

INTRODUCTION TO

Medicare-Medicaid Dual Eligibles and Service Delivery Models



KEY TAKEAWAYS

Medicare and Medicaid play important roles in the lives of millions of Americans. Medicare pays for health care for about 64 million people and Medicaid provides care and services to more than 87 million. While millions of people are entitled to coverage under both programs, their care is frequently uncoordinated and fragmented between two programs that were not designed to work together.

Over 12 million people are “dually eligible” for Medicare and Medicaid. As compared with typical Medicare enrollees, these “dual eligibles” have more chronic conditions, greater levels of disabilities, mental and physical impairments, and are more likely to need nursing home care.

Managed care plans serve dual eligible individuals through several delivery models that integrate Medicare and Medicaid benefits: dual eligible special needs plans (D-SNP), Medicare-Medicaid Plans (MMP) and Programs of All-Inclusive Care for the Elderly (PACE).

Introduction

Medicare and Medicaid have been critical parts of the American health care landscape for more than 50 years. As of 2021, the two programs provide health coverage to more than 147 million people¹ (about 43% of all Americans). Despite the maturity of these programs, there is a group of individuals—people with both Medicare and Medicaid—who rely on the two programs but who often experience their care as uncoordinated, fragmented, and at times confusing. This brief provides information about Medicare-Medicaid “dual eligible” individuals, their demographic characteristics and impacts on the Medicare and Medicaid programs, the service delivery models currently in place to integrate their care, and the role managed care plans play in serving them.

What are Medicare and Medicaid?

Medicare is a federal health insurance program for people over age 65 or who have a disability and meet related eligibility requirements. Medicare is available in all 50 states and U.S. territories and has uniform eligibility requirements based on an individual’s work history. Medicare is administered centrally by the federal Centers for Medicare & Medicaid Services (CMS).

Medicaid is a joint state/federal health coverage program for people with low incomes and/or disabilities. Medicaid eligibility is determined by states and territories within federal guidelines, based on an individual’s income and assets, or disability. Medicaid eligibility requirements vary considerably from state to state. Medicaid is administered separately by each state within an overall federal regulatory and administrative framework overseen by CMS.



What Do Medicare and Medicaid Cover?

Medicare has four parts. Part A covers the cost of services in inpatient hospitals, short-term skilled nursing and home health following hospitalization, and hospice care. Medicare Part B covers outpatient services like doctor visits, diagnostic tests, durable medical equipment, certain preventive services, and some prescription drugs (typically those administered by physicians). Medicare enrollees can choose to receive their Part A and Part B coverage through the original Medicare program or through Medicare Advantage (MA) plans, or “Part C”. Finally, Medicare Part D, which is available to people in both original Medicare and Medicare Advantage, covers outpatient prescription drugs. Most Medicare enrollees qualify for free Part A coverage. They are required to pay a monthly premium for Part B and for Part D (unless the premium is paid by their Medicare Advantage plan) and may be required to pay an additional premium for Medicare Advantage coverage. Medicare enrollees are required to pay a share of the cost of many services.



In general, for people with Medicare and Medicaid, **Medicaid** pays for the costs of care and services that Medicare does not cover, including long-term nursing home expenses; skilled nursing facility stays that exceed Medicare’s 100-day limit; home and community-based services (HCBS), including personal care provided in the home; and certain other supportive items and services not covered by Medicare. Medicaid also covers many of the services that Medicare covers. Medicare is the primary payer for those overlapping services and Medicaid provides secondary coverage. Medicaid also pays some or all of the person’s Medicare premiums and share of costs for Medicare Part A and B services, while Medicare pays those costs all or in part under Part D.

What is the Role of Managed Care in Medicare and Medicaid?

People with Medicare can choose to receive their covered services in an unmanaged “fee for service” environment – also known as original Medicare – administered by CMS through Medicare contractors or they can choose to receive benefits through MA plans. Providers bill original Medicare for services provided to original Medicare enrollees, or contract with MA plans for services provided to MA plan enrollees. Part D prescription drugs are delivered exclusively through managed care plans, either in separate drug plans for those in the original Medicare program or as a drug benefit integrated into MA plan coverage.

States have considerable latitude in how their Medicaid programs are structured. Many states contract with managed care organizations (MCO) to cover certain groups of Medicaid enrollees, such as those in the “aged/blind/disabled” (ABD) category. In some states, Medicaid enrollees are included in managed care on a mandatory basis, while in other states the individual can choose to enroll in a managed care plan.

Who Are Dually Eligible Individuals?

More than 12 million people in 2021 were enrolled in both Medicare and Medicaid. They are often referred to as “Medicare-Medicaid dual eligibles.”² There are two major groups of dual eligible individuals:

- **Full benefit dual eligible individuals** receive all Medicare and Medicaid benefits, and their Medicare premiums and cost sharing are generally paid for by Medicaid. About 72% of dual eligible individuals are in this category.² Full benefit dual eligibles typically have incomes less than the Federal Poverty Level (FPL)³ and very limited assets, though there is significant variation in eligibility requirements from state to state.
- **Partial benefit dual eligible individuals** comprise the remaining 28%. While they receive all Medicare benefits, their Medicaid benefits are limited to financial assistance from the Medicaid program to cover Medicare premiums and, depending on their income level and state of residence, assistance with cost sharing. This coverage of Medicare premiums and cost sharing is referred to as the “Medicare Savings Program.” Partial benefit dual eligible individuals have incomes and/or assets that are higher than a state’s eligibility threshold for full Medicaid coverage.

How Do Demographic and Health Characteristics of Dual Eligible Individuals Compare to Other Medicare Enrollees?

People with both Medicare and Medicaid are particularly at risk in terms of their overall health and functioning, and many require special supports and services to help them maintain or improve their health and independence. A majority of dual eligible individuals are over age 65 (62%), female (59%), and white (54%).⁴ The table below compares key demographic characteristics of Medicare-Medicaid dual eligibles with non-dual Medicare beneficiaries.⁵

Comparing Demographics of Duals Eligibles and Non-Dual Medicare Beneficiaries

Gender		Race/Ethnicity		ADL Limitations		Residence		Education	
Duals	Medicare	Duals	Medicare	Duals	Medicare	Duals	Medicare	Duals	Medicare
41% M	55% M	21% Blk	28% Blk	0: 51%	0: 80%	13% Facility	3% Facility	36% <HS	9% <HS
59% F	45% F	17% Hisp	21% Hisp	1-2: 24%	1-2: 13%	33% Alone	26% Alone	30% HS	24% HS
		54% Wht	46% Wht	3-6: 25%	3-6: 7%	14% Spouse	54% Spouse	28% Coll	66% Coll
		8% Other	8% Other			40% Other	17% Other	5% Other	1% Other

Blk=black Hisp=Hispanic Wht =white HS=high school Coll=college

Compared with typical non-dual eligible Medicare enrollees, dual eligibles typically have significantly greater limitations on **activities of daily living (ADL)** such as the ability to bathe or feed oneself, higher rates of institutionalization, and lower levels of education.

While dual eligible individuals comprise about 18% of total Medicare enrollment and 14% of Medicaid enrollment, expenditures on dual eligible individuals account for approximately 34% of total Medicare expenditures and 27% of total Medicaid expenditures.⁶ In 2020, this translates in dollar terms to \$286 billion for Medicare (out of \$829.5 billion total) and \$180 billion for Medicaid (out of \$671.2 billion total).⁷

How Do the Medicare and Medicaid Programs Coordinate Care and Services for Dual Eligible Individuals?

While Medicare and Medicaid were both established in 1965, they were never designed to work together. As noted above, the two programs have different eligibility requirements, benefits, rules, and organizational structures.⁸

Under Medicare, enrollees choose whether to receive their health benefits through original Medicare or Medicare Advantage on a voluntary basis. Under Medicaid, states determine whether to use managed care for service delivery, and if so, whether it is mandatory or voluntary for dual eligible enrollees. Further, as noted, the two programs cover many overlapping benefits, with certain additional services often available solely through Medicaid. Regardless, even for overlapping benefits, the two programs can have different coverage requirements, different administrative rules for appealing coverage denials, and separate member communication materials. Accordingly, many people with Medicare and Medicaid have struggled to navigate across the two programs, because it is unclear what services and providers are covered and how to access them. In addition, Medicare and Medicaid providers frequently are unaware of all the care and services a dual eligible person may be receiving. This leads to fragmented, uncoordinated care and duplication of services, with little focus on care for the whole person.

In the past, many states kept their dual eligible enrollees in Medicaid fee-for-service programs, thinking that the coordination challenges with Medicare were too great or the health care needs of dual eligible individuals were too complex for Medicaid managed care plans. However, as Medicaid managed care has matured, states have recognized that health plans have developed a record of success in delivering high-quality, coordinated care for dual eligible individuals. For example, in 2010, 19 state Medicaid programs, plus Washington, DC, and Puerto Rico, included dual eligible individuals in comprehensive Medicaid managed care; by 2019, that number had increased to 30 programs.⁹ And more states continue to turn to Medicaid managed care for dual eligible individuals, including automatic enrollments or even mandatory enrollments of dual eligible individuals into managed care, to ensure they receive

the coordinated care they need to help manage complex health conditions.

Concurrently, policy makers and CMS developed several delivery models that attempt to integrate Medicare and Medicaid for dual eligible individuals. States now have the option to contract with health plans specifically designed for dual eligible individuals. They offer Medicare benefits and coordinate or offer Medicaid benefits as well.

Currently there are three major plan delivery models for dual eligible individuals:

- [Dual-Eligible Special Needs Plans \(D-SNP\)](#)
- [Medicare-Medicaid Plans \(MMP\)](#)
- [Programs of All-Inclusive Care for the Elderly \(PACE\)](#)

All three models employ a model of care that emphasizes an assessment of the individual's needs, development of a care and service plan with input from an interdisciplinary care team, and coordination and oversight of the care and service plan by a care manager or service coordinator.

Dual-Eligible Special Needs Plans

D-SNPs are Medicare Advantage plans that specialize in providing coverage for people who are dually eligible for Medicare and Medicaid. In 2022, more than 4 million dually eligible individuals are enrolled in 729 D-SNPs operating in 45 states, the District of Columbia and Puerto Rico.¹⁰

First introduced in 2006, D-SNPs are primarily regulated by CMS but must also have a contract with the state in which they operate. Through this contracting process, the state decides whether and to what extent D-SNPs operating in the state will cover some or all Medicaid benefits for their dual eligible members, in addition to the Medicare benefits all D-SNPs are required to offer. The state determines the extent to which the D-SNP sponsor must coordinate benefits across the Medicare and Medicaid programs. They may also specify the geographic area(s) in which the D-SNP may operate.

A number of states have recognized D-SNPs for their potential in advancing Medicare-Medicaid integration. While states cannot require dually eligible individuals to enroll in a specific kind of Medicare plan like a D-SNP, states can require their contracted Medicaid managed care plans to offer one or more Medicare D-SNPs. Using this strategy, a state can align

the Medicaid plan enrollment of dual eligible individuals so that they receive both their Medicare and Medicaid covered services from the same organization.

The Bipartisan Budget Act (BBA) of 2018 included provisions that permanently authorized D-SNPs as a Medicare Advantage plan option.¹¹ And beginning in 2021, all D-SNPs operate under new rules aimed at promoting greater integration. D-SNPs now must conform to one of three integrated service models¹² for coordinating and/or integrating Medicare services with Medicaid long term services and supports (LTSS) and/or behavioral health and other Medicaid covered services.

The three principal models of D-SNPs are:

- 1. Care Coordination SNPs** do not cover Medicaid benefits but are required to coordinate delivery of their members' Medicare and Medicaid services as directed by the state. Some states also pay care coordination SNPs to cover their enrollees' Medicare cost sharing.
- 2. Highly Integrated Dual Eligible (HIDE) SNPs** provide full Medicare benefits and some or most Medicaid covered services through capitation arrangements with the state, through either the same legal entity or a related company.
- 3. Fully Integrated Dual Eligible (FIDE) SNPs** are D-SNPs in which the same legal entity both provides Medicare benefits and contracts with the state Medicaid agency for coverage of primary, acute, and long-term care benefits and services, consistent with state policy, under risk-based financing. As of 2022, 68 FIDE SNPs in 12 states serve over 315,000 dually eligible individuals.¹³

Medicare-Medicaid Plans

MMPs are health plans offered in some states under the Financial Alignment Initiative demonstration program created by CMS. Unlike D-SNPs, MMPs serve dually eligible individuals through three-way contracts signed by the MMP, CMS, and the state Medicaid agency. MMPs are a highly integrated health plan model for serving dually eligible individuals. The MMP creates an individualized care and service plan for each enrollee. The service plan is tailored to the individual's specific care and supportive needs. The MMP provides all of an enrollee's Medicare Part A, B, and D benefits, and all benefits available through the state's Medicaid program.

The first MMP demonstration began in Massachusetts in 2014 and was limited to dually eligible people under age 65. As of January 2022, 40 MMPs serve about 424,000 people through demonstrations in 9 states,¹⁴ many of which are available

to all full benefit dual eligibles.¹⁵ CMS has announced that the MMP demonstrations will be phased out by the end of 2025. More information about the transition is included below.

Programs of All-Inclusive Care for the Elderly (PACE)

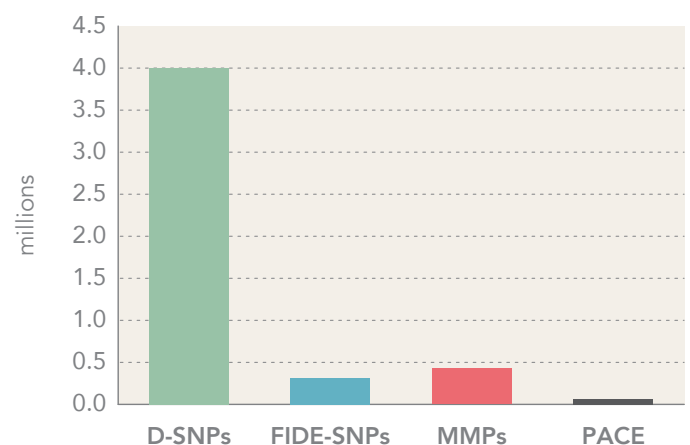
First introduced in 1972 and made permanent in 1997, PACE program plans are available in many urban areas for people aged 55 or older whose health and functional status require a nursing home level of care. PACE is designed to help these people continue living in the community instead of receiving care in a nursing home. PACE plans are a hybrid of health plan and provider. They provide all Medicare and Medicaid benefits, but enrollees receive most Medicare and Medicaid services at one location, called a "PACE center," which is structured similar to an adult day health center.¹⁶ PACE care is directed by an interdisciplinary care team that evaluates the needs of the enrollee and develops a personal care plan to address those needs.

Like MMPs, PACE plans operate under three-way contracts with CMS and their state. Although PACE enrollment is open to anyone who meets the clinical eligibility requirements and lives within the PACE plan's service area, almost all enrollees are dual eligible individuals, meaning the Medicare and Medicaid programs cover the cost of their PACE services. People who have only Medicare pay a monthly premium payment for Medicaid and Medicare Part D services provided through PACE. As of May 2022, 144 PACE plans serve 53,075 enrollees in 30 states.¹⁷ Although well established, PACE program enrollment has been limited due in part to the PACE geographic care center model, in which people travel to a central physical location several times a week to receive most of their care.

The Future of Integrated Care

The chart shows the enrollment of dual eligible individuals by delivery model in 2022 but there are significant changes in store. The *2023 Medicare Advantage-Part D Final Rule* released by CMS in May 2022 includes provisions with major implications for the future of integrated delivery models for people with Medicare and Medicaid. In the Final Rule, CMS announced its intent to phase out MMPs and the Financial Alignment Initiative demonstrations over the next several years. States will have the opportunity to transition their dual eligible MMP enrollees into highly integrated D-SNPs by the end of 2025. Otherwise, for states that do not elect this transition option, their MMPs will terminate by the end of 2023, and MMP members will select or be transitioned to the other options available in their states.

ENROLLMENT BY DELIVERY MODEL - 2022



With the phase-out of MMPs, D-SNPs become the preferred care delivery model for integrating Medicare and Medicaid services. The Final Rule adds a number of best practices gleaned from the MMP experience and applies them to D-SNPs going forward, increasing enrollee involvement in D-SNPs, assessing enrollee social needs, integrating appeals and delivery systems, and giving states additional flexibilities over plan structure.

Conclusion

People with Medicare and Medicaid have significant health challenges as compared with average Medicare or Medicaid enrollees. They experience higher rates of chronic illness, functional impairments and disabilities. Yet to address their health needs, dual eligibles must navigate across two health programs that were not designed to work together. And the cost impacts of dual eligibles on the two programs are significant and disproportional to their numbers.

Currently, D-SNPs, MMPs, and PACE plans are the most effective models for integrating Medicare and Medicaid covered services needed by dual eligibles. In the future, other models for integrating Medicare and Medicaid services may emerge. One approach would be a single unified program that combines Medicare and Medicaid into a single program, bringing greater transparency and alignment for enrollees, their families, and providers. In the meantime, the evolution of integrated delivery models and transitions from MMPs to D-SNPs will continue to provide valuable insights into integration challenges and opportunities for innovation.

Endnotes

- 1 <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html>
- 2 <https://www.cms.gov/files/document/reporttocongressmmco.pdf>
- 3 In 2022, FPL is \$13,590 annual income for one person. See <https://aspe.hhs.gov/poverty-guidelines>
- 4 <https://www.macpac.gov/topics/dually-eligible-beneficiaries/>
- 5 *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*, MACPAC, February 2022; accessed at <https://www.macpac.gov/wp-content/uploads/2022/02/Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-February-2022.pdf>
- 6 <https://www.macpac.gov/wp-content/uploads/2022/02/Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-February-2022.pdf> and <https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/>
- 7 <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>
- 8 For more information on Medicare, see <https://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html>. For more information on Medicaid, see <https://www.medicaid.gov/medicaid/eligibility/>
- 9 <https://www.kff.org/medicaid/state-indicator/dual-eligible-enrollment-in-medicaid-managed-care-by-plan-type>
- 10 <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/Special-Needs-Plan-SNP-Data>
- 11 The Bipartisan Budget Act of 2018, Section 50311; <https://www.congress.gov/bill/115th-congress/house-bill/1892>
- 12 For more information, see <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/D-SNPs>
- 13 <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/Special-Needs-Plan-SNP-Data.html>
- 14 Current MMP states include CA, IL, MA, MI, MN, OH, RI, SC and TX
- 15 https://www.integratedcareresourcecenter.com/sites/default/files/MMP_Enroll_by_State_May_2022_0.pdf
- 16 Adult day services are services in a professional care setting in which older adults, adults living with dementia, or adults living with disabilities receive individualized therapeutic, social, and health services for some part of the day.
- 17 https://www.integratedcareresourcecenter.com/sites/default/files/PACE_Enroll_by_State_May_2022.pdf