In 2000, 53 percent of total Medicaid drug spending was for dual eligibles.¹⁶ And since Medicaid costs make up 20 percent of the average state's budget today, nearly all of the states have turned to prescription drugs as a means of containing program expenditures. In fiscal year 2003, 46 states reduced reimbursements for prescriptions, begun requiring prior authorization for certain drugs, instituted preferred drug lists, and increased beneficiary copayments; some have even limited the number of prescriptions per month.¹⁷ The outcome of the debate over prescription drug coverage in Medicare will undoubtedly affect states' approaches to providing pharmacy services to their

Medicaid beneficiaries and will significantly affect the dually eligible population. (See further discussion below.)

■ *Mental Health.* Medicaid's coverage of coinsurance and outpatient services for mentally ill Medicare beneficiaries can be quite substantial because Medicare's coverage of mental health benefits is more limited.¹⁸ For example, while there is no limit on the number of benefit periods that Medicare will cover in a general hospital, Medicare will pay for a total of only 190 days in a psychiatric hospital in a person's lifetime. For most mental-health outpatient services, Medicare beneficiaries must pay coinsurance of 50 percent of the cost (as opposed to the 20 percent coinsurance people with Medicare pay for most other medical services). Moreover, many dual eligibles with mental illnesses use outpatient drugs covered by Medicaid. Medicaid payments for antipsychotic and antidepressant drugs have grown rapidly over the past decade.¹⁹ However, it is important to note that many mental health services are an optional benefit under Medicaid, so seniors are not guaranteed access to needed mental health services even when they are dually enrolled in both Medicare and Medicaid.

■ *Dental, Vision, and Hearing.* The Medicaid program can also finance routine and basic services such as dental, vision, and hearing care for dual eligibles. This coverage has proven to be critical for many low-income seniors who would otherwise go without new eye glasses or needed dental care because they do not have the ability to pay out-of-pocket. However, because these benefits are provided at the states' option for adults, they are not universally available and have been subject to cuts in the past two years as states have looked for ways to make up for severe budget shortfalls.

Supplementing Medicare: Alphabet Soup

To assist Medicare beneficiaries with incomes too high to qualify for full Medicaid but considered too low to afford private health insurance, Congress in 1986 established several Medicare "savings" programs to help with Medicare cost sharing. Today, four programs assist one million Medicare beneficiaries with the cost of Medicare premiums, deductibles, and coinsurance. These programs aid the following groups:

■ *Qualified Medicare beneficiaries, or QMBs (kwim-bees),* have incomes at or below 100 percent of the federal poverty level (\$769 per month for an individual and \$1,030 for a couple in 2003) and limited assets. For this group, the state Medicaid program pays the Medicare Part A and B premiums, deductibles, and coinsurance on behalf of the beneficiary, but the individual does not have access to other Medicaid benefits.

■ *Specified low-income Medicare beneficiaries, or SLMBs (slim-bees),* are individuals who have incomes between 100 and 120 percent of the federal poverty level (up to \$918 per month for an individual and \$1,232 for a couple in 2003) and limited assets and do not otherwise

Many dual eligibles with mental illnesses use outpatient drugs covered by Medicaid.

qualify for full Medicaid benefits. For this slightly higher income group, Medicaid pays only the Medicare Part B premium (\$58.70 per month in 2003) on behalf of the beneficiary.

■ *Qualifying individuals, or QI's (kew-eyes)*, have incomes between 120 and 135 percent of the federal poverty level (\$1,031 per month for an individual and \$1,384 for a couple in 2003) and limited assets. This group receives assistance with the Medicare Part B premium only.²⁰

■ *Qualified disabled working individuals, or QDWIs (kwid-wees)*, are a subset of dual eligibles who can have incomes up to 200 percent of the federal poverty level (\$3,078 per month for an individual and \$4,125 for a couple, including additional earned income disregards) and limited assets. These disabled individuals have not worked enough quarters to qualify for Medicare benefits without paying a premium. Medicaid pays the Part A premium for QDWIs,²¹ but they are responsible for all other Medicare deductibles and premiums.

ONGOING CHALLENGES

Eligibility and Enrollment

Although the number of seniors and disabled individuals who are eligible for both Medicare and Medicaid has increased as the population ages and medical technology advances, many low-income individuals who could benefit from Medicaid coverage are not enrolled. Only about half of all Medicare beneficiaries with incomes below the federal poverty level are enrolled in Medicaid, primarily because of a lack of awareness of the program. In addition, only a handful of states have extended Medicaid coverage up to 100 percent of the federal poverty level, so many poor elderly and disabled individuals do not have access to Medicaid benefits.²² With respect to supplemental Medicaid benefits (through programs targeted at QMBs and SLMBs), studies have found that more than half of low-income seniors who are eligible are not enrolled.

In a Kaiser Family Foundation-funded focus group study of low-income elderly individuals, the findings pointed to a lack of basic information about the program, misperceptions about the eligibility rules, and reluctance to ask for help as the key barriers to enrollment. Seniors also noted difficulty with navigating the Medicaid application and enrollment process and some dissatisfaction with caseworkers assisting them. Interestingly, the majority of seniors became very interested in enrolling in Medicaid once they had a better understanding of the program and its benefits; a "welfare stigma" was not a barrier, according to the focus group participants.²³

Although some states have attempted to implement outreach efforts similar to those that spurred success in enrollment in the State Children's Health Insurance Program (SCHIP), analysts suggest that states and the federal government could better tailor an application and enrollment process to the elderly and disabled population. For example, as with SCHIP, states

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could work to develop applications that are specific to the population being served—in the case of seniors, using larger print, omitting questions about pregnancy and child care arrangements, and offering preprinted recertification forms. In addition, providing an option for mail-in or telephone applications and co-locating eligibility workers in senior centers and assisted living complexes would ameliorate transportation barriers that can be frustrating for seniors.

With respect to enrollment in the supplemental Medicaid programs, health and socioeconomic status appeared to be the driving factors in deterring enrollment. Although still low-income, seniors who opted not to enroll in the QMB or SLMB programs were older (80 or older), more likely to be married, had slightly higher education and home ownership rates, reported being in much better health and were more likely to be enrolled in Medicare managed care or have privately purchased supplemental insurance. This group was also more likely to be Hispanic or Latino and appeared to have less contact with the health care system. The survey also noted that many non-enrolled individuals did not have a usual source of care.

In response to the difficulties facing this population, several initiatives are underway to simplify the application process and target outreach strategies to the dually eligible. For example, the Robert Wood Johnson Foundation maintains a grant program entitled State Solutions that supports efforts to increase enrollment and access to supplemental Medicaid programs.²⁴

Integration and Coordination

Most observers agree that traditional fee-for-service reimbursement has contributed to a fragmented, inefficient health care system that provides care that is rarely coordinated, even among providers receiving payment from the same insurer. For dual eligibles, this fragmentation and discontinuity of care is further exacerbated by the complicated and sometimes conflicting rules governing the Medicare and Medicaid programs. Funding streams and coverage rules often dictate where a beneficiary will receive care, even if it is inconvenient, inefficient, and unsafe.

Because the programs were developed separately and are administered separately, the burden has fallen primarily on beneficiaries (and their care givers) to understand their coverage and advocate for appropriate

Assets Tests

In addition to the requirement that individuals meet income criteria for Medicaid eligibility, most states also apply resource limits, or assets tests. In order to qualify as QMBs, SLMBs, or QIs, individuals must have resources with a value of no more than \$4,000 (for a couple, \$6,000); for those seeking full Medicaid benefits, the asset limits are \$2,000 for an individual and \$3,000 for a couple. Assets that are counted in making this calculation may include cash; bank accounts (savings and checking); stocks, bonds, annuities and certificates of deposit; real and personal property (other than a home or a car); trust funds; life insurance valued at more than \$1,500; and other items that may be converted into cash and used for food, clothing, or shelter. While several states have made the assets test more generous, these guidelines generally apply and can often disqualify individuals from Medicaid. The assets tests have also deterred individuals from applying for Medicaid benefits because many people do not know the specific rules and assume that they will have to give up their house or their car in order to get help with their medical bills. Although some states have tried to address these issues, the problem remains pervasive.²⁵

coordination of Medicare and Medicaid benefits. However, focus groups have revealed that dually eligible beneficiaries rarely understand their dual coverage and how their benefits should coordinate.²⁶ Duals may face access problems due to variations in Medicare and Medicaid coverage policies, differences in state Medicaid benefits and eligibility structures, and a lack of providers willing to treat Medicaid beneficiaries. Because many providers are not aware of the beneficiaries' dual status, patients are often billed inappropriately for Medicare copayments and/or Medicaid-covered services.

The Medicare and Medicaid programs have coverage distinctions that can make dual enrollment extremely complex. The benefit packages overlap, yet are different, and the beneficiary is usually unaware that coverage is not continuous between the two programs. Since each program has strong incentives to shift financial responsibility to the other, care is rarely coordinated. The result is often reimbursement-driven decision making that may ultimately harm the beneficiary. For example, Medicare covers "post-acute health care," which is characterized as treatment after or instead of hospitalization for an acute illness, injury, or exacerbation of a disease process. Medicaid covers long-term care—assistance with activities such as eating, bathing, and using the bathroom—to compensate for disabilities or impairments. Many dual beneficiaries enter a skilled nursing facility as a post-acute Medicare stay. Once Medicare's covered days run out or the needs shift from skilled to more personal in nature, Medicaid becomes the primary payer. Yet the state Medicaid program has no opportunity at the time of admission to the nursing facility to advise the beneficiary about noninstitutional options in the community that may be less expensive. Similarly, Medicare typically does not coordinate with long-term care providers to potentially prevent future hospitalizations. Care might be more efficiently delivered in a nursing home; due to reimbursement rules, however, beneficiaries are often transferred back to a hospital if an acute care need arises. Because of dual eligibles' poor health status and increased likelihood of using services, better coordination of their care and benefits could both save the Medicare and Medicaid programs money and result in higher quality care.

Managed Care

Over the past several years, many states, health plans, and the Centers for Medicare and Medicaid Services (CMS) have shown interest in including the dually eligible population in managed care programs. As more states have demonstrated success in reducing costs and improving care management for their younger Medicaid populations through managed care, they have argued that dually eligible beneficiaries could benefit from delivery systems in which care could be better integrated and more consciously coordinated. The Medicare program also promoted more managed care options for its beneficiaries by establishing the Medicare+Choice (M+C) program in 1997.

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Within managed care, as elsewhere, dually eligible beneficiaries encounter a myriad of conflicting participation and coverage rules. Some states require or allow dual eligibles and other Medicaid beneficiaries to enroll in a managed care plan to receive Medicaid benefits; others prohibit dual eligibles enrolled in Medicare+Choice from enrolling in a separate Medicaid managed care organization (MCO).²⁷ Where simultaneous enrollment in M+C and Medicaid managed care is allowed, states determine whether beneficiaries can receive services from within the same health plan or from two unrelated plans.²⁸

Benefit Coordination — Managed care arrangements for dual eligibles fall into four general types, depending on market factors and state regulations:

- M+C combined with Medicaid fee-for-service.
- M+C combined with Medicaid managed care within the same organization.
- M+C combined with an unrelated Medicaid MCO.
- Medicare fee-for-service combined with Medicaid MCO.

In any case, Medicare beneficiaries (including dual eligibles) cannot be required to join a managed care plan in order to receive Medicare benefits. This “freedom to choose” principle has confounded many state Medicaid directors who have sought to reduce their costs and improve integration through managed care techniques.

CMS recently commissioned a comprehensive case study analysis of managed care arrangements for dually eligible beneficiaries. The study found that current systems do not facilitate benefit coordination for dual eligibles enrolled in managed care.²⁹ Beneficiaries lack important knowledge about their coverage and are often charged inappropriately for copays and deductibles. In addition, dual eligibles experience discontinuities of care due to provider network restrictions and involuntary disenrollments. Transitions from acute to postacute to long-term care can be particularly problematic under managed care if, for example, M+C-contracted providers do not accept Medicaid or if Medicare fee-for-service providers do not participate in a Medicaid MCO’s network. When beneficiaries are enrolled in two separate managed care plans, two unrelated administrative and billing structures can further exacerbate, rather than facilitate, coordination of benefits issues.³⁰ However, some states are beginning to think creatively about integration. For example, Texas has designed a program that offers additional drug coverage to beneficiaries who choose to enroll in the same M+C plan as their Medicaid HMO.

Medicare+Choice — The majority of dual eligibles enrolled in managed care are part of the M+C program, with Medicaid serving as a secondary payer. Enrollment in M+C varies greatly among states and is highly dependent on Medicare payment rates and managed care penetration. In a few states, the percentage of dual eligibles enrolled in M+C is significant—

Beneficiaries lack important knowledge about their coverage and are often charged inappropriately for copays and deductibles.

for instance, in California, it is 11 percent; in Florida, 14 percent; and in Oregon, 28 percent.³¹ States clearly benefit when full Medicaid dual eligibles enroll in M+C plans because the plan is likely to cover expenses and Medicare coinsurance that would otherwise be covered by Medicaid (for example, for some preventive services and prescription drugs). No federal demonstration waiver is required, so states can avoid the lengthy application and approval process associated with obtaining a waiver. In addition, M+C offers more flexibility in benefit design than a program such as the Program of All-Inclusive Care for the Elderly (PACE), which exclusively serves frail individuals living in the community.³²

But M+C plans have had trouble identifying dual coverage, administering coordination of benefits, and assisting enrollees in understanding their coverage.³³ Rules meant to ensure that M+C plans do not discriminate against Medicaid beneficiaries have often made it difficult for plans to help coordinate dual coverage. For example, in the past, M+C plans were not permitted to ask about Medicaid coverage in their applications. In addition, M+C marketing regulations had been interpreted to prohibit plans from providing information specific to dual eligibles. Thus, dual beneficiaries are sometimes asked to pay copayments for which they are not liable, and these expenses may cause some to go without needed care.³⁴ In response to these problems, in July 2003, CMS released a policy memorandum clarifying that M+C plans may ask beneficiaries about Medicaid coverage and permitting plans to engage in some dual-specific marketing. There are also provisions in the Medicare reform bills currently under debate that would create a new category of specialized M+C plans that would be permitted to enroll dual eligibles or other types of frail elderly Medicare beneficiaries exclusively. If the legislation is enacted, it will enable CMS to put a regulatory structure in place that would resolve some of these issues.

The M+C program itself has struggled over the past few years, making it an unstable partner for state Medicaid programs. Due to a number of factors, many health plans have pulled out of the M+C marketplace and millions of Medicare beneficiaries have lost access to such coverage.³⁵ Those options that do remain often have higher premiums and less generous benefit packages than in the early days of the program. The higher premiums have made it difficult for low-income beneficiaries—especially dual eligibles—to stay in the program. Some states, such as California, have determined that helping their dual eligibles stay in M+C is more cost-efficient than having them come back onto the Medicaid program, where the state would be responsible for their pharmacy expenses. Thus, California pays the private M+C premiums on behalf of its full Medicaid dual eligibles. The state contracts only with plans that continue to provide pharmacy benefits.³⁶ By 2002, 48,000 dually eligible beneficiaries had enrolled in M+C plans in California through these contracts. Other states, such as Texas, have also begun to pay M+C premiums for full Medicaid duals, but the federal rules remain confusing and state practices vary significantly.

States clearly benefit when full Medicaid dual eligibles enroll in M+C plans.

Risk Adjustment — Getting the payment rate right has also been a stumbling block for Medicare and Medicaid plans that want to enroll more dual eligibles in managed care. Medicare's payment methodology normally pays health plans on the basis of the average cost for all dual eligibles, adjusted for certain demographic factors. Medicaid status serves as a proxy for poor health in the current demographic risk-adjustment payment that CMS uses to pay M+C plans. All M+C plans receive an increase in their payment for dual eligibles to compensate for their anticipated higher health costs at a rate that averages 1.5 times the average monthly payment. PACE, social health maintenance organizations (S/HMOs), and plans under certain state waivers receive an even higher payment for certain frail elderly individuals and dual eligibles.³⁷ This increase is intended as a "frailty adjuster" to reflect the increased costs associated with serving individuals at risk of nursing home placement. However, these payment differences have raised questions of efficiency and equity that continue to be controversial (see discussion of S/HMOs).

In addition, some analysts have criticized both the underlying M+C demographic rate and the frailty factors used in the demonstrations for failing to reflect differences in the cost of individual beneficiaries. This is because some dual eligibles are relatively healthy and seek few medical services, while others have much higher health costs. Striking the right balance between paying too much and paying too little is a constant challenge.

Beginning in 2004, CMS will begin phasing in a new risk-adjustment system for all M+C plans that will be based on individual diagnoses in addition to demographic factors. As part of this new payment methodology, specialty plans such as PACE, S/HMOs, and other demonstration plans (discussed below) will receive a frailty adjustment designed to replace the existing frailty factors. This adjustment will occur at the plan level and is based on a comparison of the limitations in activities of daily living for plan enrollees with those for a comparable fee-for-service population. The adjustment is intended to more accurately reflect the differences in costs. This approach will be phased in over six years, because some demonstration plans will see increases in their payment, while others will see sharp decreases. In a recent report to Congress, the Medicare Payment Advisory Commission (MedPAC) recommended that "payments should be based on beneficiaries' characteristics, not on the type of plan to which they belong."³⁸ CMS and other researchers are exploring ways to improve risk adjustment to better reflect the frailty or complexity of the dual-eligible population. Appropriate risk adjustment, along with better communication and benefit coordination, will be necessary to counter incentives managed care plans may have to avoid frail beneficiaries in the future.

Striking the right balance between paying too much and paying too little is a constant challenge.

SERVING COMPLEX POPULATIONS: PROGRAM OPTIONS

Because of the complex and often costly needs of the frail elderly and disabled populations, a great deal of energy and creativity has been put into the development of integrated care programs designed to serve the dual-eligible population in a cost-effective, high-quality environment. While the PACE, S/HMO, and Evercare programs are the most prominent examples, several states have merged pieces of different concepts to design demonstration projects that they believe best meet the needs of this population.

The Program of All-Inclusive Care for the Elderly

The PACE program grew out of a Medicare demonstration that was authorized in 1983—On Lok Senior Health Services in San Francisco. On Lok began in 1971 as an adult day care center and evolved over time into a model for successful integration of health and social services. In 1986, Congress authorized the original PACE demonstrations; the program became a permanent Medicare and Medicaid service delivery model in the Balanced Budget Act of 1997. Today, there are 28 PACE sites operating in 17 states. PACE sites served more than 6,500 frail elders in 2000.³⁹

The primary goal of the PACE model is to help the frail elderly remain in the community. Individuals who enroll in PACE must be at least 55 years of age and determined by the state to be at risk of needing nursing home placement because of health needs and difficulty performing activities of daily living. Although 96 percent of PACE enrollees are dual eligibles, it is not a participation requirement. As always, states have broad flexibility in setting standards for assessing nursing home certification, but, on average, PACE enrollees suffer from seven to eight medical diagnoses and exhibit some degree of dementia or other cognitive impairment. The majority of enrollees require assistance with walking and nearly 90 percent need assistance with taking medications, meal preparation, housework, and shopping.⁴⁰

The PACE sites act as adult day health centers that are staffed by interdisciplinary teams of physicians, nurses, social workers, case managers, and physical and occupational therapists who are committed to serving each individual by following a comprehensive care plan that has been developed by the team. Payment for PACE services is based on a combined Medicare and Medicaid capitation rate that includes an additional frailty adjuster (2.39 times the average) to account for the more intensive care needs of this vulnerable population. Most of the PACE sites are small in size, usually serving fewer than 200 enrollees.

PACE has been a popular approach in theory, and participants report high satisfaction with the program and excellent quality of care. However, policymakers have raised concerns about the program's requirement that

A great deal of energy and creativity has been put into the development of integrated care programs designed to serve the dual-eligible population.

PACE enrollees see only PACE care providers, which means that they often must change even their primary care physician. PACE's day care orientation has also been perceived as too restrictive and a reason for low enrollment.

In response to these concerns, states like Wisconsin have developed modified demonstration programs that are intended to include more flexibility for enrollees and providers. In addition, the Benefits Improvement and Protection Act of 2000 provided specific flexibility to PACE programs to use physician arrangements that differ from the traditional staff model approach.

Evercare

Evercare, a subsidiary of United Health Group, was established in 1993. The program offers a variety of Medicare, Medicaid, and private-pay long-term care products and programs that serve elderly individuals who are living independently as well as individuals who reside in assisted living facilities and nursing homes. The original Evercare Medicare demonstration was approved by CMS in 1995 and is still operating today. The primary goal of this program, known as Evercare Choice, is to provide case management for nursing home residents and to reduce the need for hospital and emergency room care. Building on the integrated model of PACE, Evercare Choice assigns a physician as well as a geriatric nurse practitioner to each resident in order to provide coordinated primary care in the nursing facility. Although the Medicare benefit package is not expanded under these demonstrations, evaluations have shown that quality of care and health outcomes have improved at the same time that hospitalizations have decreased significantly. Evercare Choice programs are operating in 11 states and serve more than 24,000 enrollees, approximately 75 percent of whom are dually eligible.

Evercare also participates in several state programs designed to provide integrated care for dual eligibles and other aged and disabled Medicaid beneficiaries; these programs include the Minnesota Senior Health Options (MSHO) program, the Arizona Long-Term Care System, and the Texas STAR+PLUS program. In addition, Evercare has recently been selected as a program contractor for the Massachusetts Senior Care Options program.

Social Health Maintenance Organizations

Medicare's S/HMO demonstration has been in operation since 1985. It tests a model of service delivery intended to integrate acute, chronic, and long-term care for the frail elderly. The first generation model, S/HMO I, emphasizes case management. All S/HMO I enrollees are entitled to receive basic Medicare benefits as well as additional benefits such as prescription drugs and eyeglasses. Those enrollees who are determined to

The primary goal of Evercare Choice is to provide case management for nursing home residents and reduce the need for hospital and emergency room care.

be at risk of institutionalization—commonly referred to as the nursing home certifiable—are entitled to long-term care benefits (such as personal care and homemaker services). Currently, three S/HMO I plans are in operation, with approximately 68,000 enrollees. A second generation of S/HMOs, established in 1996, emphasizes geriatric care and more comprehensive case management. Only a single S/HMO II, the Health Plan of Nevada, was established; it is still in operation today and serves approximately 50,000 beneficiaries.

Because S/HMOs are paid rates that are 5.3 percent higher than those paid to regular M+C plans in the same county, policymakers have questioned their cost-effectiveness. Despite S/HMOs' promise, two evaluations found "no conclusive evidence of positive effects on beneficiary health or functioning," according to a recent report by MedPAC.⁴¹ The S/HMO demonstration is scheduled to conclude on December 31, 2003, and its fate is uncertain. CMS has announced that, in the absence of congressional action, it intends to continue the demonstration through 2004, incorporating its new frailty adjustment in S/HMO's payment. MedPAC, on the other hand, has recommended that S/HMOs apply to participate in the M+C program as a coordinated care plan without special payment add-ons.

Capitated Disease Management Demonstrations

In its request for proposals for Medicare disease management demonstrations, CMS has included an option for a specialized health plan designed to serve dual eligibles exclusively. Several plans, including Evercare, AmeriChoice, and ElderHealth, have submitted proposals for these types of plans. CMS is expected to announce the awards for these demonstrations within the next several weeks.

STATE PROGRAM EXAMPLES

Wisconsin Partnership Program

In October 1998, the state of Wisconsin received Medicaid Section 1115/Medicare Section 222 waiver authority to establish a demonstration that follows the PACE model, but with less reliance on the day center aspects and smaller interdisciplinary teams. Implemented in January 1999, the Wisconsin Partnership Program serves primarily individuals who are dually eligible for Medicare and Medicaid (85 percent of enrollees in the Partnership are duals). In addition, this demonstration includes the nation's first comprehensive managed care plan designed for individuals with disabilities under the age of 65 (roughly 27 percent of Partnership enrollees are individuals with disabilities). One PACE site and four Partnership sites (the Milwaukee Community Care Organization has co-located both programs) are in operation around the state, serving a total of 1,942 individuals as of July 2003.⁴²

The Partnership program integrates health and long-term support services and includes home- and community-based services, physician services, and all medical care. Services are delivered in the participant's home or a setting of his or her choice. An interdisciplinary team coordinates all service delivery. Participants choose from an independent physician panel, although they often keep the physician with whom they already have a relationship. Differing from the PACE model, the Partnership team does not require direct participation of the primary care physicians in the team meetings; in many cases the nurse practitioner has primary responsibility for coordinating the team's activities with those of the community-based physician. Often, the nurse practitioner accompanies the enrollee to an office visit with the primary care provider.

For payment purposes, the four community-based organizations enter into a Medicaid managed care contract with the Wisconsin Department of Health and Family Services and a Medicare contract with CMS. Contractors receive monthly capitation payments for each participant, from which they pay for all participant services. Contractors are responsible for the care of each person, regardless of what agency provides the services, where the service is provided, or whether the participant is at home, in the hospital, or in a nursing home.

Texas STAR+PLUS

STAR+PLUS is a Medicaid waiver program designed to integrate the delivery of acute and long-term care services through a managed care system. Operating in Harris County (Houston), Texas, the project currently serves approximately 61,000 elderly and disabled Medicaid enrollees, 29,000 of whom are dually eligible for Medicare and Medicaid. One of two STAR+PLUS contractors, the Evercare STAR+PLUS program serves the dual-eligible population by promoting independent living and providing intensive case management services. Evercare offers enrollees the opportunity to have the same HMO provide both Medicare and Medicaid services, helping to eliminate many of the managed care coordination problems discussed earlier.

Evercare STAR+PLUS enrollees receive acute and long-term care coordination services, which include working with an individual, her or his family, and the primary care provider to develop an individual plan of care. Prescription drugs are provided through the state's Medicaid pharmacy assistance program. STAR+PLUS enrollees who are enrolled with the same MCO for both Medicare and Medicaid coverage, or are eligible under the state's Community-Based Alternatives waiver, have access to an unlimited number of prescriptions (instead of the three prescriptions per month currently available in Texas).⁴³

Partnership participants choose from an independent physician panel, although they often keep the physician with whom they already have a relationship.

Minnesota Senior Health Options and Disability Health Options

Implemented in 1997, Minnesota's MSHO demonstration was the first major demonstration designed to provide integrated services to the frail elderly dual-eligible population. The Minnesota Disability Health Options (MnDHO) program was implemented in November 2002 and was the third comprehensive managed care plan for individuals with disabilities. Enrollment in the MSHO and MnDHO programs, which operate in 10 counties, is completely voluntary. (In Minnesota, seniors receiving Medicaid are normally required to enroll in the state's Medicaid managed care program, Prepaid Medical Assistance Program, or PMAP.) MSHO enrolls the full range of dually eligible seniors, regardless of level of need, including those who are healthy, frail but living in the community, or institutionalized; MnDHO has expanded the program's coverage to individuals with disabilities.

The programs capitate all Medicare and Medicaid benefits, including home- and community-based care and nursing facility services (except for those provided beyond 180 days, which are paid on a fee-for-service basis). MSHO and MnDHO also integrate Medicare and Medicaid financing and enroll beneficiaries in the two programs simultaneously. Each MSHO enrollee is assigned a care coordinator, who may be a registered nurse, social worker, or geriatric nurse practitioner. Care coordinators for community members are often involved in all aspects of their care, from primary care visits to arranging home and community based services. Coordination of primary care for most nursing home residents is provided by geriatric nurse practitioners.

For seniors who meet nursing home criteria but live in the community, the Medicare demonstration provides a risk adjustment (the same as that for PACE programs) to the regular Medicare managed care payments. Payments for other enrollees (people in nursing homes and those living in the community) are the same as for other M+C plans.

Massachusetts Senior Care Options (SCO)

The Massachusetts SCO demonstration is in the final stage of development and review within CMS, and approval is reported to be imminent. Serving both dual-eligible and Medicaid-only beneficiaries, regardless of whether they live in the community or an institution, the demonstration will offer a geriatric model of care similar to that of Minnesota and other leading states.

DUALS AND THE RX DEBATE

The House and Senate prescription drug proposals have intensified a long-standing tug-of-war between the federal and state governments over the responsibility for dual eligibles. The key differences between the two bills, with respect to dual eligibles, are outlined in Table 1.

The prescription drug proposals have intensified a long-standing tug-of-war between the federal and state governments over the responsibility for dual eligibles.

TABLE 1
Provisions Affecting Dual Eligibles and Low-Income Beneficiaries
in the Medicare Prescription Drug Bills

Provisions	S. 1 — Prescription Drug and Medicare Improvement Act of 2003	H.R. 1 — Medicare Modernization and Prescription Drug Act of 2003
Eligibility for Medicare Part D (prescription drug benefit)	<p>“Full Medicaid” dual eligibles would not be eligible for drug coverage under the new Medicare Part D.</p> <p>“Supplemental Medicaid” dual eligibles would be eligible for Medicare Part D.</p> <p>Pharmacy+Plus enrollees would be eligible for Medicare Part D.</p>	All Medicare beneficiaries entitled under Part A or enrolled in Part B would be eligible for the new Medicare Part D.
Incentives to maintain coverage for optional populations	The federal government would pay 100% (instead of the usual Medicaid matching rate) of Medicare Part A deductible and coinsurance costs in states that maintain optional expansions for dual enrollees.	No provision.
State fiscal relief	<p>States would continue to pay the full cost of providing drug coverage for “full Medicaid” dual eligibles, according to each state’s Medicaid plan.</p> <p>The federal government would pay 100% federal matching funds for Part B premiums for “full Medicaid” and QMB eligibles with incomes between SSI level and 100% of poverty.</p>	<p>State government’s obligation for dual eligibles’ drug benefits would be phased out. States would be required to maintain Medicaid benefits as a wrap-around to Medicare benefits for dual eligibles; states could require that these persons elect Part D drug coverage.</p> <p>Federal Medicaid payments to states would be reduced by a declining percentage each year between 2006 and 2020 to offset the federal costs of providing Medicare drug benefits to individuals who would have otherwise received Medicaid benefits.</p>
Subsidies for low-income beneficiaries	<p>Cost-sharing and premium assistance would be provided to Medicare beneficiaries with incomes below 160% of poverty (excluding “full Medicaid” dual eligibles). Would build upon existing QMB, SLMB, QI structure with assistance with co-insurance, deductible, and premiums decreasing as incomes increase.</p> <p>No asset test would be required to receive assistance, but more generous assistance would be provided for those who can meet one.</p>	<p>Cost-sharing and premium assistance would be provided to Medicare beneficiaries with incomes below 135% of poverty; sliding scale premium subsidies would be available to those with incomes between 135% and 150% of FPL. Specific dollar limits would be placed on drug cost-sharing for these low-income beneficiaries (e.g., \$2 for generics, \$5 for brand-name drugs up to the initial limit).</p> <p>Asset test would be required to receive assistance.</p>
Out-of-pocket limits	Cost-sharing assistance would continue above the initial limit (\$4,500) for dual eligibles and other low-income beneficiaries.	No cost-sharing assistance would be provided for dual eligibles and low-income beneficiaries above the initial limit of \$2,000 until out-of-pocket spending (including low-income subsidy payments) reaches \$3,500.

The most significant difference between the two bills is that the Senate bill would exclude full Medicaid dual eligibles from participation in Medicare Part D, the prescription drug benefit. Under the House bill, the Medicare program would assume responsibility for all Medicare beneficiaries' prescription drug benefits, including those of dual eligibles. If the Senate version were adopted, it would represent the first time in Medicare's history that a benefit would not be provided on a universal basis to all Medicare beneficiaries. Senate proponents argue that their bill seeks to help those Medicare beneficiaries who currently do not have access to prescription drug coverage by offering generous subsidized coverage to low-income individuals whose income exceeds the Medicaid eligibility limits. The House bill, on the other hand, while universally available to all Medicare beneficiaries, contains provisions that would leave low-income beneficiaries vulnerable to significant out-of-pocket expenses. In either case, state Medicaid programs would likely have to step in to address limits in the new Medicare prescription drug benefit.⁴⁴

Even though all states have elected to provide prescription drug coverage as a Medicaid benefit, the depth and breadth of coverage vary significantly from state to state, with some states offering full access to a range of drugs and others providing only a basic package. In addition, in light of the current state fiscal crisis and the skyrocketing costs of prescription drugs in general, nearly all of the states have used prescription drugs as a primary target of cost-containment strategies. Some analysts have expressed concern that the Senate bill might encourage states to scale back eligibility for Medicaid coverage for the elderly and disabled, further reduce or eliminate Medicaid prescription drug benefits, and discontinue state-sponsored pharmacy assistance programs (and Pharmacy+Plus waivers) in order to force a shift of pharmacy costs from Medicaid to Medicare.⁴⁵

The nation's governors have unanimously endorsed the House bill. Shifting drug coverage costs of the dual eligibles onto the Medicare program (combined with a range of savings provisions) would save the states an estimated \$44 billion between 2004 and 2013. The Senate approach would provide an estimated \$20 billion in fiscal relief to the states.⁴⁶ With states facing their worst budget crises in at least two decades, the additional dollars could avert the need for states to reduce other Medicaid benefits. On the other hand, Senate defenders argue that the bill is not about state fiscal relief, but rather about "maximizing the benefit for beneficiaries who need it most."⁴⁷

CONCLUSION

Whatever the outcome of the prescription drug debate, the issues surrounding dual eligibles will continue to challenge federal and state policymakers for years to come. Both the non-elderly disabled as well as those who are 85 years or older, groups likely to be dually eligible, are the fastest-growing

Even though all states have elected to provide prescription drug coverage as a Medicaid benefit, the depth and breadth of coverage vary significantly from state to state.

segments of the Medicare population. Many of these individuals will need long-term care, either in a community-based setting or in a nursing facility or other institution. The nation's governors recently proposed that the federal government effectively "buy out" the costs of the dual-eligible population. In the wake of huge federal and state budget deficits, this debate will only intensify.

Because neither program is ultimately responsible for the performance of the entire system, and information systems are poorly consolidated, the potential for continued fragmented, ineffective, and reimbursement-driven decision-making for dual eligibles is high. While several integrated service delivery and financing strategies have shown promise, challenges related to payment, coordination, and delivery will continue to hamper success on a wide scale. Caring and paying for the nation's frailest and lowest-income individuals will be at the forefront of health policy discussions as long as health care costs are rising and the political clout of seniors and the disabled community continues to grow.

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