Introduction to Medicare-Medicaid Dual Eligibles and Service Delivery Models

ISSUE BRIEF

KEY TAKEAWAYS

Medicare and Medicaid play important roles in the lives of millions of Americans. Medicare pays for health care for about 59 million people and Medicaid provides care and services to more than 75 million. While millions of people are entitled to coverage under both programs, their care is uncoordinated and fragmented between two programs that were not designed to work together.

Approximately 12 million people have both 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-SNPs), Medicare-Medicaid Plans (MMPs) and Programs of All-Inclusive Care for the Elderly (PACE).

Introduction

Medicare and Medicaid have been critical parts of the American healthcare landscape for more than fifty years. As of 2018, the two programs provide health coverage to more than 134 million people[1] (about 40% 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 experience their care as uncoordinated, fragmented, and at times confusing. This brief provides information about Medicare-Medicaid "dual eligible" individuals, their demographics and impacts on the two public health 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 or "CMS". Medicare has three parts: Part A covers inpatient care, Part B covers outpatient and physician services, and Part D covers prescription drugs.

Medicaid is a joint state/federal program with eligibility determined by states 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 covers the cost of inpatient services like care in inpatient hospitals and short-term skilled nursing facilities, and outpatient services like doctor visits, diagnostic tests, home health care, and prescription drugs. Medicare benefits require enrollees to pay a monthly premium for Part B and 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; personal care in the home; and certain other supportive items and services not covered by Medicare. Medicaid also pays some or all of the person's share of costs for Medicare services.

How Do People in Medicare and Medicaid Receive Their Benefits?

People with Medicare can choose to receive their covered services in an unmanaged "fee for service" (FFS) environment or through managed care plans in the Medicare Advantage (MA) program. Providers bill CMS for services provided through the FFS program, or bill MA plans for services provided to MA plan enrollees. Part D prescription drugs are covered by many MA plans or are separately provided through stand-alone Prescription Drug Plans (PDPs).

States have considerable latitude in how their Medicaid programs are structured. Many states contract with managed care organizations (MCOs) to cover certain groups of Medicaid enrollees, such as those in the "aged/blind/disabled" or "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.
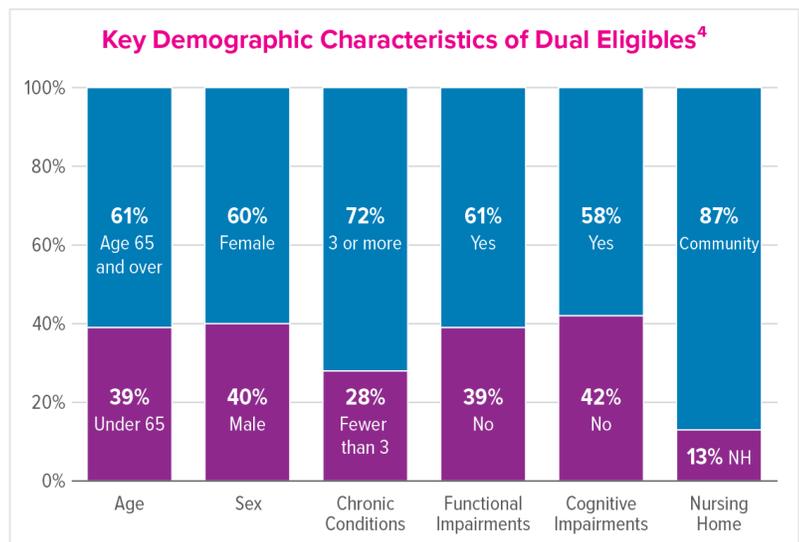
Who Are Dually Eligible Individuals?

Almost 12 million people in 2016 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 benefits and Medicaid benefits as well, and their Medicare premiums and cost sharing are generally paid-for by Medicaid. About 72 percent of dual eligible individuals are in this category. [2] Full benefit dual eligibles typically have incomes less than 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 percent. [2] 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 cost sharing is sometimes 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 coverage.

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

People with both Medicare and Medicaid are particularly at risk in terms of their health and financial security, and many require special supports and services to help them maintain or improve their health. The table to the right provides an overview of key demographic characteristics.[4] Compared with most Medicare enrollees, dual eligibles typically have more chronic conditions and greater levels of physical disabilities, cognitive impairments, and serious mental illness.

A majority of dual eligible individuals are over age 65 (61 percent), female (60 percent), and white (56 percent). They tend to experience significant health challenges. Seventy-two percent have three or more

Key Demographic Characteristics of Dual Eligibles[4]

61% Age 65 and over	60% Female	72% 3 or more	61% Yes	58% Yes	87% Community
39% Under 65	40% Male	28% Fewer than 3	39% No	42% No	13% NH
Age	Sex	Chronic Conditions	Functional Impairments	Cognitive Impairments	Nursing Home

chronic conditions, 61 percent have functional impairments, and 58 percent have cognitive/mental impairments. While the majority of dual eligible individuals live in home or community settings, a significant percentage (13 percent) reside in nursing homes or other long-term care facilities.

While dual eligible individuals comprise about 20 percent of total Medicare enrollment and 15 percent of Medicaid enrollment, expenditures on dual eligible individuals account for approximately 35 percent of the total expenses of both programs.[5] In dollar terms for 2016, this translates to $235 billion dollars for Medicare (out of $672 billion total) and $193 billion for Medicaid (out of $553 billion total).[6]

How Do the Medicare and Medicaid Programs Coordinate 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.[7]

Under Medicare, enrollees have the choice of whether to participate in the FFS program or Medicare Advantage on a voluntary basis, while participation in or exclusion from Medicaid managed care can be mandatory under Medicaid. Accordingly, many people with Medicare and Medicaid have struggled to navigate across the two programs. 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, 21 states (including Washington, DC and Puerto Rico) included dual eligible individuals in comprehensive Medicaid managed care; by 2016, that number had increased to 28 states[8]. 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-SNPs)

- Medicare-Medicaid Plans (MMPs)

- 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)

D-SNPs are Medicare Advantage plans that specialize in providing coverage for approximately 2 million dually eligible individuals in 2018[9]. 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 can determine 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 the 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, and may also specify the geographic area(s) in which the D-SNP may operate.

There are three principal models of D-SNPs:[10]

- *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.

- *Highly-integrated SNPs* provide full Medicare benefits and some or most Medicaid covered services through capitation arrangements with the state.

- *Fully Integrated Dual Eligible (FIDE) SNPs* are D-SNPs that provide Medicare benefits and contract 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 2018, FIDE SNPs in 12 states serve over 130,000 dually eligible individuals.[11]

A number of states have recognized D-SNPs for their potential in advancing Medicare-Medicaid integration and require their contracted Medicaid managed care plans to offer 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.

Starting in 2021, all D-SNPs will be subject to new rules aimed at promoting greater integration.[12] D-SNPs will be required to meet one of three integrated service models for coordinating and/or integrating Medicare services with Medicaid long term services and supports (LTSS) and/or behavioral health and other Medicaid covered services.

Medicare-Medicaid Plans (MMPs)

MMPs are health plans that are offered through a 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 the most integrated health plan model for serving dually eligible individuals in a single program. The MMP creates an individualized care and service plan for each enrollee. The service plan is tailored to the specific care and needs an individual requires. 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 2018, 50 MMPs serve 383,000 people through demonstrations in nine states.[13]

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 cities for people age 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.[14] PACE care is directed by an interdisciplinary care team that evaluates the needs of 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 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 the PACE. As of January 2018, 124 PACE plans serve 41,079 enrollees in 31 states.[15]

Enrollment by Delivery Model – 2018
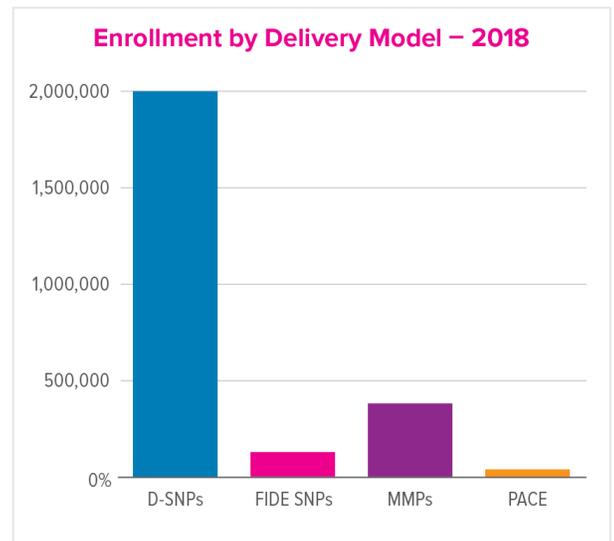
The chart to the right shows the enrollment of dual eligible individuals by delivery model in 2018.

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.

Three major managed care delivery models have emerged as the best options currently available for integrating care and services for people with Medicare and Medicaid.

- **D-SNPs** are Medicare plans that enroll only dual eligible individuals . They contract with the state Medicaid agency to coordinate care and have the highest enrollment of the integrated

models. States may contract with their SNP organizations to include Medicaid benefits as well. FIDE-SNPs are the most highly integrated examples of the SNP model.

- **MMPs** are demonstration plans that cover all Medicare and Medicaid services through three-way contracts between the plan, the state Medicaid agency and the federal government. They cover all Medicare and Medicaid benefits.

- **PACE** plans are hybrid health plan/provider site models that enroll people who require nursing-level care. Most care is provided in a central PACE clinic site. PACE plans are the oldest of the integrated models but have a smaller footprint.

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 three integrated delivery models 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/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/DataStatisticalResources/Downloads/Eleven-YearEver-EnrolledTrendsReport_2006-2016.pdf.

[3] In 2018, FPL is $12,140 annual income for one person. See https://aspe.hhs.gov/poverty-guidelines

[4] https://www.kff.org/medicaid/issue-brief/medicaids-role-for-medicare-beneficiaries/

[5] https://www.kff.org/medicaid/issue-brief/medicaids-role-for-medicare-beneficiaries/, https://www.kff.org/medicare/report/a-primer-on-medicare-key-facts-about-the-medicare-program-and-the-people-it-covers/

[6] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html

[7] 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/

[8] https://www.kff.org/medicaid/state-indicator/dual-eligible-enrollment-in-medicaid-managed-care-by-plan-type/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[9] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data-Items/SNP-Comprehensive-Report-2018-D-SNP 01.html?DLPage=1&DLEntries=10&DLSort=1&DLSortDir=descending

[10] For more information, see https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/DualEligibleSNP.html#s2

[11] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html

[12] The Bipartisan Budget Act of 2018, Section 50311

[13] http://www.integratedcareresourcecenter.com/PDFs/MMP_Enroll_by_State_April_2018.pdf

[14] 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.

[15] http://www.integratedcareresourcecenter.com/PDFs/PACE_Enroll_by_State_Jan_2018.pdf