



Beneficiaries Dually Eligible for Medicare and Medicaid



Medicaid and CHIP Payment and Access Commission

Key Points

Who are dually eligible beneficiaries?

- 11.4 million individuals in 2015
- Age 65 or older or disabled (or both), and low income; 59 percent age 65 and older in 2012
- First eligible for Medicare or Medicaid and then can enroll in the other program; may join both programs simultaneously
- A diverse population including some individuals who are relatively healthy and others with multiple chronic conditions, physical disabilities, and cognitive impairments

What does each program cover?

- Medicare covers:
 - acute and post-acute services such as doctor's visits, short stays in skilled nursing facility after hospitalization
 - most enrollees receive Medicare Part A (hospital insurance) automatically, and can choose to enroll in Part B (medical insurance) and Part D (prescription drug coverage)
 - some are enrolled in Medicare's managed care option (Part C, Medicare Advantage) which covers Part A and B benefits and sometimes prescription drugs
- Medicaid covers:
 - assistance with Medicare premiums and cost sharing
 - long-term services and supports such as nursing home care, as well as other services not covered by Medicare

How much does it cost to serve these beneficiaries?

- \$187.0 billion in Medicare in 2012
 - 34 percent of all Medicare spending for 20 percent of all Medicare enrollees
- \$118.8 billion in Medicaid in 2012
 - 33 percent of all Medicaid spending for 15 percent of all Medicaid enrollees

Challenges and concerns

- Diverse population but includes many with extensive health needs, high health care costs
- Programs not designed to work together
 - policies may have competing incentives
 - may be confusing to beneficiaries
- Coordinating care may improve outcomes and reduce costs but models not fully tested and no one-size-fits-all solution

Eligibility

Beneficiaries become dually eligible in different ways

- Enroll in Medicare or Medicaid first and subsequently become eligible for the other program or enroll in both at the same time
- Medicare is a federal program
 - entitlement for workers, dependents, and survivors
 - eligibility rules are uniform
- Medicaid is a joint federal and state program
 - entitlement for individuals who meet eligibility criteria; eligibility rules vary by state
 - states have flexibility as to how they structure their programs within broad federal guidelines

Reasons for Medicare eligibility

- Age
 - 47 percent of dually eligible beneficiaries in 2012
- Disability
 - 52 percent of dually eligible beneficiaries in 2012
- End-stage renal disease
 - 1 percent of dually eligible beneficiaries in 2012

Pathways for Medicaid eligibility

- Supplemental Security Income (SSI) program (mandatory pathway; all states must provide)
 - 36 percent of dually eligible beneficiaries
 - individuals receiving SSI generally are automatically eligible for Medicaid at 74 percent of the federal poverty level (FPL) (about \$9,000 in 2017)
- Poverty-related (optional pathway)
 - 37 percent of dually eligible beneficiaries
 - states can choose to cover individuals up to 100 percent FPL (\$12,060 in 2017)

Other optional Medicaid pathways

- Medically needy for individuals who have incurred high medical expenses
- Special income limit or other means for individuals requiring an institutional level of care
- Section 1115 waiver in states with approved waivers from CMS

Beneficiary Characteristics

Characteristics of dually eligible beneficiaries

- Diverse population including relatively healthy individuals as well as people with multiple chronic conditions, physical disabilities, and cognitive impairments
- Primarily:
 - age 65 and over (59 percent in 2012)
 - female (61 percent)
 - white/non-Hispanic (57 percent)
 - reside in urban areas (76 percent)

Demographic Characteristics of Dually Eligible Beneficiaries, 2012

| Demographic characteristic | Dually eligible beneficiaries | | |
|-------------------------------|-------------------------------|--------------|------------------|
| | All | Under age 65 | Age 65 and older |
| Gender | | | |
| Male | 39% | 48% | 32% |
| Female | 61 | 52 | 68 |
| Race/ethnicity | | | |
| White/non-Hispanic | 57 | 62 | 54 |
| African American/non-Hispanic | 20 | 24 | 18 |
| Hispanic | 16 | 11 | 19 |
| Other | 7 | 3 | 10 |
| Residence | | | |
| Urban | 76 | 74 | 77 |
| Rural | 24 | 26 | 23 |

Notes: Exhibit includes all dually eligible beneficiaries. Percentages may not sum to 100 percent due to rounding.

Source: MACPAC and MedPAC, 2017, [Data book: Beneficiaries dually eligible for Medicare and Medicaid](#), Exhibit 6.

Prevalence of Chronic Conditions Among Dually Eligible Beneficiaries, 2012

| Condition | Dually eligible beneficiaries | |
|--|-------------------------------|------------------|
| | Under age 65 | Age 65 and older |
| Cognitive impairment | | |
| Alzheimer's disease or related dementia | 3% | 23% |
| Intellectual disabilities and related conditions | 8 | 1 |
| Medical conditions | | |
| Diabetes | 23 | 35 |
| Hypertension | 40 | 66 |
| Behavioral health conditions | | |
| Depression | 32 | 22 |
| Schizophrenia and other psychotic disorders | 14 | 7 |

Notes: Based on enrollees in fee for service (FFS). Chronic conditions are identified using Medicare FFS claims. Exhibit excludes beneficiaries enrolled in Medicare Advantage plans because Medicare FFS claims are not available for those individuals. Beneficiaries with end-stage renal disease are also excluded.

Source: MACPAC and MedPAC, 2017, [Data book: Beneficiaries dually eligible for Medicare and Medicaid](#), Exhibit 8.

Benefits

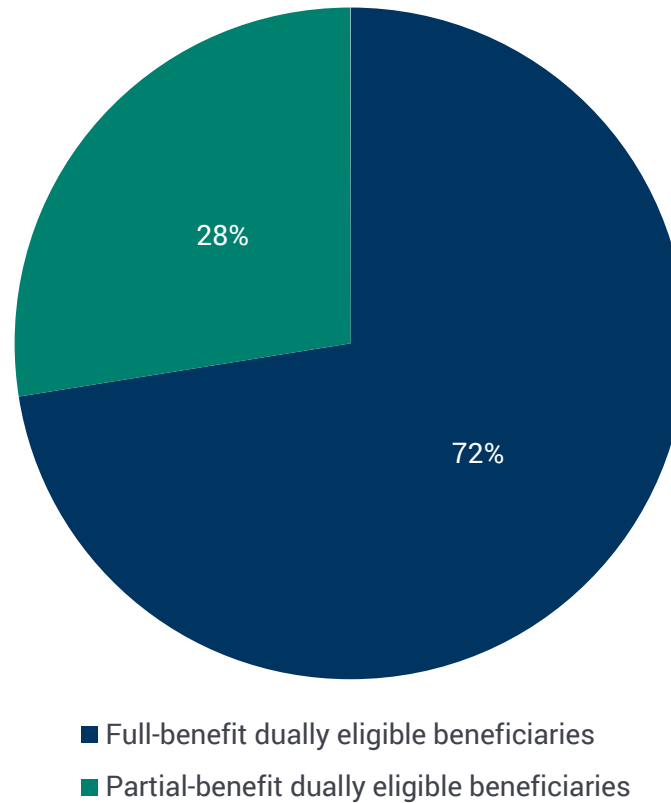
Medicare versus Medicaid benefits for dually eligible beneficiaries

- Medicare benefits are the same for all beneficiaries
- Medicaid benefits differ depending on
 - whether an individual qualifies for full or partial Medicaid benefits
 - state adoption of optional benefits

Full versus partial Medicaid benefits

- Full-benefit dually eligible beneficiaries:
 - receive coverage of mandatory Medicaid benefits
 - receive optional Medicaid benefits if states provide these
 - may or may not receive assistance through the Medicare Savings Programs (MSPs)
- Partial-benefit dually eligible beneficiaries:
 - receive Medicaid coverage limited to payment of Medicare premiums and cost sharing
 - are covered through enrollment in MSPs

Most dually eligible beneficiaries are eligible for full Medicaid benefits



Note: Data are for 2012. Include all dually eligible beneficiaries.

Source: MACPAC and MedPAC, 2017, [Data book: Beneficiaries dually eligible for Medicare and Medicaid](#), Exhibit 1.

Full Medicaid benefits include long-term services and supports (LTSS)

- Focus on maintaining—and sometimes improving—functioning (e.g., assistance with basic tasks of everyday life or with skills related to independent living)
- May be needed on a regular or occasional basis, for a few months or for many years
- Medicare only covers:
 - short nursing home stays following acute care episodes
 - certain skilled nursing care or therapies provided in the home

Types of Medicaid-covered LTSS

- May be provided in institutions or through home and community-based services (HCBS)
- States must cover nursing facility services and home health
- HCBS include:
 - personal care services received at home
 - services provided at adult day care centers
- Can be provided under state plan or waiver authority
- Increasing proportion of LTSS provided through HCBS; referred to as rebalancing

Medicaid assistance with Medicare cost sharing

- Four different Medicare Savings Programs (MSPs) with different eligibility criteria
 - Qualified Medicare Beneficiary (QMB) program
 - Specified Low-Income Medicare Beneficiary (SLMB) program
 - Qualifying Individual (QI) program
 - Qualified Disabled and Working Individuals (QDWI) program
- MSPs have low rates of participation; for example, only about 53 percent of beneficiaries eligible for QMB program are enrolled
- QMB program is the biggest MSP with 7.2 million enrollees in 2015; covers those with incomes below 100 percent FPL

State policies affecting payment of Medicare cost sharing

- States have flexibility in how they pay providers for Medicare cost-sharing amounts.
- Most states limit payment of Medicare deductibles and coinsurance to the lesser of Medicare cost-sharing amount or difference between Medicare payment and Medicaid rate for the service.
- Medicare pays certain providers (e.g., hospitals, skilled nursing facilities) for a portion of the cost sharing that cannot be collected from beneficiaries (often referred to as bad debt). The cost sharing for dually eligible beneficiaries that is not paid by state Medicaid agencies as a result of lesser-of policies is included in these Medicare bad debt payments.

Delivery Systems

Multiple delivery systems serving dually eligible beneficiaries

- Medicare options:
 - Fee for service
 - Medicare Advantage managed care plans including dual eligible special needs plans (D-SNPs)
- Medicaid options:
 - Fee for service
 - Comprehensive risk-based managed care for acute care
 - Limited benefit plan: transportation, behavioral health
 - Managed long-term services and supports
 - Comprehensive risk-based managed care for both acute care and long-term services and supports

Dually eligible beneficiaries more likely to be in fee for service compared to non-dual Medicaid beneficiaries in 2012

| Type of Medicaid enrollment | Dually eligible beneficiaries | | | | | Non-dual Medicaid beneficiaries (disabled, under age 65) |
|--|-------------------------------|--------------|------------------|--------------|-----------------|--|
| | All | Under age 65 | Age 65 and older | Full benefit | Partial benefit | |
| Fee for service (FFS) only | 55% | 54% | 55% | 41% | 91% | 20% |
| FFS and limited-benefit managed care only | 30 | 30 | 30 | 38 | 7 | 26 |
| At least one month of comprehensive managed care | 16 | 16 | 16 | 21 | 2 | 54 |

Notes: Percentages may not sum to 100 percent due to rounding. Exhibit includes all dually eligible beneficiaries. The non-dual Medicaid beneficiary category excludes non-disabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries age 65 and older who do not have Medicare coverage. Limited benefit plans may include transportation, behavioral health care, or dental services. Comprehensive managed care plans generally include most acute care services covered by the state's Medicaid program, but may carve out certain benefits to be provided through a FFS or a limited benefit plan.

Source: MACPAC and MedPAC, 2017, [Data book: Beneficiaries dually eligible for Medicare and Medicaid](#), Exhibit 12.

Many dually eligible beneficiaries enrolled in multiple managed care plans, 2011

| Medicare coverage | Medicaid coverage | | | | | | | | Total | % of total |
|---------------------------------|--------------------------------|------------|---|------------|---------------------------------|------------|--|------------|------------------|-------------|
| | No comprehensive managed care | | | | Any comprehensive managed care | | | | | |
| | Medicaid FFS only ¹ | % of total | Any limited-benefit managed care ² | % of total | Comprehensive managed care only | % of total | Both comprehensive and limited-benefit managed care ³ | % of total | | |
| Total | 3,443,144 | 48% | 2,629,728 | 37% | 281,338 | 4% | 849,277 | 12% | 7,203,487 | 100% |
| FFS | 3,030,334 | 50% | 2,215,405 | 37% | 159,365 | 3% | 621,774 | 10% | 6,026,878 | 84% |
| Medicare Advantage ⁴ | 188,380 | 51% | 134,838 | 36% | 12,897 | 3% | 33,992 | 9% | 370,107 | 5% |
| D-SNP | 183,644 | 25% | 245,792 | 34% | 107,967 | 15% | 191,233 | 26% | 728,636 | 10% |
| I-SNP | 30,751 | 72% | 11,175 | 26% | 153 | 0% | 813 | 2% | 42,892 | 1% |
| C-SNP | 10,035 | 29% | 22,518 | 64% | 956 | 3% | 1,465 | 4% | 34,974 | 0% |

Notes: D-SNP is dual eligible special needs plan. C-SNP is chronic condition special needs plan. I-SNP is institutional special needs plan. FFS is fee for service. Individuals enrolled in a Section 1876 cost plan, an employer or union sponsored Part D retiree plan, a continuing care retirement community demonstration, an end-stage renal disease managed care demonstration, or who have missing or unknown Medicaid or Medicare enrollment are not included in the table. Dually eligible beneficiaries shown here have at least one month of dual enrollment during the year, referred to as an ever enrolled count. Partial-benefit dually eligible beneficiaries and PACE enrollees are excluded. Enrollment in Medicare Part D is not depicted in this table. Enrollment in the territories is not included.

¹ Includes enrollees in Medicaid primary care case management.

² Does not include beneficiaries with both a comprehensive and a limited-benefit Medicaid managed care plan.

³ Limited-benefit Medicaid managed care refers to plans that only cover a specific type of benefit, such as oral health, behavioral health, LTSS, or transportation. Data reflects enrollment in at least one limited-benefit plan.

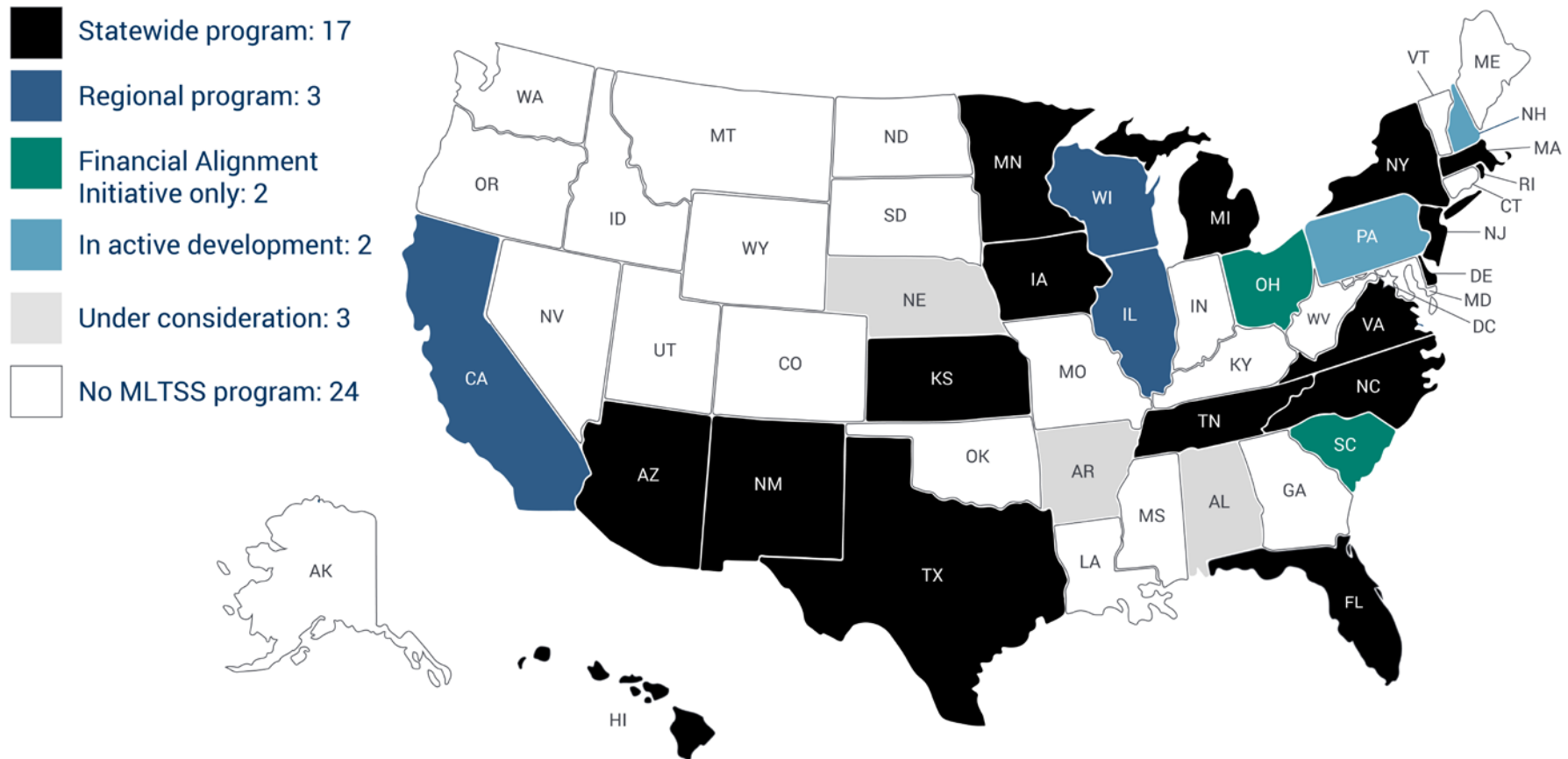
⁴ Medicare Advantage plans shown here include coordinated care plans (i.e., health maintenance organizations, and regional and local preferred provider organizations), Medicare Advantage private FFS plans, and Medicare medical savings account plans.

Source: Acumen LLC analysis of Medicaid and Medicare enrollment and claims data for MACPAC.

States are increasingly using managed long-term services and supports (MLTSS)

- From 2004 to 2017, the number of states with an MLTSS program grew from 8 to 22 states
 - two states have programs in active development
 - three states are currently considering MLTSS adoption
- Most states include both institutional care and home and community-based services in the capitated monthly rate paid to plans

State adoption of MLTSS, July 2017



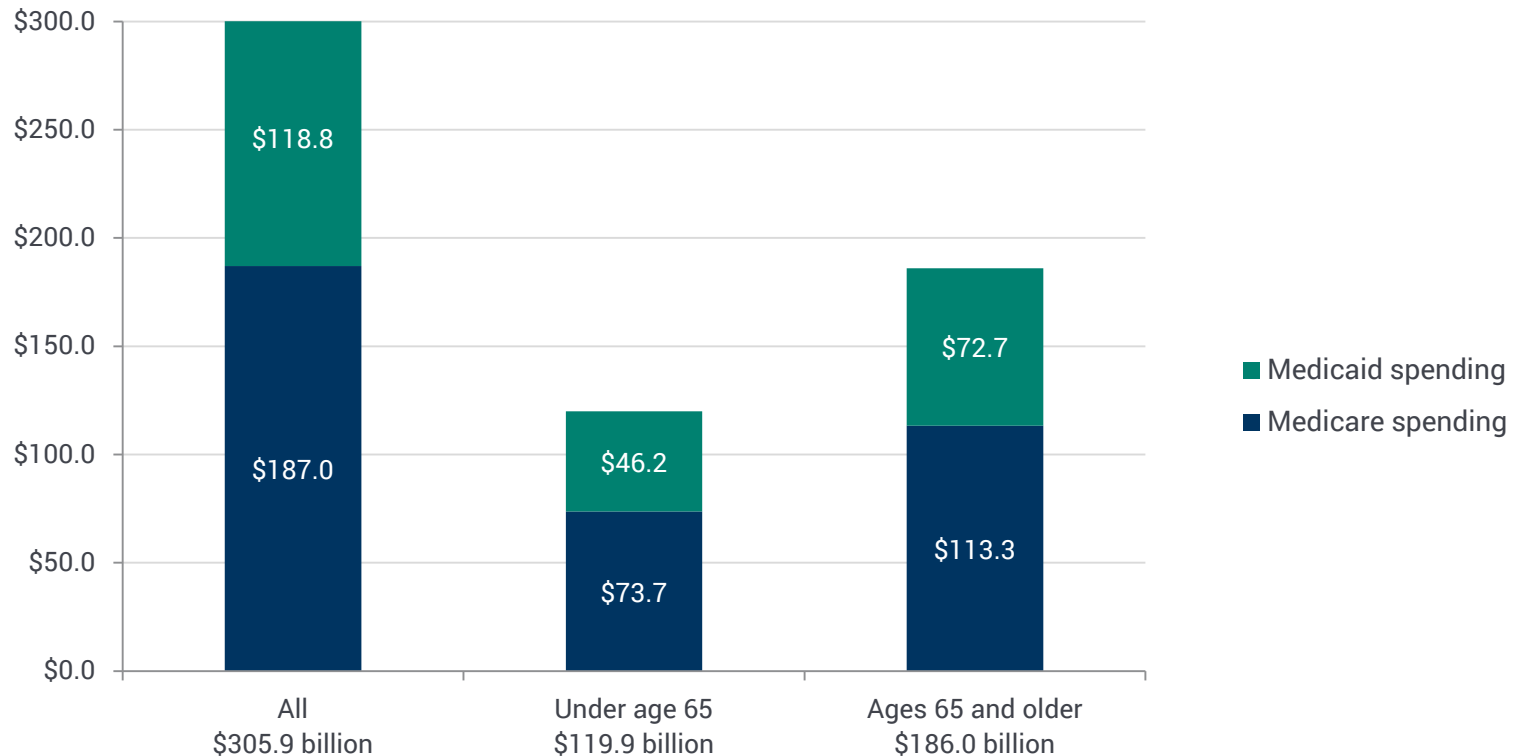
Source: [National Association of States United for Aging and Disabilities](#).

Program Spending

Medicare and Medicaid spent \$305.9 billion on dually eligible beneficiaries in 2012

- Medicaid accounted for 39 percent (\$118.8 billion) of spending broken out as follows:
 - Full-benefit dually eligible beneficiaries = \$116.7 billion
 - Partial-benefit dually eligible beneficiaries = \$2.1 billion
 - Dually eligible beneficiaries under 65 = \$46.2 billion
 - Dually eligible beneficiaries age 65 and over = \$72.7 billion

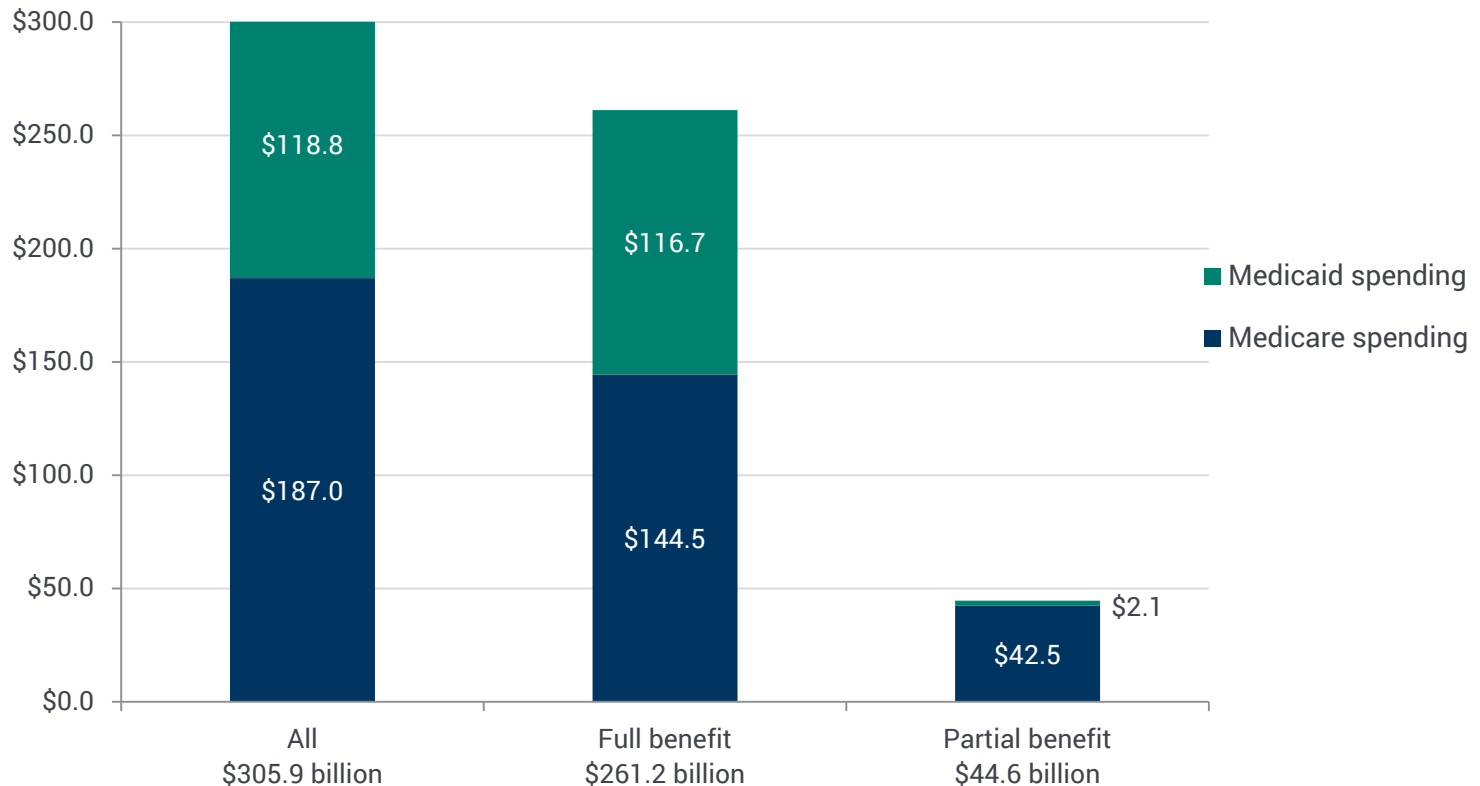
Medicare and Medicaid Spending on Dually Eligible Beneficiaries by Age, 2012 (billions)



Note: Includes all dually eligible beneficiaries. Medicaid spending excludes Medicaid payment of Medicare premiums. Excludes administrative spending. Totals may not sum due to rounding.

Source: MACPAC and MedPAC, 2017, [Data book: Beneficiaries dually eligible for Medicare and Medicaid](#), Exhibit 3.

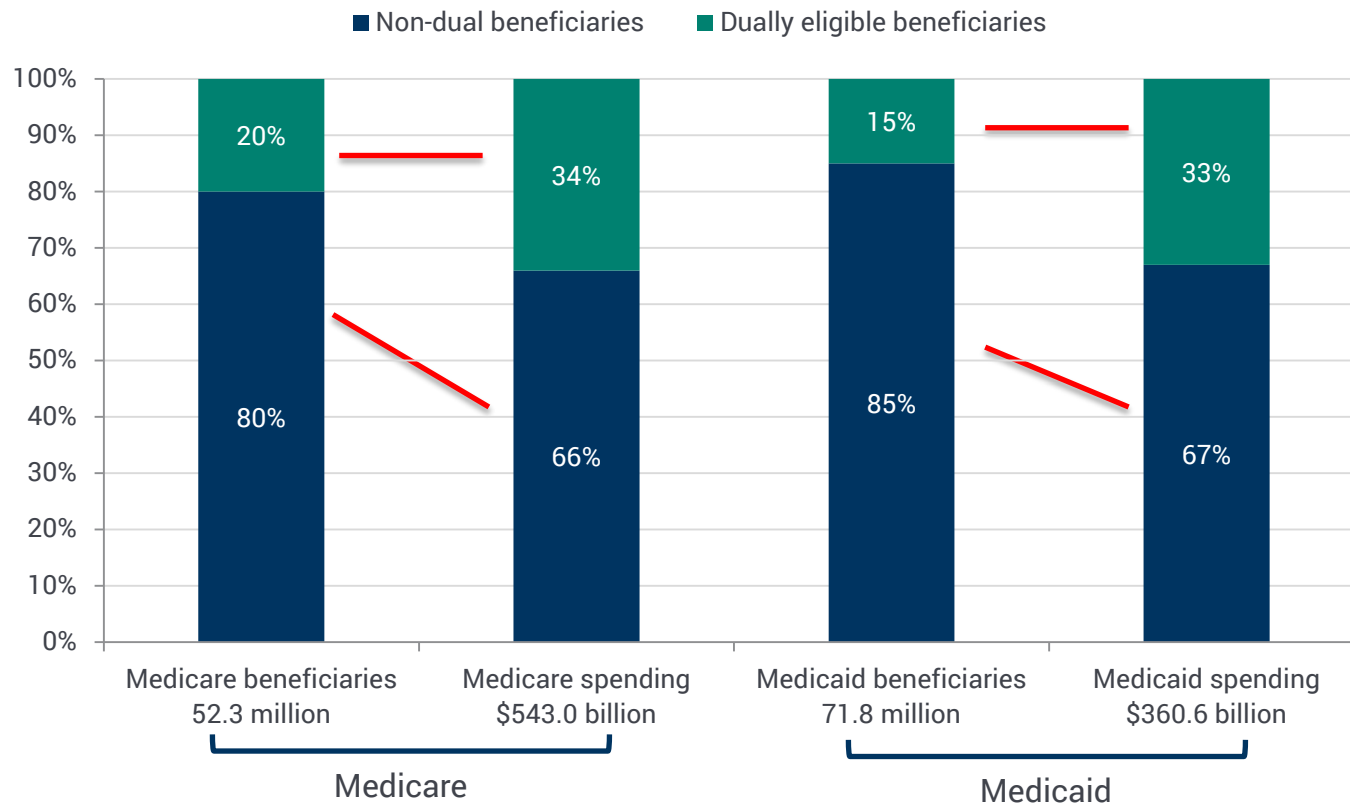
Medicare and Medicaid Spending on Dually Eligible Beneficiaries by Benefit Type, 2012 (billions)



Note: Includes all dually eligible beneficiaries. Medicaid spending excludes Medicaid payment of Medicare premiums. Excludes administrative spending. Totals may not sum due to rounding.

Source: MACPAC and MedPAC, 2017, [Data book: Beneficiaries dually eligible for Medicare and Medicaid](#), Exhibit 3.

Dually eligible beneficiaries account for disproportionate share of spending



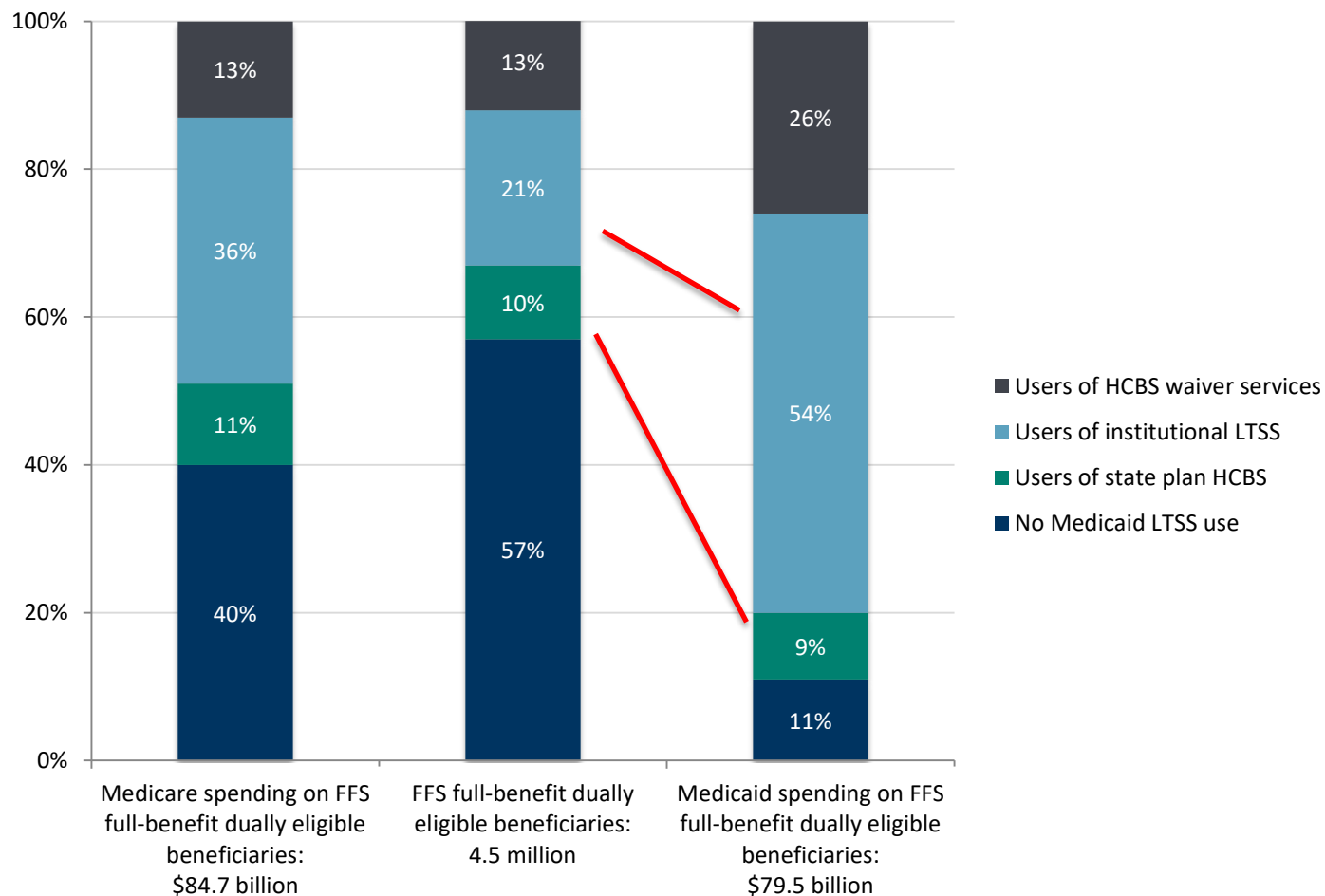
Notes: Data are for 2012. Includes all dually eligible beneficiaries. Medicaid spending excludes Medicaid payment of Medicare premiums. Excludes administrative spending. Medicaid figures include Medicaid-expansion CHIP beneficiaries. Totals may not sum due to rounding.

Source: MACPAC and MedPAC, 2017, [Data book: Beneficiaries dually eligible for Medicare and Medicaid](#), Exhibit 4.

Long-term services and supports (LTSS) users have disproportionately high spending

- Medicare and Medicaid spending on fee-for-service full-benefit dually eligible beneficiaries is driven by Medicaid institutional LTSS
- One-fifth of beneficiaries who used Medicaid institutional LTSS accounted for more than half of Medicaid spending for full-benefit dually eligible beneficiaries.

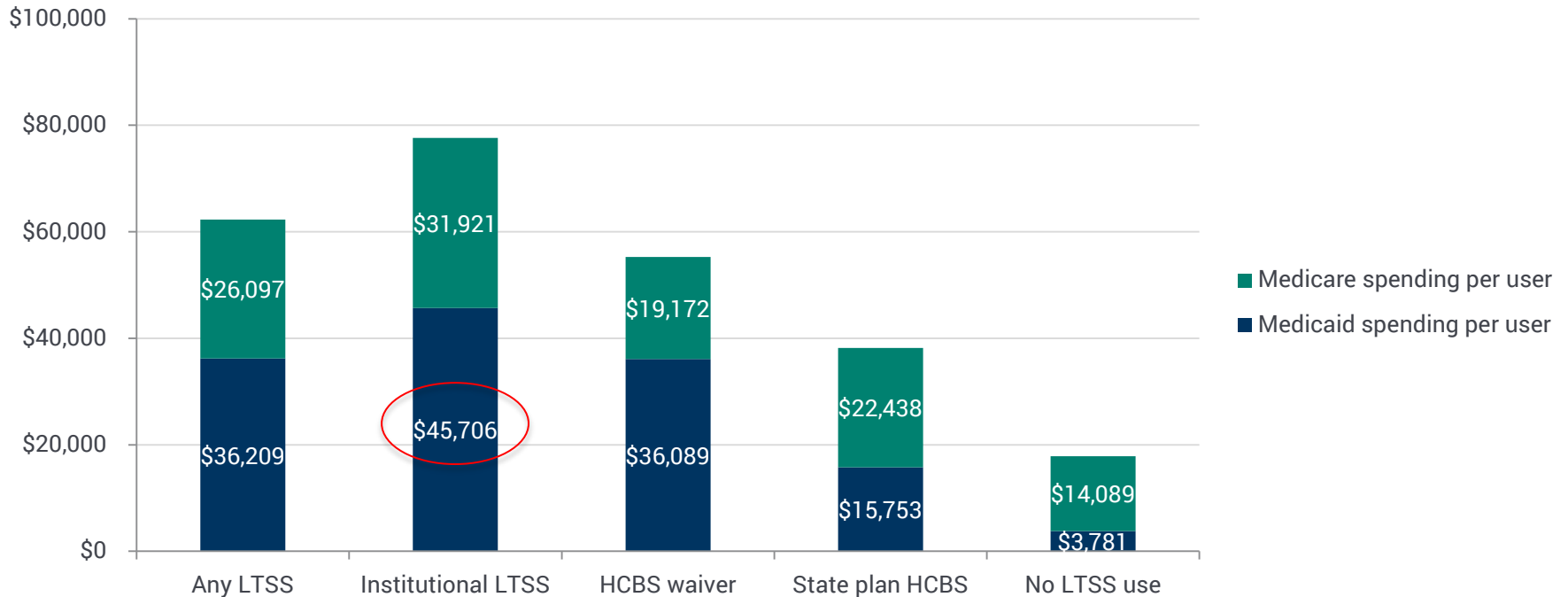
LTSS users have disproportionately high spending in both Medicare and Medicaid



Notes: Data are for 2012. LTSS is long-term services and supports. Limited to full-benefit dually eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending excludes Medicaid payment of Medicare premiums. Excludes administrative spending. Percentages may not sum due to rounding.

Source: MACPAC and MedPAC, 2017, *Data book: Beneficiaries dually eligible for Medicare and Medicaid*, Exhibit 17.

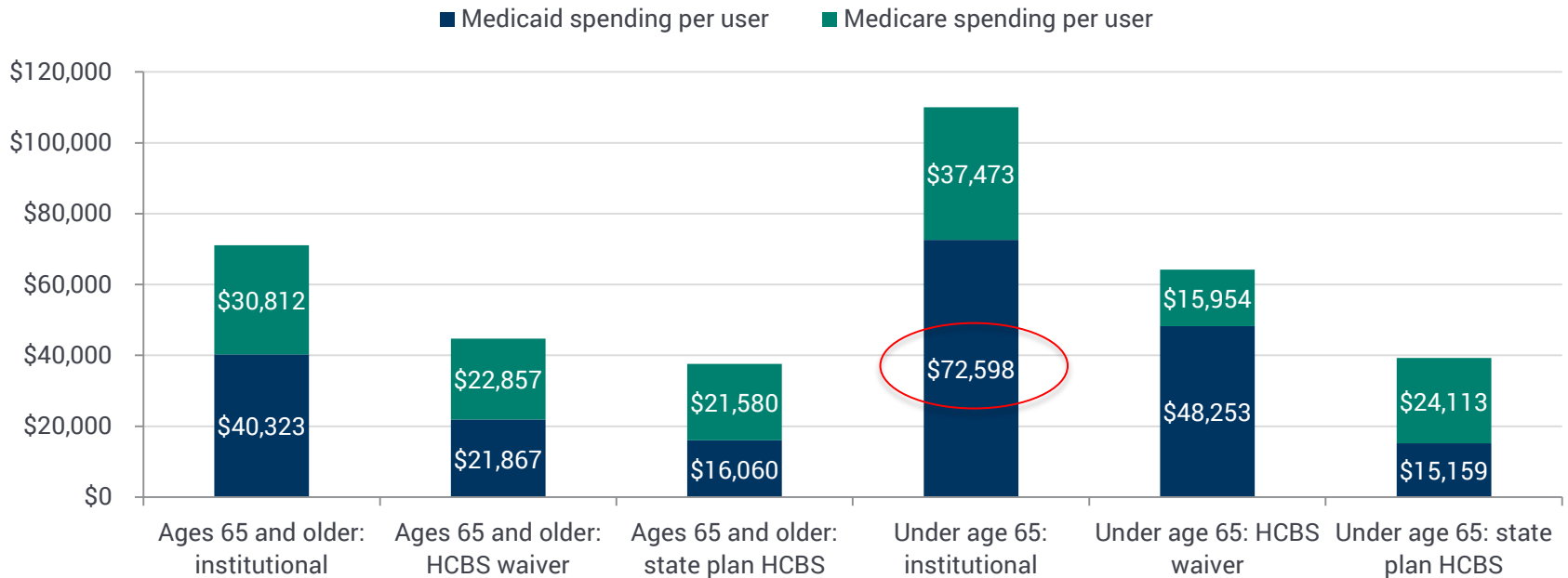
Per user spending for institutional LTSS was highest in 2012



Notes: LTSS is long-term services and supports. Limited to full-benefit dually eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending excludes Medicaid payment of Medicare premiums. Excludes administrative spending. Medicare and Medicaid spending components sum to an amount greater than the total because combined per user spending includes a small number of individuals who used either Medicare or Medicaid services, but not both.

Source: MACPAC and MedPAC, 2017, [Data book: Beneficiaries dually eligible for Medicare and Medicaid](#), Exhibit 18.

Among Medicaid LTSS users who are dually eligible, those under age 65 living in institutions had highest per person spending



Notes: Data are for 2012. LTSS is long-term services and supports. Limited to full-benefit dually eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending excludes Medicaid payment of Medicare premiums. Excludes administrative spending. Medicare and Medicaid spending components sum to an amount greater than the total because combined per user spending includes a small number of individuals who used either Medicare or Medicaid services, but not both.

Source: MACPAC and MedPAC, 2017, [Data book: Beneficiaries dually eligible for Medicare and Medicaid](#), Exhibit 19.

Integration of Care

Integrating care for dually eligible beneficiaries is challenging

- High-cost, high-need population
- Programs have different histories and different rules
- Providers and plans have varying experience coordinating and managing care for this population
- Benefits of integration must be made clear to beneficiaries to keep them enrolled in integrated models

Current efforts to integrate Medicare and Medicaid

- Multiple approaches:
 - Leveraging Dual Eligible Special Needs Plans (D-SNPs)
 - Programs of All-Inclusive Care for the Elderly (PACE)
 - Financial Alignment Initiative (FAI) demonstration (often referred to as duals demos)
- More than one approach underway in many states
- Some time limited and require legislative action or extensions by CMS

Leveraging dual eligible special needs plans (D-SNPs)

- Type of Medicare Advantage plan designed for dually eligible beneficiaries
 - Often provides additional benefits such as dental or hearing coverage
- Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) required D-SNPs to have a contract with the state Medicaid agency
 - D-SNPs currently operate in 38 states and DC
 - Contracts vary in the extent to which D-SNPs coordinate a beneficiary's Medicaid benefits
- D-SNP authority expires at end of 2018

Integrating D-SNPs

- Some states are aligning D-SNPs and managed long-term services and supports (MLTSS)
 - may require MLTSS plans to offer a companion D-SNP
 - encourage beneficiaries to enroll in companion D-SNP that manages both Medicare and Medicaid benefits
- Fully-integrated dual eligible special needs plans (FIDE-SNPs) are a sub-type of D-SNP that provide beneficiaries with a single integrated plan, including coverage of LTSS

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

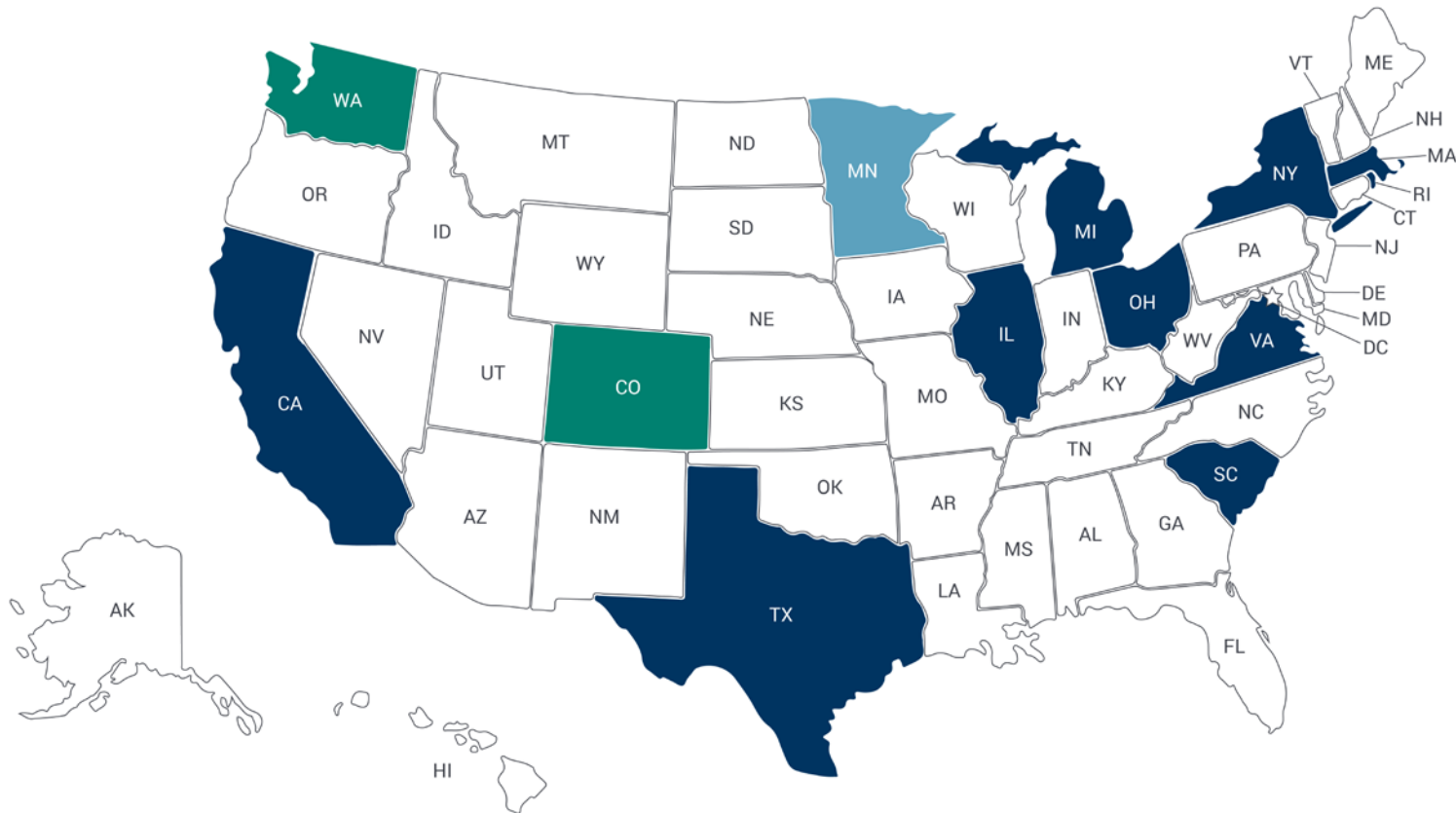
- Day center with interdisciplinary care team providing comprehensive medical and social services to beneficiaries aged 55 and older
- States can offer PACE services to Medicaid beneficiaries as an optional benefit
- As of August 2017 there were 39,608 individuals participating in PACE, most of whom were dually eligible
- PACE Innovation Act of 2015 (P.L. 114-85) gave CMS authority to test new PACE-like models for younger beneficiaries

Financial Alignment Initiative (FAI) demonstration

- Created by the Affordable Care Act
- Thirteen states participating and testing three models:
 - capitated model (10 states) with three-way contract between the state, CMS, and plans
 - managed FFS model (2 states) in which state and CMS enter into agreement allowing state to benefit from savings generated through improved quality or reduced costs
 - alternative model (1 state) designed to align administrative functions between program
- As of August 2017, there were a total of 403,366 beneficiaries in capitated models

FAI participation, August 2017

■ Capitated model: 10 ■ Alternative model: 1 ■ Managed fee-for-service model: 2 □ Not participating: 38



Notes: Colorado and Virginia will end their demonstrations in December 2017. Colorado is transitioning beneficiaries to the state's accountable care collaborative. Virginia is phasing in a statewide mandatory managed long-term services and supports program this year.

Sources: [Centers for Medicare & Medicaid Services](#), [Colorado Department of Health Care Policy & Financing](#), and [Virginia Department of Medical Assistance Services](#).

FAI timetable

- Began in 2013 and was originally intended to last three years
- CMS has extended the original end date twice:
 - in July 2015, CMS offered all participating states a two-year extension to December 31, 2018
 - in January 2017, CMS offered three states (Massachusetts, Minnesota, and Washington) a two-year extension to December 31, 2020

FAI issues: Passive enrollment

- Capitated model states typically provide an opt-in period for beneficiaries to select a plan, followed by a passive enrollment period during which remaining beneficiaries are automatically assigned
- Passive enrollment is a departure from Medicare's rules
- Advocates strongly opposed passive enrollment; some states suspended passive enrollment in the face of that opposition

FAI issues: Enrollment has been lower than expected

- Beneficiaries can opt out of the demonstration during the initial enrollment period
 - as of June 2017, approximately 32 percent of all eligible beneficiaries in Massachusetts, and 50 percent in California, opted out
- Beneficiaries opt out due to provider influence, confusing enrollment materials, and a lack of information on how the program will benefit them
- Beneficiaries who are dissatisfied with their plan can disenroll at any time
- Some plans have left the demonstration because they needed higher enrollment to cover costs

FAI issues: Data delays have made it difficult to assess results

- Published evaluations only available for first year experience in Massachusetts and Washington
 - Massachusetts evaluation found beneficiaries enrolled in the demonstration were sicker and used more of certain services than those who did not enroll;
 - evaluators said care interventions may take time to have an effect
- Difficult to assess the long-term viability of the models being tested
- Extensions allow more time for evaluation

Challenges and Policy Questions

Aligning Medicare and Medicaid

- To what extent does having two different programs serving this population lead to:
 - higher costs overall?
 - cost shifting between programs?
 - fragmented or duplicative care?
 - confusion for beneficiaries?
- What could be achieved by alignment? What are the barriers to alignment?
 - enrollment/disenrollment
 - payment and coverage policies
 - appeals and grievances in FFS
 - use of managed care

Integration of care

- What have we learned from testing models to integrate care?
- What should the future of the Financial Alignment Initiative be?
- Should dual eligible special needs plans be reauthorized?
- How do we educate/inform beneficiaries and providers on the benefits of integrated options?

Barriers to access

- Medicaid policies for paying Medicare cost sharing may create barriers by making it more difficult to use outpatient care and increasing use of safety-net providers
- Low enrollment in MSPs may result in barriers to receipt of care

Role of managed care

- Moving from fee for service to managed care raises questions:
 - Should all dually eligible beneficiaries be in managed care?
 - How do we ensure a smooth transition?
 - Are additional beneficiary protections needed?

Resources from MACPAC

- General information about dually eligible beneficiaries
 - [*Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid*](#) (produced jointly with MedPAC)
 - [*The Roles of Medicare and Medicaid for a Diverse Dual-Eligible Population*](#) (March 2013 [*Report to Congress on Medicaid and CHIP*](#))
 - [MACPAC website](#)
- Financial Alignment Initiative demonstrations
 - [*An issue brief with separate fact sheets for each state*](#)

Resources from MACPAC

- Managed Care
 - [Medicaid and Medicare Plan Enrollment for Dually Eligible Beneficiaries](#)
 - [Issues in Setting Medicaid Capitation Rates for Integrated Care Plans](#)
- Medicare Savings Programs
 - [Medicare Savings Programs: New Estimates Continue to Show Many Eligible Individuals Not Enrolled](#)
 - [State Medicaid Payment Policies for Medicare Cost Sharing](#)
 - [Effects of Medicaid Coverage of Medicare Cost Sharing on Access to Care](#)



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