

CHAPTER

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**Care needs for  
dual-eligible beneficiaries**

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# Care needs for dual-eligible beneficiaries

## Chapter summary

Dual-eligible beneficiaries are eligible for both Medicare and Medicaid benefits. In 2011, about 19 percent of Medicare beneficiaries (about 10 million) were dual eligible. The dual-eligible population is diverse and includes individuals with multiple chronic conditions; difficulties with activities of daily living; cognitive impairments such as dementia; individuals with physical disabilities, developmental disabilities, and severe mental illness; and some individuals who are relatively healthy but have a low income. Because of their diverse needs, dual-eligible beneficiaries require a mix of medical care, long-term care, behavioral health services, and social services. Given the challenges this population faces in accessing services through two payment and delivery systems, programs that coordinate dual-eligible beneficiaries' Medicare and Medicaid benefits (which we refer to as Medicare–Medicaid coordination programs) have the potential to improve dual-eligible beneficiaries' access to services and quality of care. This chapter reviews pathways to dual eligibility, updated Medicare and Medicaid spending on dual-eligible beneficiaries for 2009, and care coordination best practices from Medicare–Medicaid coordination programs.

- **Pathways to eligibility**—Dual-eligible beneficiaries age 65 or older obtain Medicare eligibility due to age and receipt of Social Security benefits. They may have income and assets low enough to qualify for Medicaid when they enter the Medicare program or they may obtain Medicaid

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eligibility (and dual-eligible status) after spending down their income and assets on medical expenses. Dual-eligible beneficiaries under the age of 65 obtain Medicare eligibility through disability (a physical disability, developmental disability, end-stage renal disease (ESRD), or disabling mental health condition), generally through the Social Security Disability Insurance (SSDI) program. Beneficiaries on SSDI can become dually eligible if their income and assets qualify them for Supplemental Security Income in their state.

- ***Medicare and Medicaid spending***—Close to 6 million dual-eligible beneficiaries (excluding beneficiaries enrolled in Medicare Advantage plans and those with ESRD) who were enrolled in Medicare fee-for-service (FFS) in 2009 met the inclusion criteria from our analysis. These beneficiaries collectively accounted for almost \$93 billion in Medicare FFS and Part D spending. Dual-eligible beneficiaries age 65 or older accounted for almost two-thirds of this spending and had higher average per capita spending than dual-eligible beneficiaries under the age of 65. In 2009, Medicaid FFS and managed care spending on dual-eligible beneficiaries totaled \$80 billion, while combined Medicare and Medicaid spending for these beneficiaries was approximately \$173 billion. Medicare accounted for just over half of the combined spending for both the older and the younger dual-eligible populations. Total federal spending on dual-eligible beneficiaries—Medicare spending and the federal portion of Medicaid spending on dual-eligible beneficiaries—is higher than state spending.
- ***Long-term care services and supports***—Medicaid-covered long-term care services and supports (LTSS) can be provided in institutions or in the community. In 2009, slightly more than one-third of Medicare FFS dual-eligible beneficiaries utilized Medicaid-covered LTSS services (excluding beneficiaries with ESRD). Medicaid spending per capita was much higher for LTSS users (\$35,031) than for non-LTSS users (\$2,374). Medicare accounted for 40 percent of combined spending for LTSS users and 83 percent of combined spending for non-LTSS users. For LTSS users both over and under the age of 65, Medicaid LTSS spending per capita was more than twice as high for institutional LTSS services compared to community-based LTSS services.
- ***Severe and persistent mental illness***—We defined severe and persistent mental illness (SPMI) as the presence of schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, or paranoid disorder. In 2009, 20 percent of all dual-eligible beneficiaries enrolled in FFS during the entire year (excluding beneficiaries with ESRD) had at least one SPMI condition. Almost one-third of dual-eligible beneficiaries under the age of 65 had an SPMI

condition, compared with 10 percent of dual-eligible beneficiaries age 65 or older. Two-thirds of SPMI beneficiaries age 65 or older utilized LTSS services in 2009, while less than one-quarter of the younger dual-eligible population with SPMI were LTSS users. Average Medicare and Medicaid spending per capita was higher for SPMI dual-eligible beneficiaries age 65 or older than for those under the age of 65.

- ***Care delivery systems for dual-eligible beneficiaries***—We conducted structured interviews with stakeholders (federally qualified health centers (FQHCs) and community health centers (CHCs), primary care physicians, health systems, behavioral health providers, aging services organizations, community-based care managers, beneficiary advocates, and health plans) in five states with Medicare–Medicaid coordination programs. Dual-eligible beneficiaries (both those enrolled in Medicare–Medicaid coordination programs and those not enrolled in those programs) were consistently reported to need high-contact, on-the-ground, intensive care management given that their issues are not likely to be resolved in a few physician visits. Dual-eligible beneficiaries’ providers tend to operate only in their respective settings and communication with one another across settings regarding a patient’s care is not common. Medicare–Medicaid coordination programs focus on getting providers in various settings—for example, hospitals, physicians’ offices, and social service agencies, among others—to communicate with one another regarding a beneficiary’s care. These programs also seek to leverage community-based resources, including care coordination activities at FQHCs and CHCs. Many FQHCs and CHCs are uniquely positioned to coordinate care for dual-eligible beneficiaries because they provide primary care, behavioral health services, and care management services, often at the same clinic site. ■



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## Introduction

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Dual-eligible beneficiaries are eligible for both Medicare and Medicaid benefits. In 2011, about 19 percent of Medicare beneficiaries (about 10 million) were dual eligible.<sup>1</sup> The dual-eligible population is diverse and includes individuals with multiple chronic conditions; difficulties with activities of daily living; cognitive impairments such as dementia; individuals with physical disabilities, developmental disabilities, and severe mental illness; and some individuals who are relatively healthy. Because of their diverse needs, dual-eligible beneficiaries require a mix of medical care, long-term care, behavioral health services, and social services. Dual-eligible beneficiaries also have fewer financial resources than the general Medicare population. In 2006, more than half of dual-eligible beneficiaries had incomes below the poverty line, compared with 8 percent of non-dual-eligible Medicare beneficiaries (Medicare Payment Advisory Commission 2010).

Given the challenges this population faces in accessing services through two payment and delivery systems, programs that coordinate dual-eligible beneficiaries' Medicare and Medicaid benefits (which we refer to as Medicare–Medicaid coordination programs) have the potential to improve dual-eligible beneficiaries' access to services and quality of care. Current Medicare–Medicaid coordination programs are either capitated managed care programs, in which both Medicare and Medicaid services are capitated, or they are Medicaid programs in which Medicare services are provided through Medicare fee-for-service (FFS). The capitated programs are operated by health plans, which are financially at risk for the Medicare and Medicaid services they furnish.<sup>2</sup> The Medicare–Medicaid coordination programs that operate under Medicare FFS generally adopt a medical home approach. These coordination programs receive a per member per month fee from Medicare or Medicaid to coordinate beneficiaries' Medicare and Medicaid benefits, but Medicare services are still paid through FFS.

In general, there are small numbers of Medicare–Medicaid coordination programs, and enrollment in these programs tends to be low (Medicare Payment Advisory Commission 2010). Most dual-eligible beneficiaries are enrolled in traditional FFS Medicare or Medicare Advantage (MA) plans that do not coordinate their Medicaid benefits. This chapter reviews the pathways to dual eligibility, updated Medicare and Medicaid spending on dual-eligible beneficiaries for 2009, and care coordination best practices from Medicare–Medicaid coordination programs.

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## Overview of dual-eligible beneficiaries

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There are different pathways to becoming a dual-eligible beneficiary. Partly because of this fact, dual-eligible beneficiaries are not a homogeneous group. Individuals 65 years or older qualify for Medicare on the basis of age and receipt of Social Security benefits.<sup>3</sup> Medicaid, by contrast, is a program for people with limited income and assets. Medicare beneficiaries 65 or older can be eligible for Medicaid and become dual-eligible beneficiaries if they meet their state's Medicaid income and asset criteria. For individuals under age 65, Medicare entitlement is based on disability. Workers under the age of 65 who have paid into Social Security and become disabled can qualify for Social Security Disability Insurance (SSDI). SSDI beneficiaries qualify for Medicare benefits after 24 months of Social Security status as a disabled person.<sup>4</sup> If SSDI beneficiaries also have incomes that are low enough to qualify for Supplemental Security Income (SSI) payments, they also qualify for Medicaid benefits in most states (Woodcock et al. 2011).<sup>5</sup> SSDI beneficiaries may have a physical disability, an intellectual or developmental disability, or a mental health condition. In some states, Medicare beneficiaries in either age group may also qualify for Medicaid through medically needy eligibility by “spending down” income and assets, generally during a nursing home stay. These individuals are Medicare beneficiaries who do not initially meet the Medicaid income and assets requirements but incur medical expenses that reduce their income and assets to the level that qualifies for a state's medically needy program.

### Full-benefit and partial-benefit dual-eligible beneficiaries

Dual-eligible beneficiaries (both those age 65 or older and those under age 65) can be full-benefit dual-eligible beneficiaries or partial-benefit dual-eligible beneficiaries. Full-benefit dual-eligible beneficiaries receive all the services that Medicaid covers in their state (including long-term care) as well as assistance with their Medicare premiums and other cost sharing. (For a complete list of mandatory and optional Medicaid benefits, see online Appendix 6-A to this chapter at <http://www.medpac.gov>).

Partial-benefit dual-eligible beneficiaries qualify for Medicaid coverage through the Medicare Savings Program (MSP) (Table 6-1, p. 150). Partial-benefit dual-eligible beneficiaries have limited incomes and assets, but their income and assets are not low enough to qualify them for full Medicaid benefits in their state. These dual-eligible

**TABLE  
6-1**

**Medicare Savings Program**

Medicare Savings Program	Eligibility requirements	Cost-sharing assistance	Funding
<b>Qualified Medicare beneficiaries (QMB)</b>	<ul style="list-style-type: none"> <li>Income &lt; 100% FPL</li> <li>Resources do not exceed SSI limit</li> </ul>	Payment of Medicare Part A and Part B: <ul style="list-style-type: none"> <li>Premiums</li> <li>Deductibles</li> <li>Coinsurance</li> <li>Copayment</li> </ul> Eligible for Part D LIS	Payment comes from the state's Medicaid program funds and is eligible for federal match.
<b>Specified low-income Medicare beneficiaries (SLMB)</b>	<ul style="list-style-type: none"> <li>Income &gt; 100% FPL, but &lt;120%</li> <li>Resources do not exceed SSI limit</li> </ul>	Payment of: <ul style="list-style-type: none"> <li>Medicare Part B premiums</li> </ul> Eligible for Part D LIS	Payment comes from the state's Medicaid program funds and is eligible for federal match.
<b>Qualified individuals</b>	<ul style="list-style-type: none"> <li>Income &gt; 120% FPL, but &lt;135%</li> <li>Resources do not exceed SSI limit</li> </ul>	Payment of: <ul style="list-style-type: none"> <li>Medicare Part B premiums</li> </ul> Eligible for Part D LIS	Expenditures are 100% federally funded and total expenditures are limited by statute.
<b>Qualified disabled and working individuals</b>	<ul style="list-style-type: none"> <li>Those who lost Medicare Part A benefits due to returning to work</li> <li>Income &lt; 200% FPL</li> <li>Resources do not exceed SSI limit</li> </ul>	Payment of: <ul style="list-style-type: none"> <li>Medicare Part A premiums</li> </ul>	Payment comes from the state's Medicaid program funds and is eligible for federal match.

Note: FPL (federal poverty limit), (SSI) supplemental security income, LIS (low-income subsidy). Two categories of QMBs and SLMBs—QMB plus and SLMB plus—are eligible for full Medicaid benefits in addition to cost-sharing assistance. Other dual-eligible beneficiaries qualify for full Medicaid benefits but do not qualify through the Medicare Savings Program.

Source: Centers for Medicare & Medicaid Services 2012.

beneficiaries are eligible for assistance only with their Medicare premiums or other cost sharing. There are four categories of partial-benefit dual-eligible beneficiaries in the MSP program: qualified Medicare beneficiaries, specified low-income Medicare beneficiaries, qualified individuals, and qualified disabled and working individuals. Qualified Medicare beneficiaries are eligible for Medicaid assistance for their entire Medicare cost sharing (Part A premium, Part B premium, deductibles, and coinsurance) and are eligible for the low-income subsidy in Part D, Medicare's prescription drug program. The other categories of partial-benefit dual-eligible beneficiaries are eligible for assistance with only some of their Medicare cost sharing, and they are also eligible for the low-income subsidy (see Table 6-A1 in the online appendix to this chapter, available at <http://www.medpac.gov>, for a more detailed description of MSP categories).<sup>6</sup>

**Beneficiary demographics**

According to 2011 data for the FFS Medicare population, dual-eligible beneficiaries were more likely than other

beneficiaries to belong to racial and ethnic minority groups. However, Whites still constituted the majority of both dual-eligible beneficiaries and non-dual-eligible beneficiaries. Of the beneficiaries enrolled in FFS Medicare, about 58 percent of dual-eligible beneficiaries were White compared with 84 percent of non-dual eligibles.<sup>7</sup> At 19 percent of the dual-eligible population, African Americans accounted for the second largest racial or ethnic group of dual-eligible beneficiaries. In contrast, African Americans accounted for 8 percent of the non-dual-eligible population. Hispanics accounted for the third largest racial or ethnic group of dual-eligible beneficiaries, constituting 14 percent of dual-eligible beneficiaries. About 4.5 percent of the non-dual-eligible FFS population was Hispanic.

**Medicare and Medicaid benefits for dual-eligible beneficiaries**

Medicare is the primary payer for dual-eligible beneficiaries. These beneficiaries are eligible for the same Medicare benefits as other Medicare beneficiaries.



For Medicaid, there are certain services that states must cover for dual-eligible beneficiaries, including nursing home care, Medicare cost sharing, coverage for inpatient hospital and nursing facility services when Part A coverage is exhausted, and nonskilled home health care (see Table 6-A2 in the online appendix to this chapter, available at <http://www.medpac.gov>). States have the option to cover other services—such as dental, vision, hearing, and transportation to medical appointments. In general, Medicare coverage lacks social support services, such as transportation to and from medical appointments. Since the Medicare benefit is limited in this way, Medicaid provides services that wrap around Medicare’s acute care benefit. There is considerable variation across states in the services covered, resulting in different benefits for dual-eligible beneficiaries depending on where they live.

Medicaid is a joint federal- and state-funded program. The costs of Medicaid services are shared between the federal government and states, with the states receiving federal matching funds (also known as federal medical assistance percentage). The amount of the federal match a state can receive is based on each state’s per capita income, but the federal government pays at least half the cost of Medicaid services. States with the lowest level of per capita income receive the highest levels of federal matching funds.

### **Long-term care services and supports**

Long-term care services and supports (LTSS) are supportive services for individuals with limited capacity for self-care (O’Shaughnessy 2013). Medicaid covers a broad range of LTSS that are provided in institutions or in the community. Institutional LTSS include services provided in nursing facilities, intermediate care facilities for people with developmental disabilities, inpatient psychiatric services for individuals under age 21, and services for individuals age 65 or older in an institution for mental illnesses (Centers for Medicare & Medicaid Services 2013). Community-based LTSS may include home health and personal care services, along with a variety of other services that vary by state. Community-based LTSS offer beneficiaries the option to receive services in their own home or community and serve a variety of populations, including those with mental illness, intellectual disabilities, and physical disabilities.

States are required to include some LTSS in their state plan (a document that specifies the scope of the state’s Medicaid program). States may also offer LTSS through the home- and community-based services (HCBS) waiver programs. HCBS waiver programs can offer

a broader array of LTSS than those covered under a state plan, and they can be limited to specific groups of dual-eligible beneficiaries (such as the intellectually and developmentally disabled). Many states focus on rebalancing their long-term care system by trying to offer LTSS in the home or community rather than in an institutional setting.

### **Behavioral health services**

Behavioral health services consist of mental health and substance abuse services. For behavioral health services, Medicare currently covers reasonable and necessary partial hospitalizations and traditional outpatient and inpatient visits to behavioral health providers (Bella 2012). Although federal law does not contain explicit provisions for which types of behavioral health services can be provided, all state Medicaid programs offer some mental health and substance abuse services. Compared with Medicare, Medicaid programs can cover a broader range of behavioral health services, which can include social work; personal care; rehabilitation and preventive services; clinic services (such as in a community mental health center); and targeted case management intended to help beneficiaries access social, medical, educational, and other services (Shirk 2008).

### **Outcomes of Medicare–Medicaid coordination programs**

The literature generally suggests that Medicare–Medicaid coordination programs for dual-eligible beneficiaries can reduce hospital and nursing home utilization and health care expenditures. Most of the evidence on Medicare–Medicaid coordination programs is specific to the Program of All-Inclusive Care for the Elderly (PACE)—a capitated, provider-based Medicare–Medicaid coordination program (Medicare Payment Advisory Commission 2012). A number of evaluations and research studies show that beneficiaries enrolled in PACE had fewer hospitalizations and nursing home admissions and a lower mortality rate than similar beneficiaries who were not enrolled in PACE. In one CMS-sponsored evaluation, the study group consisted of beneficiaries who enrolled at 11 PACE sites, and the comparison group consisted of beneficiaries who expressed interest in joining one of these PACE sites, had a home visit conducted by PACE staff, and decided not to enroll in the program (Chatterji et al. 1998). PACE enrollees in this study were 50 percent less likely than comparison group members to have had 1 or more hospital admissions at the 6-month follow-up and 40 percent less likely at the 12-month follow-up. They also had fewer

hospital days than the comparison group. At the 6-month follow-up, the mean number of hospital days for PACE enrollees was 1.9 days, compared with 6.1 days for the comparison group. At 12 months, PACE enrollees averaged 3 fewer days in the hospital than comparison group members. Nursing home use was also lower for PACE enrollees at 6 months and 12 months after baseline. At the six-month follow-up, 30 percent of comparison group members had one or more admissions to a nursing home compared with 10 percent for PACE enrollees. At the 12-month follow-up, PACE enrollees were 52 percent less likely than comparison group members to have had a nursing home stay.

PACE enrollees also had better self-reported health status and quality of life and a lower mortality rate than the comparison group. At six months after baseline, 43 percent of PACE enrollees reported being in good or excellent health, compared with 37 percent of the comparison group, and 72 percent of PACE enrollees reported their lives were “pretty satisfying,” compared with 55 percent of the comparison group. Mortality was also lower among the PACE enrollees. Over the 2.5-year observation period, 19 percent of PACE enrollees died, compared with 25 percent of the comparison group. Regression results estimated a median life expectancy of 5.2 years for PACE enrollees and 3.9 years for comparison group members.

Another evaluation found that PACE enrollees in one state had a lower risk of dying and greater stability in physical functioning than Medicaid beneficiaries receiving HCBS services in that state. However, the state spent more on PACE enrollees than on HCBS enrollees. This difference may have been because the PACE enrollees had similar acuity to the HCBS population but the state payment rates for PACE were higher than for the HCBS program (Mancuso et al. 2005). Another study compared five-year survival rates for enrollees in PACE with enrollees in a HCBS program and beneficiaries residing in nursing homes (Wieland et al. 2010). The study found that the median survival rate was longest for PACE enrollees at 4.2 years, compared with 3.5 years for enrollees in the waiver program and 2.3 years for beneficiaries in nursing homes.

### **Savings from Medicare–Medicaid coordination programs and LTSS rebalancing**

Lower utilization and health care costs do not necessarily result in savings to the Medicare and Medicaid programs. Payment to the plans operating Medicare–Medicaid

coordination programs, including PACE providers, are based on the same capitated system under which all MA plans are paid. Whether Medicare–Medicaid coordination programs reduce Medicare spending depends on how the capitation rates compare with FFS spending. Medicare currently spends more on beneficiaries who enroll in MA plans than the program would have spent had the beneficiaries remained in FFS. Although payments to MA plans in aggregate are projected to be closer to FFS spending levels in 2013 than they were in 2012, they are still projected to be 4 percent higher than FFS spending in 2013 (Medicare Payment Advisory Commission 2013).

Savings to the Medicaid program might accrue through rebalancing Medicaid LTSS. Rebalancing refers to increasing the proportion of LTSS provided through HCBS while reducing the proportion furnished in institutions. Rebalancing efforts can occur through Medicare–Medicaid coordination programs or through state initiatives that are independent of coordination with Medicare. The evidence of Medicaid savings due to rebalancing is limited and study findings are mixed. An Agency for Healthcare Research and Quality (AHRQ) review of the literature on this topic from 1995 to 2012 found insufficient evidence to compare costs of HCBS and nursing home services (Wysocki et al. 2012). AHRQ considered the evidence to be insufficient because the studies accounted for Medicaid spending on nursing home services but did not account for total Medicaid spending or Medicaid beneficiaries’ out-of-pocket spending. The literature review also found that HCBS can reduce Medicaid spending on a per user basis by avoiding a more costly nursing home stay; however, total Medicaid spending might not be reduced if nursing home beds continue to be filled by other Medicaid beneficiaries.

Another systematic review concluded that evaluations of Medicaid HCBS waivers were weak (Grabowski 2006). One study discussed in the review—a 1994 Government Accountability Office (GAO) study of Oregon, Washington, and Wisconsin—compared unadjusted per capita expenditures for Medicaid beneficiaries in nursing homes and those in HCBS waivers (Government Accountability Office 1995). GAO found that average Medicaid expenditures per capita were higher for Medicaid beneficiaries in nursing homes than for those receiving HCBS waiver services. However, Grabowski (2006) noted that this study did not assess aggregate Medicaid spending, thus limiting its findings. The GAO study also found that the number of nursing home beds in the three states examined decreased slightly

between 1982 and 1993, while the number of nursing home beds increased nationally by 20 percent over the same period. Another study analyzed whether growth in HCBS Medicaid spending was associated with overall Medicaid savings in Colorado, Oregon, and Washington by comparing projected and actual Medicaid long-term care costs (Alexih et al. 1996). The study estimated that HCBS spending resulted in overall Medicaid savings in each state. However, Grabowski noted that not all confounding factors were controlled for in this study. Most notably, these states had other nursing home diversion policies in place.

A more recent study developed a statistical model using Medicaid data between 1995 and 2009 from almost every state to assess the effect of rebalancing on overall Medicaid LTSS expenditures (Kaye 2012). The research found that shifting LTSS spending toward HCBS has a nonlinear effect on Medicaid LTSS spending. Gradual rebalancing—defined as shifting about 2 percentage points of LTSS spending toward HCBS each year—can reduce overall Medicaid LTSS spending by an estimated 15 percent over 10 years. However, the effects of faster rebalancing are not consistent. Rapid rebalancing can reduce Medicaid LTSS spending if funds are shifted toward waiver programs. Alternatively, it can have no effect on spending if rebalancing efforts favor personal care services.

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## Medicare and Medicaid spending on dual-eligible beneficiaries

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The following results are based on a quantitative analysis of combined Medicare and Medicaid data for dual-eligible beneficiaries. We analyzed Medicare and Medicaid spending for beneficiaries who were enrolled in Medicare FFS Part A and Part B every month they were eligible for Medicare in 2009. This definition includes beneficiaries who were not eligible for Medicare for the entire year and beneficiaries who died during the year. From this population, we divided beneficiaries into dual-eligible and non-dual-eligible beneficiaries. We defined dual-eligible beneficiaries as having dual-eligible status the entire time they were enrolled in Medicare in 2009; non-dual-eligible beneficiaries never had dual-eligible status.<sup>8</sup> Of all beneficiaries enrolled in FFS Medicare in 2009, about 11 percent of beneficiaries with any dual eligibility during the year were both dual eligible and

non-dual eligible during the year, and about 1 percent were both Medicaid only and dual eligible. These groups were excluded from the analyses presented in Table 6-2 through Table 6-6 but were included in the analysis of beneficiaries with severe and persistent mental illness (SPMI) (Table 6-7). Other groups excluded from Table 6-2 through Table 6-7 are beneficiaries who were enrolled in an MA plan during the entire year, beneficiaries who were enrolled in both Medicare FFS and an MA plan during the year, beneficiaries with end-stage renal disease (ESRD), beneficiaries enrolled only in Medicare Part A, and beneficiaries enrolled only in Medicare Part B.

In 2009, close to 6 million dual-eligible beneficiaries (excluding ESRD beneficiaries) were enrolled in Medicare FFS and met the inclusion criteria for our analysis (Table 6-2, p. 154). Most dual-eligible beneficiaries (58 percent) were age 65 or older and about 42 percent were under age 65. A little more than three-quarters (76 percent) of dual-eligible beneficiaries were full-benefit dual eligibles and 20 percent were partial-benefit dual eligibles. About 4 percent of dual-eligible beneficiaries in this sample were both full-benefit and partial-benefit dual eligibles during the year. These beneficiaries are included in the analysis, but results for them are not displayed separately.

In 2009, Medicare spent close to \$93 billion on FFS and Part D benefits for dual-eligible beneficiaries enrolled in FFS. Dual-eligible beneficiaries age 65 or older accounted for more spending than younger dual-eligible beneficiaries. The dual-eligible beneficiaries age 65 or older accounted for almost two-thirds (62 percent) of Medicare spending on dual-eligible beneficiaries. Per capita spending was also higher for these beneficiaries (\$16,878) compared with younger dual-eligible beneficiaries (\$14,183). In 2009, full-benefit beneficiaries accounted for almost 80 percent of Medicare spending on the dual-eligible population, while partial-benefit beneficiaries accounted for 15 percent. Those who were both full-benefit and partial-benefit beneficiaries during the year accounted for the remainder of spending (6 percent) (data not shown).

In 2009, Medicare FFS and Part D spending on non-dual-eligible Medicare beneficiaries was close to \$200 billion, more than twice the amount spent on dual-eligible beneficiaries in that year. However, per capita spending on dual-eligible beneficiaries in FFS (\$15,743) was almost twice the per capita spending on non-dual-eligible Medicare beneficiaries (\$8,081).

**TABLE  
6-2**

**Medicare spending for beneficiaries enrolled in Medicare FFS, 2009**

Category of beneficiary	Number of beneficiaries (in millions)	Percent of dual eligibles	Medicare spending, FFS and Part D (in billions)	Percent of Medicare spending for dual eligibles	Per capita spending
All dual eligibles	5.9	100%	\$92.9	100%	\$15,743
Age 65 or older	3.4	58	57.6	62	16,878
Under age 65	2.5	42	35.3	38	14,183
Full benefit*	4.5	76	73.1	79	16,371
Partial benefit*	1.2	20	14.4	15	12,215
Non-dual-eligible Medicare beneficiaries	24.6	0	199.0	0	8,081

Note: FFS (fee-for-service). Data exclude end-stage renal disease beneficiaries. The per capita spending amounts in the table were calculated using nonrounded numbers and therefore may not exactly match per capita spending calculations using the Medicare spending and number of beneficiaries in the table.  
\*“Full benefit” and “partial benefit” do not sum to 100 percent because 4 percent of the dual eligibles in our sample had both full-benefit and partial-benefit dual-eligible status in 2009.

Source: Common Medicare Environment, Medicare Standard Analytical File claims, and Part D Medicare data. Dual eligibility defined using the Common Medicare Environment.

On average, Medicare spending per user was higher for dual-eligible beneficiaries than for non-dual-eligible beneficiaries for inpatient services, outpatient services, skilled nursing facility services, home health care, hospice, durable medical equipment, physician and supplier services, and Part D drugs (Table 6-3). Per user Part D spending was almost three times higher for dual-eligible beneficiaries (\$4,473) than for non-dual-eligible beneficiaries (\$1,517). Compared with the younger dual-eligible population, per user Medicare spending was higher for dual eligibles age 65 or older for skilled nursing facility, home health care, hospice, and physician and supplier services. In contrast, compared with the dual-eligible population age 65 or older, per user Medicare spending for inpatient services, outpatient services, durable medical equipment, and Part D services was higher for dual-eligible beneficiaries under the age of 65. Medicare expenditures per user were higher for full-benefit dual-eligible beneficiaries than for partial-benefit dual-eligible beneficiaries for each type of service in this analysis and for Part D drugs.

In 2009, Medicaid spending on dual-eligible beneficiaries in Medicare FFS totaled \$80 billion (Table 6-4). The Medicaid spending estimates include Medicaid FFS and managed care spending but do not include Medicaid payments of Medicare premiums. Almost 60 percent of Medicaid spending was for dual-eligible beneficiaries age 65 or older. However, dual-eligible beneficiaries under the age of 65 had slightly higher

per capita Medicaid spending (\$13,651) than the older dual-eligible population (\$13,501). Combined Medicare and Medicaid spending for dual-eligible beneficiaries in 2009 was approximately \$173 billion. Medicare accounted for just over half of combined spending for both the older (56 percent) and the younger (51 percent) dual-eligible populations. Total federal spending on dual-eligible beneficiaries—Medicare spending and the federal portion of Medicaid spending on dual-eligible beneficiaries—is not reflected in these estimates. Total federal spending on the dual-eligible population is higher than state spending for these beneficiaries.

**Users of long-term care services and supports**

LTSS users in our analysis consist of beneficiaries who utilized any Medicaid-covered institutional or community-based LTSS. Institutional LTSS includes psychiatric hospital services for the aged, inpatient psychiatric services for individuals age 21 years or younger, intermediate care facility services for persons with intellectual disabilities, and nursing facility services. Community-based LTSS consist of home health services, personal care services, and HCBS.

In 2009, slightly more than one-third (34 percent) of Medicare FFS dual-eligible beneficiaries utilized Medicaid-covered LTSS (Table 6-5, p. 156). A larger portion of dual-eligible beneficiaries age 65 or older used

**TABLE  
6-3**

**Medicare per user spending by type of service, 2009**

Category of Medicare beneficiary	Per user Medicare FFS spending							Per user Part D spending
	Inpatient hospital	Outpatient services	Home health	Hospice	SNF	DME	Physician/supplier	
All dual eligibles	\$18,145	\$1,829	\$7,320	\$13,261	\$15,130	\$1,248	\$2,703	\$4,473
Age 65 or older	17,973	1,811	7,590	13,370	15,214	1,077	2,893	3,828
Under age 65	18,453	1,853	6,542	12,183	14,679	1,527	2,434	5,367
Full benefit	18,532	1,849	7,462	13,726	15,395	1,292	2,757	4,675
Partial benefit	15,800	1,654	7,095	10,107	11,065	1,062	2,374	3,599
Non-dual-eligible Medicare beneficiaries	16,233	1,434	5,165	10,342	12,890	796	2,494	1,517

Note: FFS (fee-for-service), SNF (skilled nursing facility), DME (durable medical equipment). Outpatient services include outpatient hospital services and federally qualified health center services. Data exclude end-stage renal disease beneficiaries. The per capita spending amounts and combined spending were calculated using nonrounded numbers. Both full and partial dual-eligible beneficiaries are included in the analysis. "Full benefit" and "partial benefit" do not sum to 100 percent because 4 percent of the dual eligibles in our sample had both full-benefit and partial-benefit dual-eligible status in 2009.

Source: Common Medicare Environment, Medicare Standard Analytical File claims, Part D Medicare data, and Medicaid Statistical Information System data. Dual eligibility defined using the Common Medicare Environment.

LTSS (40 percent) than did those under the age of 65 (26 percent). However, Medicaid per capita spending was higher for the younger LTSS users (\$44,560) than for the older LTSS users (\$30,513).

Medicaid per capita spending was much higher for LTSS users (\$35,031) than for non-LTSS users (\$2,374). This finding is expected, given that LTSS users by definition utilize Medicaid-covered institutional or community-based long-term care services and non-LTSS users do not. Medicaid per capita spending on LTSS users was also more than twice as high as average Medicaid per capita

spending for all dual-eligible beneficiaries (\$13,564, shown in Table 6-4). The Medicaid per capita spending amount for all dual-eligible beneficiaries is a reflection of the lower Medicaid per capita spending on non-LTSS users (\$2,374), who account for about two-thirds (66 percent) of dual-eligible beneficiaries.

The higher Medicaid per capita spending on LTSS users is also reflected in Medicare's portion of combined spending. For all dual-eligible beneficiaries, Medicare accounted for the majority of spending (54 percent, shown in Table 6-4). However, Medicare's portion of combined spending

**TABLE  
6-4**

**Combined Medicare and Medicaid spending, 2009**

Category of Medicare beneficiary	Medicaid spending (in billions)	Per capita Medicaid spending	Combined Medicare and Medicaid spending (in billions)	Medicare's proportion of combined spending
All dual eligibles	\$80.0	\$13,564	\$172.9	54%
Age 65 or older	46.1	13,501	103.7	56
Under age 65	33.9	13,651	69.2	51

Note: Data exclude end-stage renal disease beneficiaries. Total federal spending on dual-eligible beneficiaries (Medicare plus the federal portion of Medicaid) is not reflected in this table. The per capita spending amounts and combined spending were calculated using nonrounded numbers. Medicaid spending includes Medicaid fee-for-service and managed care spending. Medicaid payments of Medicare premiums are not included.

Source: Common Medicare Environment, Medicare Standard Analytical File claims, Medicare Part D data, and Medicaid Statistical Information System data. Dual eligibility defined using the Common Medicare Environment.

**TABLE  
6-5**

**Spending for Medicaid LTSS and non-LTSS users, 2009**

Category of dual eligible	LTSS users			
	Percent of beneficiaries	Per capita Medicare spending	Per capita Medicaid spending	Medicare's proportion of combined spending
All dual eligibles	34%	\$23,398	\$35,031	40%
Age 65 or older	40	24,585	30,513	45
Under age 65	26	20,893	44,560	32

  

Category of dual eligible	Non-LTSS users			
	Percent of beneficiaries	Per capita Medicare spending	Per capita Medicaid spending	Medicare's proportion of combined spending
All dual eligibles	66	11,752	2,374	83
Age 65 or older	60	11,704	2,078	85
Under age 65	74	11,806	2,704	81

Note: LTSS (long-term care services and supports). Data exclude end-stage renal disease beneficiaries. The per capita spending amounts and combined spending were calculated using nonrounded numbers. Medicaid spending includes Medicaid fee-for-service and managed care spending. Medicaid payments of Medicare premiums are not included. Both full and partial dual-eligible beneficiaries are included in the analysis.

Source: Common Medicare Environment, Medicare Standard Analytical File claims, Medicare Part D data, and Medicaid Statistical Information System data. Dual eligibility defined using the Common Medicare Environment.

dropped to 40 percent for all dual-eligible LTSS users. In contrast, Medicare was the predominant payer (83 percent of combined spending) for dual-eligible beneficiaries who did not use LTSS. However, Medicare per capita spending was higher for dual-eligible beneficiaries who were LTSS users than for those who were non-LTSS users. Average Medicare per capita spending for all dual eligibles was

\$15,743 (Table 6-2, p. 154), reflecting higher Medicare per capita spending on LTSS users (\$23,398) and lower Medicare per capita spending on non-LTSS users (\$11,752) (Table 6-5).

Among dual-eligible beneficiaries who utilized LTSS in 2009, Medicaid per user spending was higher for institutional LTSS (\$43,420) than for community-based LTSS (\$19,908) (Table 6-6). This spending reflects the inclusion of room and board and other expenses that make Medicaid rates for institutional LTSS generally higher than the rates for community-based LTSS. Among LTSS users both under age 65 and 65 or older, Medicaid per user LTSS spending for institutional LTSS services was more than twice as high as the spending for community-based LTSS services.

**Severe and persistent mental illness**

We defined beneficiaries as having SPMI if Medicare claims indicated that they had one of the following conditions: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, or paranoid disorder. We selected these conditions to be consistent with the conditions that qualify a Medicare beneficiary to enroll in a chronic condition special needs Medicare Advantage plan. While other mental health conditions and substance abuse can also complicate Medicare beneficiaries' care,

**TABLE  
6-6**

**Medicaid spending for institutional and community-based LTSS spending, 2009**

Category of dual-eligible LTSS user	Medicaid per user spending	
	Institutional LTSS	Community-based LTSS
All dual eligibles	\$43,420	\$19,908
Age 65 or older	38,196	13,582
Under age 65	67,299	28,672

Note: LTSS (long-term care services and supports). Data exclude end-stage renal disease beneficiaries. The per capita spending amounts and combined spending were calculated using nonrounded numbers. Medicaid spending includes Medicaid fee-for-service and managed care spending. Medicaid payments of Medicare premiums are not included.

Source: Common Medicare Environment, Medicare Standard Analytical File claims, Medicare Part D data, Medicaid Statistical Information System data. Dual eligibility defined using the Common Medicare Environment.

**TABLE  
6-7**

**Medicare FFS beneficiaries with a severe and persistent mental illness, 2009**

Category of Medicare beneficiary	Number of SPMI beneficiaries	Percent of beneficiary category*	Percent of SPMI beneficiaries who are LTSS users	Per capita Medicare spending	Per capita Medicaid spending
All dual eligibles	1,303,700	20%	37%	\$23,570	\$16,403
Age 65 or older	400,700	10	66	32,562	25,303
Under age 65	903,000	32	24	19,580	12,454

Note: FFS (fee-for-service), SPMI (serious and persistent mental illness), LTSS (long-term care services and supports). Data exclude end-stage renal disease beneficiaries. The per capita spending amounts and combined spending were calculated using nonrounded numbers. SPMI is identified using Medicare claims and is defined as presence of schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, or paranoid disorder.

\*The numerator and denominator use an “ever dual” definition that includes dual-eligible beneficiaries who switched between dual-eligible status and non-dual-eligible Medicare beneficiary or non-dual-eligible Medicaid beneficiary status during 2009. These beneficiaries who were not dual eligibles for the entire year were excluded from the results in Table 6-2 through Table 6-6. Medicaid spending includes Medicaid FFS and managed care spending. Medicaid payments of Medicare premiums are not included.

Source: Common Medicare Environment, Medicare Standard Analytical File claims, and Part D Medicare data. Dual eligibility defined using the Common Medicare Environment.

we focused exclusively on SPMI conditions for the purposes of this analysis.

In 2009, about 1.3 million beneficiaries, or 20 percent of all dual-eligible beneficiaries enrolled in FFS Medicare during the entire year, had at least one SPMI (Table 6-7). Almost one-third of dual-eligible beneficiaries under the age of 65 had an SPMI (32 percent) compared with 10 percent of the dual-eligible population over age 65. The presence of a disabling mental health condition can qualify an individual as disabled under SSDI, which is the main pathway to Medicare and dual-eligible status for individuals under the age of 65. Two-thirds of SPMI beneficiaries age 65 or older utilized LTSS in 2009, while less than one-quarter of the younger dual-eligible population with SPMI were LTSS users.

Among those with an SPMI, per capita Medicare and Medicaid spending was higher for dual-eligible beneficiaries age 65 or older than for the younger population. Further work needs to be done to better understand the SPMI population in general; however, higher per capita spending for older dual-eligible beneficiaries with SPMI could reflect the larger proportion of LTSS users among this population—who incur higher Medicare and Medicaid spending in general (Table 6-5)—greater overall use of health care services among this population, or the presence of comorbid conditions that increase utilization or that are costly to treat.

**Care delivery systems for dual-eligible beneficiaries**

Dual-eligible beneficiaries—both those enrolled in and those not enrolled in Medicare–Medicaid coordination programs—tend to have more complex medical and nonmedical needs than non-dual-eligible Medicare beneficiaries, according to our interviews with stakeholders in five states (see text box on the analytic methodology, pp. 158–159). Interviewees consistently reported that many dual-eligible beneficiaries need high-contact, on-the-ground, intensive care management, and their issues are not likely to be resolved in a few physician visits. Dual-eligible beneficiaries also tend to receive care from multiple medical and nonmedical providers, such as LTSS, behavioral health services, and social services. Communication across settings regarding a patient’s care is not common. Medicare–Medicaid coordination programs focus on getting providers in various settings—for example, hospitals, physicians’ offices, and social service agencies, among others—to communicate with one another regarding a beneficiary’s care. Medicare–Medicaid coordination programs do not receive a separate Medicare payment for their care coordination activities; instead, they finance the activities through their current Medicare and Medicaid funds. These programs also seek to leverage community-based resources, including care coordination activities at federally qualified health centers (FQHCs) and community health centers (CHCs).

## Analytic methodology

**W**e assessed care coordination for dual-eligible beneficiaries through interviews with stakeholders who interact with beneficiaries in their communities. The goal of the analysis was to learn about care coordination under existing Medicare–Medicaid coordination programs. For that reason, we did not include the CMS financial alignment demonstrations that are being implemented in a few states. We conducted structured interviews with stakeholders in five states with Medicare–Medicaid coordination programs. We selected these five states to obtain variety in the degree of integration between Medicare and Medicaid within the programs and in the length of time each program has been operating:

- **Florida**—The nursing home diversion program began in 1998. This program serves dual-eligible beneficiaries who require a nursing home level of care with the goal of keeping beneficiaries in the community rather than in nursing facilities.

Enrollment in the program is voluntary. The program covers Medicaid nursing home and community-based long-term care services but does not include Medicare benefits.

- **Massachusetts**—The Massachusetts Senior Care Options program began in 2004. Dual-eligible beneficiaries age 65 or older are eligible to enroll in the program on a voluntary basis. The program covers all Medicare and Medicaid benefits, including institutional and community-based long-term care services.
- **Minnesota**—There are two Medicare–Medicaid coordination programs for dual-eligible beneficiaries in Minnesota. Minnesota Senior Health Options is the program for dual-eligible beneficiaries age 65 or older. The program began in 1997; it is voluntary and covers all Medicare and Medicaid acute care services, behavioral health

*(continued next page)*

### **Complex physical and nonphysical needs affect dual-eligible beneficiaries' health and require intensive care management**

In general, interviewees across all five states described dual-eligible beneficiaries as having more complex care needs than other Medicare beneficiaries. Dual-eligible beneficiaries' physical health can be affected by poverty, inadequate housing, behavioral health conditions, physical or developmental disabilities, cognitive deficiencies, and frailty. For example, one interviewee described beneficiaries who were not compliant with their medication regimens—and were therefore at risk of rehospitalizations—because they could afford to fill prescriptions only after their Social Security checks arrived. Interviews across states consistently reported that dual-eligible beneficiaries needed more intensive care management than other Medicare beneficiaries. One care manager cited the multiple conditions of one under-65 dual-eligible beneficiary: paraplegic; wheelchair dependent; homeless; addicted to opiates, methadone, and alcohol; and diabetic. The care manager noted that this individual is an example of someone whose needs will not be resolved in a few physician or care manager visits.

Medicare–Medicaid coordination programs were generally reported to offer dual-eligible beneficiaries more high-contact, in-person, and intensive care management relative to MA plans and traditional FFS. Case managers reported attending doctor appointments (including behavioral health appointments) with beneficiaries, keeping track of beneficiaries' upcoming doctor appointments, becoming familiar with beneficiaries and their providers, and making home visits. With respect to beneficiaries with behavioral health conditions, one interviewee noted that being familiar with the beneficiary enables care managers to distinguish between baseline behavior and an acute behavioral health crisis.

Interviewees across states also emphasized the importance of coordination programs' care managers being familiar with social services and other resources that are available in beneficiaries' communities. However, one care manager from the North Carolina program noted that, while she can refer beneficiaries to social services, she cannot help them if waiting lists or funding cuts to social services limit their access. The care manager also noted that she can



## Analytic methodology (cont.)

services, community-based long-term care services, and up to 180 days of nursing home care. Nursing home utilization after 180 days is paid for through fee-for-service (FFS) Medicare. Minnesota Special Needs Basic Care is a voluntary program for dual-eligible beneficiaries under the age of 65 with disabilities. It coordinates Medicare and Medicaid acute services and Medicaid behavioral health services.

- **North Carolina**—The North Carolina Community Care Networks program is a medical home and shared-savings program for Medicaid beneficiaries. In 2010, it expanded to include Medicare benefits for dual-eligible beneficiaries. The program provides dual-eligible beneficiaries with care management. It receives a portion of the Medicare savings that may eventually accrue. Medicare benefits are paid through FFS under this program.

- **Wisconsin**—The Wisconsin Partnership Program began in 1999. The program is voluntary and targeted at adults with physical disabilities and the nursing-home-certifiable elderly. It covers all Medicare services and all Medicaid acute services, community-based long-term care services, and nursing home services.

We interviewed primary care physicians, health systems, behavioral health providers, aging services organizations, community-based care managers, beneficiary advocates, stakeholders from federally qualified health centers and community health centers, and care managers and leadership staff at health plans operating Medicare–Medicaid coordination programs.

The interviews focused on all dual-eligible beneficiaries, including those enrolled in the above programs, those enrolled in Medicare FFS, and those enrolled in Medicare Advantage plans. ■

be a resource only for the community services that she is aware of. The North Carolina programs' continual care manager training and education help this care manager stay educated about community resources and other care management best practices.

The complex needs of dual-eligible beneficiaries can also affect their access to care. Transportation was often cited as a barrier to access to care across most states. For example, one Massachusetts care manager described a dual-eligible beneficiary with physical disabilities who lives on the second floor of a building without an elevator. This beneficiary missed medical appointments if no one was available to carry her down the stairs to exit her building. Some interviewees also noted a lack of public transportation in rural areas, and Medicaid-funded transportation services are sometimes unreliable. Interviewees in every state we interviewed said that access to behavioral health services is a challenge. Reasons for this problem include shortages of behavioral health providers, long waiting lists for behavioral health clinics, and behavioral health providers not accepting Medicare or Medicaid.

### **Dual-eligible beneficiaries receive care from multiple providers; their care is often fragmented among discrete providers**

Dual-eligible beneficiaries receive care from multiple medical, LTSS, behavioral, and social services providers. Interviewees across states described the delivery system for dual-eligible beneficiaries as “siloed,” with providers frequently not communicating with one another. Lack of coordination among providers is not limited to the transitions between Medicare and Medicaid services. Interviewees gave examples of coordination not occurring between community-based care managers, FQHCs, primary care providers, specialists, hospitals, nursing facilities, community-based LTSS providers, behavioral health providers, and social services. Coordination between physical and behavioral health was also highlighted as a problem across states. Some interviewees noted that navigating uncoordinated systems can be especially challenging for beneficiaries with cognitive impairments.

Many interviewees across states described poor communication occurring during care transitions. In

particular, interviewees described lack of communication between primary care providers (including FQHCs and CHCs) and hospitals and nursing facilities during care transitions. The primary care providers' ability to provide postdischarge follow-up care is compromised if they are not notified of a hospitalization or discharge from a nursing facility. Another common communication failure during care transitions occurs between hospitals or nursing facilities and care managers for community-based LTSS. One community-based LTSS care manager in Massachusetts cited an example of a nursing facility that did not communicate with the LTSS care manager on the date of a beneficiary's discharge to home. As a result, the necessary home care services were not in place and the individual was rehospitalized three times.

Poor coordination across discrete provider settings is an issue for dual-eligible beneficiaries in Medicare FFS, MA plans, and Medicare–Medicaid coordination programs. Reasons interviewees gave for the poor coordination include providers not having time to coordinate with one another, Medicare–Medicaid coordination programs or regular MA plans not managing all services for dual-eligible beneficiaries, and providers or health plans not being aware of the individuals with whom they should be coordinating. Having multiple care managers can also complicate coordination. Dual-eligible beneficiaries may be assigned separate care managers from a health plan, a primary care provider, a HCBS provider, and a behavioral health provider. Too many care managers who are not coordinating with each other can result in duplicative efforts or conflicting messages or services being given to the beneficiary.

### **Programs for dual-eligible beneficiaries use multiple practices to coordinate services across providers**

Many interviewees noted that the Medicare–Medicaid coordination programs have a comprehensive approach to care management that extends beyond management of physical health. From our interviews with relevant personnel in the five states studied, we found that common care coordination practices across Medicare–Medicaid coordination programs include coordinating treatment and medication regimens across providers; linking dual-eligible beneficiaries with social services in the community; conducting home visits to assess beneficiaries and coordinate with HCBS providers; and focusing on care transitions, follow-up care after hospitalizations, and having HCBS services in place when beneficiaries are discharged home. One care manager from the North

Carolina Community Care Networks program described herself as the beneficiary's resource for medical, behavioral, and social services and stated that she felt "empowered" by the program to help beneficiaries in ways that she could not before the program.

Some Medicare–Medicaid coordination programs assign or embed care managers in CHCs or hospitals. For example, one health plan in the Wisconsin Medicare–Medicaid program assigns a nurse practitioner to work with one CHC to coordinate dual-eligible beneficiaries' primary, specialty, and behavioral health care. The nurse practitioner visits the clinic almost every day, which enables her to communicate with the clinics' physicians, attend beneficiaries' appointments, and help with medication reconciliation by bringing updated medication lists to the clinic. Medicare–Medicaid coordination programs also sometimes coordinate with community-based providers. Care managers at one health plan in Wisconsin's program, for example, communicate with staff at assisted living facilities. In North Carolina's program, care managers in one region coordinate with staff at homes for mentally ill or disabled beneficiaries to address medication and care issues.

Medicare–Medicaid coordination programs can also facilitate electronic sharing of health information between providers and care managers. Providers reported that not having access to medical records and relying on phone calls and faxes to communicate were major barriers to providers coordinating with one another. Some health plans have access to the electronic medical record systems of providers in their region. They reported that this access helped them to collect information and manage beneficiaries. For example, one health plan has access to the electronic medical records of the providers in its network. Care managers at the health plan can send e-mails and messages to all providers on a beneficiary's care team, and providers can access beneficiaries' care plans and advanced directives.

### **Programs for dual-eligible beneficiaries can leverage the efforts of providers that take the initiative to coordinate a patient's care across settings**

Medicare–Medicaid coordination programs can also leverage care management that is occurring in the community. Some providers and community-based care management organizations are knowledgeable about the community's HCBS and social services or are able to provide high-contact, in-person care. For example,

one health plan in Minnesota's Special Needs Basic Care program for disabled beneficiaries employs its own care managers and contracts with care management organizations in the community and with behavioral health care managers. The health plan matches beneficiaries to a care manager with expertise in the beneficiary's disability, including being aware of which local resources are available to the beneficiary.

Some of the health plans in Massachusetts's Senior Care Options (SCO) program contract with an aging services agency. For the dual-eligible beneficiaries enrolled in the SCO program, care managers at the aging services agency conduct in-person assessments and make recommendations for a plan of care; they meet with beneficiaries monthly at first and then quarterly once the beneficiaries' care needs are stable. The SCO health plans can also refer to the agencies' network of social service agencies as needed. One of the smaller health plans in the SCO program locates some of the health plan's care managers at the aging services agency.

### **FQHCs and CHCs are uniquely positioned to coordinate care for dual-eligible beneficiaries**

According to our interviews, many FQHCs and CHCs are uniquely positioned to coordinate care across many of the services that dual-eligible beneficiaries use. We interviewed FQHC or CHC staff in states except Minnesota, and this finding was consistent across states. FQHCs and CHCs serve Medicare beneficiaries, Medicaid beneficiaries, and the uninsured. They are in a unique position because they tend to provide combinations of primary care, behavioral health services, and care

management. Some of the FQHCs and CHCs we interviewed also provide nutrition, pharmacy, lab, and radiology services at their clinics. They often provide multiple services at a single clinic, enabling patients to receive care for more than one condition during the same visit. For example, one Massachusetts FQHC offers both primary care and behavioral health services in its clinic. Up to half of the dual-eligible beneficiaries the clinic sees have behavioral health conditions. Every primary care office setting in the clinic has a behavioral health consult room, and a behavioral health provider is on site or on call at all times. Multiple services within the same FQHC or CHC also help care managers coordinate with the clinic's various providers. The clinics' care managers also often refer beneficiaries to social services.

Most of the FQHCs we interviewed were applying to become accredited as patient-centered medical homes by the National Committee for Quality Assurance. Contracting with these clinics can enable enrollees in Medicare–Medicaid coordination programs to have access to a medical home in their community. FQHCs and CHCs are limited, however, in the extent to which they can coordinate services. Because they are providers rather than payers, they may not have access to all medication information. Some FQHCs and CHCs reported being limited in the amount of care management they can afford. For example, one Florida FQHC serves about 63,000 patients and can afford to employ only 9 care managers. However, Medicare–Medicaid coordination programs can support the care management efforts of FQHCs and CHCs. In one region in North Carolina's Community Care Networks program, a care manager is jointly funded by an FQHC and the North Carolina program. ■

## Endnotes

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- 1 The 10 million is an estimate of any Medicare beneficiaries with dual-eligible status during 2011.
- 2 In our March 2013 report, the Commission recommended that Medicare Advantage dual-eligible special needs plans (D-SNPs) that clinically and financially integrate Medicare and Medicaid benefits should be permanently reauthorized by statute. Under this recommendation, D-SNPs moving forward would be Medicare–Medicaid coordination programs, rather than furnishing only Medicare services for dual-eligible beneficiaries, as some D-SNPs currently do.
- 3 Individuals who are 65 or older and do not have Social Security coverage can “buy in” to Medicare Part B; if they buy Part B, they can also purchase Part A. To purchase Medicare, a person must be a citizen or have been a legal resident for at least five years.
- 4 The 24-month waiting period is shorter for individuals with end-stage renal disease. There is no waiting period for individuals with amyotrophic lateral sclerosis.
- 5 Receiving SSI cash assistance qualifies individuals for Medicaid benefits in 39 states and the District of Columbia. Eleven states have more restrictive income limits for Medicaid eligibility than the SSI income limits. These states are referred to as 209(b) states (Woodcock et al. 2011).
- 6 In general, most states do not pay providers the full Medicare cost-sharing liability (Mitchell and Haber 2004).
- 7 Data are from the Commission’s analysis of 2011 Common Medicare Environment. Medicare data generally undercount the number of Hispanics and as such incorrectly state the proportion of beneficiaries in other race categories. We adjusted the Common Medicare Environment data to address this issue.
- 8 Dual-eligible status was identified by using the 2009 Common Medicare Environment data.

## References

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- Alecxih, L. M., S. Lutsky, J. Corea, et al. 1996. *Estimated cost savings from the use of home and community-based alternatives to nursing facility care in three states*. Working paper 9618. Washington, DC: AARP.
- Bella, M., Centers for Medicare & Medicaid Services. 2012. Examining Medicare and Medicaid coordination for dual-eligibles. Testimony before the Special Committee on Aging, U. S. Senate. July 18th.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. Long-term services & support. <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Long-Term-Services-and-Support.html>.
- Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2012. Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) at a Glance (January 2012). [http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare\\_beneficiaries\\_dual\\_eligibles\\_at\\_a\\_glance.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf)
- Chatterji, P., N. R. Burstein, D. Kidder, et al. 1998. *Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) demonstration: The impact of PACE on participant outcomes*. HCFA contract #500-96-0003/TO4. Report prepared by Abt Associates for the Health Care Financing Administration. Baltimore, MD: HCFA.
- Government Accountability Office. 1995. *Medicaid: Restructuring approaches leave many questions*. GAO/HEHS-95-103. Washington, DC: GAO.
- Grabowski, D. C. 2006. The cost-effectiveness of noninstitutional long-term care services: Review and synthesis of the most recent evidence. *Medical Care Research and Review* 63, no. 1 (February): 3-28.
- Kaye, H. S. 2012. Gradual rebalancing of Medicaid long-term services and supports saves money and serves more people, statistical model shows. *Health Affairs* 31, no. 6 (June): 1195-1203.
- Mancuso, D., G. Yamashiro, and B. Felver. 2005. *PACE: An evaluation*. Olympia, WA: Washington State Department of Social and Health Services Research & Data Analysis Division.
- Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.
- Medicare Payment Advisory Commission. 2010. *Report to the Congress: Aligning incentives in Medicare*. Washington, DC: MedPAC.
- Mitchell, J. B., and S. G. Haber. 2004. State payment limitations on Medicare cost-sharing: Impact on dually eligible beneficiaries. *Inquiry* 41, no. 4 (Winter): 391-400.
- O'Shaughnessy, C. V. 2013. *The basics: National spending for long-term services and supports (LTSS), 2011*. Washington, DC: National Health Policy Forum.
- Shirk, C. 2008. *Medicaid and mental health services*. Background paper. Washington, DC: National Health Policy Forum.
- Wieland, D., R. Boland, J. Baskins, et al. 2010. Five-year survival in a Program of All-inclusive Care for Elderly compared with alternative institutional and home- and community-based care. *Journal of Gerontology: Medical Sciences* 65, no. 7 (July): 721-726.
- Woodcock, C., S. Cannon-Jones, A. Tripp, et al. 2011. *Pathways to Medicare-Medicaid eligibility: A literature review*. Baltimore, MD: The Hilltop Institute, UMBC.
- Wysocki, A., M. Butler, R. L. Kane, et al. 2012. *Long-term care for older adults: A review of home and community-based services versus institutional care*. Comparative effectiveness review, no. 81. Prepared by the Minnesota Evidence-based Practice Center under Contract No. 290-2007-10064-I. AHRQ Publication No.12(13)-EHC134-EF. Rockville, MD: Agency for Healthcare Research and Quality. [www.effectivehealthcare.ahrq.gov/reports/final.cfm](http://www.effectivehealthcare.ahrq.gov/reports/final.cfm).

