Making Medicaid Work

FOR THE 21ST CENTURY

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Medicare and Medicaid Dual Eligibles

Individuals with certain combinations of needs who enroll in both the state-administered Medicaid program and the federally-administered Medicare program are referred to as dual eligibles. Currently, dual eligibles receive prescription drugs and most long-term care benefits from Medicaid, while they are covered by Medicare for acute benefits such as doctor's visits and inpatient hospital care. Medicaid also picks up the financial responsibility for Medicare's out-of-pocket costs, such as premiums, deductibles, and copayments.

Because dual eligibles receive benefits from both Medicare and Medicaid, many care coordination challenges arise in delivering high-quality, cost-effective, and comprehensive benefits across the two programs. Many of these challenges will continue to exist – some will be ameliorated, others compounded – when the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 is fully implemented in January 2006 and the Medicare program takes over responsibility for the prescription drug benefits delivered to dual eligibles.

Current Situation

In calendar year 2000, approximately 7.2 million Americans were dual eligibles who received benefits from both the Medicaid and Medicare programs:

- More than six million of the 7.2 million individuals are full benefit dual eligibles, entitled to the entire array of health care benefits available in each program.
- Another one million are enrolled in some form of Medicare savings program, in which the Medicaid program provides financial assistance to cover the individual's Medicare out-of-pocket costs for coinsurance, deductibles, and/or premiums, but does not otherwise provide Medicaid health benefits.[1]

Full benefit dual eligibles are the most expensive members of both the Medicaid and Medicare programs.[2] Dual eligibles accounted for about 16 percent of the Medicaid program's enrollment and 42 percent of its overall expenditures.[3] They make up 18 percent of the Medicare program's enrollment, but Medicare spent even more on their care than Medicaid.[4] In 1999, total health care expenditures of dual eligibles from all sources (Medicare, Medicaid, out-of-pocket) averaged $16,278, more than twice the average expenditure ($7,396) for a non-dual Medicare beneficiary.[5]

Compared to other Medicare beneficiaries, dual eligibles are sicker, poorer, and more likely to have chronic health conditions and to need institutional care. In particular,

- Dual eligibles are more than four times more likely to have a cognitive or mental impairment (40 percent compared to 9 percent of non-dually eligible Medicare beneficiaries);
- Dual eligibles are more than twice as likely to be members of racial and ethnic minorities (42 percent compared to 16 percent of non-dually eligible Medicare beneficiaries);
- Over 60 percent of dual eligibles have a limitation in at least one activity of daily living (such as eating, dressing, or bathing) that would require attendant care, a benefit available in most Medicaid programs but unavailable in Medicare;

- Dual eligibles are more likely to suffer from a chronic and serious health condition such as diabetes, pulmonary disease, or stroke; and
- Medicaid pays for the costs of nursing home care for many more Medicare beneficiaries than does Medicare.[6]

What Works Well and What Doesn't

Dual eligibles are often poor, frail, and dependent on a wide range of health care benefits to meet their overall health care needs. The current policies deliver a comprehensive set of benefits across the two programs. In general, Medicare provides benefits to meet an individual's acute care needs (doctors, hospitals, and, beginning in 2006, pharmacy), while Medicaid provides long-term care benefits (long-term nursing home coverage, attendant care) as well as financial support to cover Medicare's out-of-pocket obligations.

The current financing arrangement for dual eligibles also spreads the financial burden, with the federal government paying for all Medicare-covered services and, on average, 57 percent of the cost of all Medicaid-covered services, while states pay for the remaining Medicaid costs.[7] The current policies also help protect the dual eligibles from an out-of-pocket financial burden that could impede access to needed care.

Although the current situation provides dual eligibles a full range of health care benefits, at no- or low-cost to the individual, it has several deficiencies.

1. Care coordination challenges

Both Medicare and Medicaid benefits are crucial to the health of dual eligibles. However, care coordination across the two programs, administered by different government entities, is challenging.

- Medicaid pays the nursing home costs for just under 70 percent of the nation's nursing facility residents. For more than half of these individuals, the nursing facility stay began as a post-acute admission following a hospital stay, which was covered by Medicare. The hospital stay led to a nursing facility admission for short-term rehabilitation services (again covered by Medicare) but, after a time, the Medicare coverage ended, the resident was not discharged, and she then spent down her assets until Medicaid became the payer.[8]

  In this all-too-common situation, Medicare served as the gateway to the nursing facility admission. The Medicaid program, which might have been able to offer home and community-based services as an alternative to the nursing facility, could not easily have diverted the individual into those services, because Medicaid only learned of the person's eligibility for Medicaid long after the admission to the nursing facility occurred. In this way, Medicare's benefit design reinforces a bias toward institutional care in health delivery, one that differs from most state Medicaid programs' desire to promote community-based care.[9]

- Medicare inpatient services are dependent on well-delivered and coordinated Medicaid long-term care services. For instance, the quality of care rendered by Medicaid-paid nursing homes care is related to the utilization of Medicare-paid inpatient hospital care: avoidance of falls and bedsores during a Medicaid nursing home stay helps the Medicare program avoid unnecessary hospitalizations. But coordination of care across these long-term care and inpatient settings is uncommon.

2. Coordination challenges in quality oversight and program administration

Apart from care coordination challenges, the administration and policies of the Medicare and Medicaid programs make it difficult for the programs to better manage quality outcomes and the benefits for which the two programs are responsible. The two programs:

- Do not share beneficiary-level data on health services received or health diagnoses that are needed to improve disease or case management;
- Do not coordinate quality initiatives or outcome measures in such areas as hospital admissions from Medicaid-funded nursing facility stays (to identify preventable hospitalizations related to poor quality in Medicaid-paid nursing home care);
- Do not coordinate delivery system models (such as managed care initiatives);
- Do not coordinate provider participation standards, to make it simpler for providers to comply with a uniform set of expectations; and

Workgroup participants agree that the Medicaid program should support the health and well-being of low-income populations by prudently managing programs that ensure access to quality health care and support services through a federal-state financial partnership. As a result, the workgroup has sought to foster systems of care and payment for dual eligibles that treat the whole person, prevent cost-shifting between Medicare and Medicaid, and divide costs fairly between the federal and state governments.

- Do not mandate that Medicare quality improvement organizations (QIOs) identify dual eligibles as a subsample in Medicare program quality reviews.

3. Challenges due to overlapping benefits

Challenges to serving dual eligibles arise when Medicare and Medicaid both cover a benefit but the coverage is not coordinated. In this situation, Medicaid may pay for a service even though Medicare, as primary insurer, should bear the responsibility.

For example, Medicare commonly only covers home health care for homebound Medicare beneficiaries. When Medicare incorrectly denies home health care for a dually eligible person, asserting that he is not homebound, Medicaid often ends up providing home health benefits to a dually eligible person.[10]

When the two programs offer overlapping benefits, as in the home health care example, it is important to ensure that the Medicare program provides primary coverage within its coverage rules. Yet access to the Medicare benefit depends not only on the coverage criteria for the benefit (for example, being homebound) but on other factors as well, such as whether Medicare pays its providers adequately and in a timely fashion. When the Medicare program incorrectly denies access to its benefits or fails to ease delivery of the benefit based on other factors (payment rates, medical necessity criteria) and Medicaid also offers that benefit, then Medicaid pays when it should not. This challenge, related to overlapping benefits, also arises in other benefits (for example, skilled nursing home care and durable medical equipment).

How the Current System Can Be Improved

Although the current policies deliver a comprehensive set of benefits at no or low cost to dual eligible beneficiaries, workgroup members agree that service delivery for dual eligibles needs to be improved to address care coordination problems, quality oversight challenges, and a bias towards institutional care. To those ends, workgroup members explored a number of options for improving services for dual eligibles:

Data sharing across the programs. In order to improve care coordination, Medicare and state Medicaid programs could share data on service utilization by dual eligibles. This might involve developing data-sharing arrangements (including confidentiality protocols, common files and interfaces, and common fields) in order to transmit information on a regular and timely basis from Medicare to state Medicaid agencies.

Improve policies to reduce the likelihood of cost shifting. For benefits offered by both Medicare and Medicaid, the Medicare program could review its policies in the areas of payment adequacy, benefit design, and medical necessity to ensure that its beneficiaries have appropriate access to these benefits through Medicare, rather than initially seeking those benefits from Medicaid.

Coordinate managed care programs. The Medicare Modernization Act attempts to revive Medicare managed care. Some states also operate Medicaid managed care programs that enroll dual eligibles. Several changes to Medicare managed care policy have the potential to improve the coordination of managed care across the two programs. One of these would be to permit a demonstration project that would allow a state to enroll dual eligibles in a mandatory managed care program that covers both Medicare and Medicaid

benefits. In addition, the methods for determining Medicare capitation rates could be changed to better reflect the fact that dual eligibles are sicker and more likely to have chronic health conditions than other Medicare beneficiaries and that these differences likely result in higher service utilization. Better coordination also could occur between Medicare managed care and Medicaid fee-for-service.

Increase focus on measuring quality of care for dual eligibles. To better monitor the quality of care rendered to dual eligibles, the Medicare program could mandate that Medicare quality improvement organizations (QIOs) identify dual eligibles as a subsample in quality reviews.

Improving care coordination in Medicare. Medicare could consider adding a benefit for care coordination that would assist patients in navigating and coordinating the services they receive from care providers. Care coordination also can prvent avoidable hospitaliztions by monitoring nursing home care, and it can provide information about alternatives to nursing facility care.[11] For example, a care coordinator is able to review all of the medications a patient is taking to identify which ones may produce adverse drug-to-drug side effects when taken together; the care coordinator can then coordinate with the appropriate physicians to revise the patient's drug regimen to avoid this problem.

Care coordination also can prevent avoidable hospitalizations by monitoring nursing home care and providing information about alternatives to nursing facility care when a Medicare beneficiary is discharged from a hospital. Specialized care coordination can also assist dual eligibles diagnosed with mental illness, developmental disabilities, as well as younger people with physical disabilities.

The Care Management Demonstration included in the Medicare Modernization Act will permit limited pilots of care coordination. Given that the evidence already has proven the value of care coordination in programs such as Medicaid, the pilot could be expanded and incorporated as an authorized service in the Medicare program. Care coordination is especially important for those dual eligibles who elect to stay within Medicare's fee-for-service program, where no person or entity coordinates dual eligibles' multiple direct care providers and services.

This brief is a product of NASHP's project on Making Medicaid Work for the 21st Century. For more information on the project and a list of advisory group participants, visit the NASHP website at **www.nashp.org.**

This issue brief was prepared by Charles Milligan, a consultant to the workgroup.

[1] Kaiser Commission on Medicaid and the Uninsured, "Dual Enrollees: Medicaid's Role in Filling in Medicare's Gaps," drawing upon data from the Medicare Current Beneficiary Survey conducted by the Centers for Medicare and Medicaid Services (CMS), (Washington, DC: The Commission, March 2004).

[2] Unless otherwise indicated, the remainder of this issue brief will focus on full benefit dual eligibles.

[3] Jocelyn Guyer, "A Prescription Drug Benefit in Medicare: Implications for Medicaid and Low-Income Medicare Beneficiaries," (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2003).

[4] Ibid.

[5] Jennifer Ryan and Nora Super, "Dually Eligible for Medicare and Medicaid: Two for One or Double Jeopardy?" Issue Brief No. 794 (Washington, DC: National Health Policy Forum, September 30, 2003).

[6] Ibid.

[7] Federal financing of state Medicaid programs ranges from a low of 50 percent to a high of 77 percent. The exact amount a state receives is dependent on a formula that primarily takes into account the state's per capita income.

[8] Ryan and Super.

[9] Medicare's benefit design has other limitations as well: because the needs of Medicare beneficiaries exceed the scope of the Medicare benefit, the U.S. General Accounting Office has estimated that Medicare fails to cover fully 45 percent of the cost of care for Medicare beneficiaries. Because of this, 80 percent of all Medicare beneficiaries obtain some form of supplemental coverage; for dual eligibles that supplemental coverage comes from Medicaid. William J. Scanlon, U.S. General Accounting Office, "Medigap: Current Policies Contain Coverage Gaps, Undermine Cost Control Incentives," testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, GAO 02-533T, March 14, 2002.

[10] The Lewin Group, Medicaid Cost Containment: Report No. 3, prepared for the Washington State Legislature, January 2003, 48.

[11] A. Chen, R. Brown, N. Archibald, et al, Best Practices in Coordinated Care (Princeton, NJ: Mathematica Policy Research, Inc., 2000).