



## Medicare and Medicaid Dual Eligibles: Meeting Diverse, Complex, and Costly Needs

## FORUM SESSION ANNOUNCEMENT

A DISCUSSION FEATURING:

**Mark Miller, PhD**

*Executive Director*

Medicare Payment Advisory Commission

**Melanie Bella**

*Senior Vice President for Policy and Operations*

Center for Health Care Strategies, Inc.

WITH COMMENTS BY:

**Hilary Dalin**

*Associate Director, My Medicare Matters*

National Council on Aging

FRIDAY, JULY 23, 2010

9:00AM–9:30AM—Refreshments

9:30AM–11:30AM—Discussion

LOCATION

Reserve Officers Association  
One Constitution Avenue, NE  
Congressional Hall of Honor  
Fifth Floor

*(Across from the Dirksen  
Senate Office Building)*

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There are over 8 million beneficiaries who are dually eligible for Medicare and Medicaid services. Approximately, two-thirds of this population is aged 65 and older, and one-third is disabled and under age 65. While the “duals” represent only 16 percent of the total Medicare population and 18 percent of the total Medicaid population, they account for almost 25 percent of total Medicare spending and 46 percent of total Medicaid spending.<sup>1</sup> The health care status of the dually eligible population is quite diverse; many of these individuals have substantial and costly medical and long-term service and support needs, but some have only limited needs. The variation in duals’ health status can present challenges to providers and policymakers trying to meet their needs and contain costs in both the Medicare and Medicaid programs.

**BACKGROUND**

Medicare is the primary payer for dually eligible beneficiaries (“dual eligibles”), covering all acute care (hospital) services, outpatient and physician services, dialysis, prescription drugs, and post-acute care services (for example, skilled nursing facility services and home health). Medicaid “wraps around” Medicare for dual eligibles, paying Medicare premiums, deductibles, and copays and covering services with limited or no Medicare coverage. For example, Medicaid covers nursing home care when a resident’s Medicare skilled nursing coverage ends. In addition, Medicaid provides dual eligibles with coverage for transportation to medical appointments and coverage for all optional benefits available under the Medicaid state plans, which may include dental, vision, hearing, personal care, home and community-based services, and home health care.

Dual eligibles are usually classified according to the levels of assistance they receive. Approximately 80 percent of the population qualifies for full Medicaid benefits, including long-term services and supports, and are often referred to as “full duals.” The rest of the duals have slightly higher incomes and qualify only for Medicaid assistance with Medicare premiums and cost-sharing. This group of dual eligibles, known as “partial duals,” are the beneficiaries enrolled in the Medicare Savings Programs.<sup>2</sup>

Beneficiaries can become dually eligible for both Medicare and Medicaid in several ways. Medicare beneficiaries can become Medicaid-eligible by “spending down” their income to meet Medicaid financial eligibility criteria, usually due to long-term care expenses such as nursing home care. Other duals are Medicaid beneficiaries initially

and later become Medicare beneficiaries, primarily due to age or receipt of Social Security Disability Insurance (SSDI). This subgroup of duals includes individuals who have disabilities due to physical, mental, or cognitive conditions and who may or may not reside in the community.

As mentioned, health care status and needs within the duals population vary greatly, as does the use of Medicare and Medicaid benefits. Some duals are healthy and have limited medical needs, and some have multiple impairments, including physical, mental, and cognitive. Duals reside in the community as well as in nursing homes and intermediate care facilities for people with mental retardation (ICF-MRs). There are duals receiving just Medicaid assistance for Medicare premiums and cost-sharing, and there are duals receiving the full gamut of acute and long-term care services the two programs have to offer. There also are many duals who are in between these extremes, accessing benefits from both programs.

## THE CHALLENGES

The challenges Medicare and Medicaid face serving the dually eligible population vary with the type of duals (that is, full versus partial), their health needs, and the setting in which they receive services (that is, community versus institution). For example, access to Medicare providers can be an issue when Medicaid does not pay the full Medicare cost sharing. Medicare and Medicaid have different coverage standards for some of the same benefits, and duals are sometimes improperly billed for cost sharing. Conflicting financial incentives among nursing home and hospital providers can result in inappropriate transfers and settings of care. Finally, balancing beneficiaries' rights and freedom of choice with the need to try innovative approaches to improve care outcomes and to better control federal and state spending has been a perennial challenge.

Policymakers have been trying to address coordination of services and financing for dual eligibles across Medicare and Medicaid in recent years. Most duals receive care in a fee-for-service setting, which can lead to fragmented and poorly coordinated care between providers and programs. Multiple providers and lack of accountability can also lead to unnecessary emergency room utilization, hospitalizations, and nursing home placement for dually eligible beneficiaries. Different delivery, financing, and administrative policies and procedures between Medicare and Medicaid makes duals' interactions with the health care system an often complicated and bureaucratic challenge for providers

and beneficiaries alike. The situation is further compounded by different program and provider incentives, which can result in beneficiaries “ping-ponging” between Medicare and Medicaid providers in acute and long-term care settings. The net result for these beneficiaries, too often, is poor patient outcomes and high costs for both Medicare and Medicaid.

The solutions for better patient outcomes and better controlled spending for dually eligible populations may be as varied as the population itself. Better coordination of services and financing across providers and programs has long been viewed by many as a means to improve health outcomes and reduce costs. However, integration is not easy, nor is it always preferred by all stakeholders involved. While there are some successful models of integrated services and financing, the number of dual beneficiaries participating in these programs is small and replication in different states and markets can be difficult.

## SESSION

This Forum session will examine the diversity of the dually eligible population and the challenges Medicare and Medicaid encounter serving this beneficiary group—especially the high-cost, high-needs beneficiaries. The benefits and challenges of coordinating care across Medicare and Medicaid providers, including how different program and provider incentives can affect duals’ care and costs, will be discussed. Speakers will highlight current approaches to integrate care and financing (such as Special Needs Plans [known as SNPs] and the Program of All-Inclusive Care for the Elderly [known as PACE]) and their effect on duals’ care. They will also examine some alternative models states are pursuing to coordinate services and control spending and the challenges and concerns they present at the federal level.

## KEY QUESTIONS:

- What are the characteristics of the dually eligible population, and how do they differ from other Medicare and Medicaid beneficiaries?
- What are the various subgroups (for example, institutionalized, cognitively impaired, community based) of the dually eligible population, and how do the care needs of these subgroups differ? How does per capita spending vary by subgroup?
- Do Medicare and Medicaid work at cross purposes? What is the impact on the quality of beneficiary care and program expenditures?

- How could coordination of Medicare and Medicaid services (and possibly integration of financing) make a difference to beneficiary care and public financing? For whom is coordination likely to make a difference?
- From Medicare's perspective, what are the risks of integrating services and financing between Medicare and Medicaid? Can they be mitigated?
- Why is care coordination across Medicare and Medicaid, particularly for high-cost/high-need dual eligibles, difficult? How do conflicting program incentives between Medicare and Medicaid and the resulting behavior of the provider (for example, nursing home or hospital) affect care coordination?
- From the beneficiaries' perspective, what more is needed to eliminate barriers?

## SPEAKERS

**Mark Miller, PhD**, executive director of Medicare Payment Advisory Committee (MedPAC), will begin the discussion with a presentation on the characteristics of dually eligible beneficiaries and the per capita spending for various subgroups of duals. Mr. Miller will also discuss some of the conflicting incentives of Medicare and Medicaid and how they can undermine patient care and cost control. He will describe current models of integration (such as PACE and SNPs) and their effect on beneficiary care coordination and cost containment for the dual eligibles. **Melanie Bella** is senior vice president for policy and operations at the Center for Health Care Strategies, Inc., and a former Indiana state Medicaid director. Ms. Bella's presentation will address how integration can make a difference in patient care and cost control from the state perspective. She will also discuss the challenges states face in trying to align the two largest health care payers. Finally, Ms. Bella will discuss some of the innovative approaches, beyond PACE and SNPs, that states are pursuing to integrate Medicare and Medicaid services and financing. **Hilary Dalin**, an associate director at the National Council on Aging, leads *My Medicare Matters*, a public-private partnership that includes federal agencies, community organizations, professionals, and volunteers who help people understand Medicare. Ms. Dalin will provide comments on the various challenges dual eligibles face in receiving services from both Medicare and Medicaid and on opportunities for the new Federal Coordinated Health Care Office created under the Patient Protection and Affordable Care Act. (P.L. 111-148).

## ENDNOTES

1. J. Holohan, D.M. Miller, and D. Rousseau, "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2005," Kaiser Commission on Medicaid and the Uninsured, February 2009; available at [www.kff.org/medicaid/7846.cfm](http://www.kff.org/medicaid/7846.cfm).
2. There are four Medicare Savings Programs with different levels of financial assistance for which Medicare beneficiaries may qualify, depending on their income: (i) Qualified Medicare Beneficiary (QMB), income less than 100 percent of the FPL; (ii) Specified Low-Income Medicare Beneficiary (SLMB), income between 100 and 120 percent of the FPL; (iii) Qualified Individual (QI), income between 120 and 135 percent of the FPL; (iv) Qualified Disabled and Working Individual (QDWI), income up to 200 percent of the FPL.