CHAPTER 3

Dual eligible beneficiaries: An overview

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In this chapter

- Who are dual eligibles?
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Dual eligibles are a vulnerable and costly group. They tend to be poor and report lower health status than other beneficiaries, and cost Medicare about 60 percent more than nondual eligibles. Nevertheless, our profile of dual eligibles finds a diverse population, with spending concentrated among a minority of beneficiaries and a significant portion reporting good health and few physical and cognitive limitations.

Coverage and payment policies, which affect how beneficiaries receive their care, are complicated by the intersection of Medicare and 50 separate state Medicaid policies. The Commission finds that current policy toward dual eligibles creates incentives to shift costs between payers, often hinders efforts to improve quality and coordinate care, and may reduce access to care. This chapter provides a foundation for assessing policy alternatives available to the Medicare program for addressing the care needs and costliness of beneficiaries who are eligible for both Medicare and Medicaid.

Dual eligibles are persons who qualify, in some way, for both Medicare and Medicaid coverage. Medicare covers their acute care services, while Medicaid covers Medicare premiums and cost sharing, and—for those below certain income and asset thresholds—long-term care services and, until 2006, prescription drugs, among other services. We use the term "dual eligible" to encompass all Medicare beneficiaries who receive Medicaid assistance, including those who receive the full range of Medicaid benefits and those who receive assistance only with Medicare premiums or cost sharing.

Dual eligibles as a whole are a particularly vulnerable subgroup of Medicare beneficiaries. By virtue of their eligibility for Medicaid coverage, they tend to be poor and report lower health status than other beneficiaries. Medicaid plays an important role in reducing out-of-pocket spending for this population and potentially improving access to care.

Dual eligibles are more expensive for Medicare than other beneficiaries. About 15 to 17 percent (6.2 to 7.0 million) of Medicare beneficiaries in 2001 were dual eligible, accounting for about 22 to 26 percent of Medicare spending.[1] Total spending—across all payers—for dual eligibles averaged about $20,840 per person in 2001, more than twice the amount for other Medicare beneficiaries.

Given dual eligibles' vulnerability and relative costliness, do Medicare's current eligibility, coverage, and payment policies promote access to quality care for this population? Could their needs be better met? And, are there ways to meet their needs more cost effectively? This chapter provides a foundation for assessing the need for policy alternatives and reports information about dual eligibles that could be used to guide future policy in this area.

Because of MedPAC's charter to recommend improvements to the Medicare program, we address these questions from the Medicare perspective. This focus should not diminish the significant resources and energy states devote to assisting dual eligibles, however. In 1999, dual eligibles represented 19 percent of Medicaid recipients and accounted for 35 percent of Medicaid spending (Kaiser 2003a). Accordingly, a complete assessment of the impact of current policy and alternative policies must take into account how resources can be aligned across both programs to improve dual eligibles' access to quality care.

Our profile of dual eligibles, based on analysis of Medicare Current Beneficiary Survey (MCBS) data, finds a diverse population. Although a high proportion have characteristics associated with being poor (e.g., female, minority, poorly educated), they vary greatly in other respects (e.g., living situation, health status, age). We find that over one-third of dual eligibles are under 65, 38 percent have cognitive or mental impairments, 22 percent have multiple physical impairments, and 23 percent are institutionalized. However, a full 40 percent of all dual eligibles have less debilitating physical conditions or no impairments at all.

Medicare spending on dual eligibles is concentrated among a minority of the population. Dual eligibles are more likely to use all types of Medicare-covered services than nondual eligibles, and average Medicare spending is higher for dual eligibles across all services. However, when we consider average Medicare spending on services only for those beneficiaries who actually use services, we find that dual eligibles have lower spending per beneficiary than other beneficiaries for hospital, skilled nursing facility (SNF), and home health services. Dual eligibles are also more likely to receive care in long-term care facilities than other Medicare beneficiaries.

Dual eligibles' access to care is generally good. We found, from analyzing MCBS and Consumer Assessment of Health Plans Survey (CAHPS) data, that about 86 percent of dual eligibles report having a usual source of care and receiving both immediate and regular care when needing it. However, beneficiaries with other sources of supplemental insurance tend to rate their access more highly. Medicare-only beneficiaries (those with no supplemental insurance) rate their access worse than dual eligibles on some measures and better than dual eligibles on others.

Coverage and payment policies affect how beneficiaries receive their care and, so, influence access to care as well as the quality and cost of the care. Both Medicare and Medicaid (which includes some 50 state programs) have rules and processes for determining which program covers which service and the payment amount for each service. Specifically, we find that the current coverage and payment policies for dual eligibles:

- create incentives to shift costs between payers;
- often hinder efforts to improve quality and coordination of care;

- lead to coverage conflicts that are difficult to resolve;
- may threaten access to care; and
- are inconsistent on whether dual eligibles are considered Medicare beneficiaries first—meaning that Medicare protections should prevail when Medicare and Medicaid program requirements conflict.

Who are dual eligibles?

Dual eligibles are those who meet eligibility requirements for both Medicare and Medicaid and are enrolled in both programs. We explore these technical qualifications before profiling their demographic and health status characteristics. Naturally, many characteristics of the dual eligible population are related to their eligibility qualifications.

What are the criteria for dual eligibility?

Medicare beneficiaries can qualify for Medicaid if they meet certain income and resource requirements or have high health care bills. Each state sets its own eligibility standards and determines the scope of benefits provided to Medicaid beneficiaries, within federal guidelines.

Dual eligibles can be divided into several different categories, each qualifying for a different set of covered benefits (Table 3-1, p. 74). Although identifying which beneficiaries are in which category is important for our understanding of the spending and care patterns of dual eligibles, most data sources that researchers rely upon (e.g., the enrollment data base and MCBS) do not explicitly identify a beneficiary's eligibility category. Efforts are underway to better link Medicare and Medicaid data, but in the meantime, it is important to understand conceptually the differences between "full" dual eligibles and those who participate only in the Medicare Savings Programs, which offer partial supplemental coverage.

Full dual eligibles

Most dual eligibles qualify to receive full Medicaid benefits. Full dual eligibles are entitled to receive all benefits covered by Medicaid, such as nursing home and other institutional care, home care, dental care, mental health care and therapy, eye care, transportation to and from providers, and prescription drug coverage.[2] Medicaid also pays their Medicare Part A (if necessary) and Part B premiums and cost sharing for all Medicare Part A and Part B services.

Beneficiaries have two pathways to receiving full Medicaid benefits. First, they may be eligible if they have incomes less than or equal to 73 percent of poverty (the Supplemental Security Income eligibility level) and assets not in excess of $2,000 for individuals and $3,000 for couples. States have the option to set higher asset thresholds and extend full Medicaid benefits to beneficiaries with incomes up to 100 percent of poverty.

Beneficiaries can also receive full Medicaid benefits if their medical expenses are high enough to reduce their net income below a state-specified level. These beneficiaries are considered "medically needy." Often, beneficiaries become medically needy if they have a chronic illness like diabetes or dementia that leads to significant and overwhelming medical expenses, or if they move to a nursing home. States are not required to offer medically needy programs, but 39 states do. For medically needy beneficiaries, states also have the option of paying the Part B premium.

Two additional programs are available to states to assist low-income beneficiaries: the Special Income Rule for Nursing Home Residents program, known as the 300 percent rule, and the Home- and Community-Based Services Waivers program. The 300 percent rule allows beneficiaries with incomes up to 300 percent of the Supplemental Security Income eligibility income level to receive full Medicaid benefits, Medicare Part B premiums, and cost sharing if they are in an institution.[3] The latter program provides Medicaid-covered home- and community-based services to those beneficiaries who would be eligible for Medicaid if they resided in an institution. These beneficiaries might then continue to live in the community with assistance (personal care, for example) rather than in an institution.

Medicare savings programs

Beneficiaries with somewhat higher income and asset levels are eligible for more limited Medicaid coverage. Beneficiaries with income and assets that exceed state requirements for Medicaid but have incomes below 100 percent of poverty and meet an asset test (no more than

TABLE 3-1

How do Medicare beneficiaries qualify for Medicaid?

Type of dual eligible	Medicaid benefits	Eligibility criteria: Required	Eligibility criteria: Optional
Full dual			
Meets low-income standard	Wrap-around Medicaid benefits, Medicare premiums and cost sharing	Income: ≤73 percent of FPL* Asset limit: $2,000 (individual) $3,000 (couple)	Income: 74–100 percent of FPL Asset limit: higher asset threshold
Medically needy (has high medical expenses)	Wrap-around Medicaid benefits, Medicare premiums and cost sharing (extent of coverage may vary by state)	None	By deducting incurred medical expenses from income, individual may spend down to a state-specified level
Medicare savings program			
QMB	Medicare premiums and cost sharing	Income: up to 100 percent of FPL Asset limit: $4,000 (individual) $6,000 (couple)	None
SLMB	Part B premium	Income: 100–120 percent of FPL Asset limit: $4,000 (individual) $6,000 (couple)	None
QI**	Part B premium	Income: 120–135 percent of FPL Asset limit: $4,000 (individual) $6,000 (couple)	None

Note: FPL (federal poverty level), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual). These requirements apply for 2003.
* States that elect the so-called "209b option" can set more stringent income and asset limits.
** The QI program is funded under a block grant that was extended through September 31, 2004.

$4,000 for an individual and $6,000 for a couple) are eligible to be qualified Medicare beneficiaries (QMBs). Medicaid pays their Medicare premiums and cost sharing.[4]

Beneficiaries with incomes between 100 and 120 percent of poverty are eligible to be specified low-income Medicare beneficiaries (SLMBs). Medicaid pays their Part B premium.

Medicare beneficiaries may also receive benefits through the qualifying individual (QI) program. The Balanced Budget Act of 1997 established the QI program as a capped federal allocation to states, out of which states pay the Part B premiums for qualifying Medicare beneficiaries. Originally set to last five years, starting in 1998, the QI program was recently extended through September 31, 2004. Because the QI program is subject to an annual federal funding cap, the number of Medicare beneficiaries who may participate in the program is limited.

Some Medicare beneficiaries who previously qualified for Medicare because of a disability but then returned to work may purchase Medicare Parts A and B. If their income is

less than 200 percent of poverty but they do not qualify for any other Medicaid assistance, they may be eligible for the Qualified Disabled and Working Individuals program, through which Medicaid pays their Part A premiums.

Implications of eligibility criteria

Eligibility and benefits offered to dual eligibles can vary greatly by state. Medicare beneficiaries residing in one state might qualify for full wrap-around Medicaid benefits, coinsurance, and cost sharing, while similar beneficiaries in another state might only qualify to have their Medicare Part B premiums paid. These differences in eligibility across states translate into differences in basic health insurance coverage and out-of-pocket spending, which can in turn affect access to needed health care.

Also, even if beneficiaries are eligible for Medicaid benefits, they may not be enrolled in the program, which may limit their use of health care. Seventy-eight percent of those who qualify for the QMB program are enrolled and only 18 percent of those eligible for the SLMB program are enrolled (Moon et al. 1998).[5] The barriers to program participation are numerous. Beneficiary education about the programs is often underfunded or lacking. Welfare workers, Social Security Administration employees, and community-based organizations may not know enough about the programs to conduct effective outreach, and states, facing increasing budgetary pressures in recent years, may not have the resources to implement or maintain extensive outreach programs. Beneficiaries may choose not to enroll if the state has Medicaid estate recovery requirements. Furthermore, enrollment processes that require long waits in welfare offices, face-to-face interviews, and extensive documentation of income and assets can deter beneficiaries from enrolling. Language and transportation pose further difficulties.

What are the demographic and health characteristics of the dual eligible population?

How do dual eligibles differ from other Medicare beneficiaries? Dual eligibles are more likely to have characteristics that make them more vulnerable—such as fewer resources and poorer health—than nondual eligibles. However, many other characteristics—such as age, disability level, living arrangement, and health status—vary significantly among dual eligibles.

Overview of the dual eligible population

By definition, dual eligibles are poor: over 60 percent live below the poverty level, and 94 percent live below 200 percent of poverty (Table 3-2, p. 76).[6] A disproportionate share lack a high school diploma and are African American or Hispanic. They are also more likely to be female.

The dual eligible population is more likely than the rest of the Medicare population to be disabled (under age 65 and eligible for Medicare because of a disability) or at least 85 years old. More than one-third of dual eligibles are eligible for Medicare because they are disabled, and 14 percent are age 85 or older. In fact, dual eligibles are three times more likely to be disabled than the nondual eligible population.

Relative to nondual eligibles, dual eligibles report poorer health status on the MCBS. The majority report good or fair status, but just over 20 percent of the dual eligible population (compared with less than 10 percent of the nondual eligible population) report being in poor health. Dual eligibles are also more likely to have greater limitations in activities of daily living (ADLs)—e.g., bathing and dressing—than nondual eligibles. One-third of dual eligibles have impairments in three to six ADLs. A full 45 percent of dual eligibles do not report any limitations in these activities.

Almost one-quarter of dual eligibles reside in an institution, compared with 3 percent of nondual eligibles. Although a small proportion live with their spouses, one-third of dual eligibles live with family members and non-relatives, and another one-third live alone.

Dual eligibles are more likely to suffer from cognitive impairment and mental disorders, and they have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer's disease than do nondual eligibles (Murray and Shatto 1998, CMS 2002).

The vast majority of dual eligibles have no other supplemental insurance—other than Medicaid—and those who do often obtain such coverage through other public programs (such as the Department of Veterans Affairs or a state-sponsored drug plan).

TABLE 3-2

Differences between nondual and dual eligible beneficiaries, 2001

Characteristics	Nondual eligible	Dual eligible
Demographics		
Male	45%	38%
Female	55	62
White, non-Hispanic	84	57
African American, non-Hispanic	7	21
Hispanic	6	15
Other	3	7
<65	10	36
65–74	47	26
75–84	32	24
85+	11	14
Health status and ADLs		
Excellent or very good	43	17
Good or fair	49	62
Poor	8	21
No ADLs	71	45
1–2 ADLs	19	22
3–6 ADLs	10	33
Residence		
Urban (in an MSA)	77	73
Rural (non-MSA)	23	27
Institution	3	23
Alone	28	31
With spouse	55	16
With children, nonrelatives, others	14	31
Education		
No high school diploma	28	62
High school diploma only	31	23
Some college or more	41	15
Income status		
Below poverty	9	62
100–125% of poverty	9	20
125–200% of poverty	24	12
200–400% of poverty	38	4
Over 400% of poverty	21	1
Supplemental insurance status		
Medicare or Medicare/Medicaid only	12	91
Medicare managed care	18	1
Employer	36	1
Medigap	26	1
Medigap/employer	5	0
Other	2	7

Note: ADL (activity of daily living), MSA (metropolitan statistical area). We count beneficiaries as dual eligibles if the months they qualify for Medicaid exceed the number of months they qualify for other supplemental insurance. In 2001, poverty was defined as income of $8,494 for people living alone and $10,715 for married couples.

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

Subgroups of dual eligibles

Because the heterogeneity of the dual eligible population makes it difficult to identify the typical dual eligible, we identified six subgroups of dual eligibles that share similar health status profiles and reasons for Medicare eligibility. Segmenting the population in this way and examining changes in the composition and spending patterns over time may help policymakers better target policy options to particular groups (Table 3-3).[7]

Both for aged beneficiaries and for beneficiaries eligible for Medicare because of a disability, we identified the following subgroups of beneficiaries with:

- Mental or cognitive disabilities,
- Limitations in two or more ADLs (and no mental or cognitive disabilities), and
- Limitations in fewer than two ADLs (and no mental or cognitive disabilities).

This analysis excludes beneficiaries with end-stage renal disease and is based on pooled MCBS data over two separate three-year periods. We identified beneficiaries with mental or cognitive disabilities primarily by survey responses, diagnosis and other information from Medicare claims, and self-reported prescription drug use. We did not assign those who reported only depression to this category. We determined beneficiaries' difficulty with ADLs based on survey responses.[8]

Among aged dual eligibles, just less than half have fewer than two ADL limitations and about one-third have mental or cognitive impairments. The smallest group of aged dual eligibles consists of those with more than two ADL limitations. About 17 percent of aged dual eligibles were initially eligible for Medicare due to a disability before they were 65.[9]

Dual eligibles who are under 65 and eligible for Medicare because of a disability have a different health status profile than the aged dual eligibles, with the majority (more than one-half) having mental or cognitive impairments. Similar to the aged dual eligibles, however, relatively few of the under 65 disabled dual eligibles have two or more ADL limitations and no cognitive or mental problems.

TABLE 3-3

The characteristics of dual eligible beneficiaries are changing

Subgroup	1993–1995	1999–2001
Under 65 and disabled	28.2%	34.4%
Mentally or cognitively impaired	14.4	17.9
Limitations in two or more ADLs	3.9	5.4
Limitations in fewer than two ADLs	9.9	11.1
Aged	71.8	65.6
Mentally or cognitively impaired	21.6	20.7
Limitations in two or more ADLs	18.4	14.8
Limitations in fewer than two ADLs	31.9	30.2

Note: ADL (activity of daily living).

Source: MedPAC analysis of Cost and Use file, 1993–1995 and 1999–2001 Medicare Current Beneficiary Survey.

Length of dual eligibility

Understanding how long beneficiaries stay dually eligible and the stability of the population over time may help policymakers determine the benefits of targeting care management activities to this population. Using consecutive years of data indicating whether a state Medicaid program paid any portion of beneficiary costs for Medicare Part A, Part B, or both, we found that beneficiaries tended to remain on Medicaid for relatively long periods of time. Of beneficiaries who became dually eligible between 1994 and 1996, nearly half (47 percent) remained dually eligible for more than six years (Figure 3-1). Only 14 percent of those who became dually eligible between 1994 and 1996 were dual eligibles for one year or less. This analysis does not include all medically needy dual eligibles because the data do not allow us to identify all of them.

Overall, among all dual eligibles:

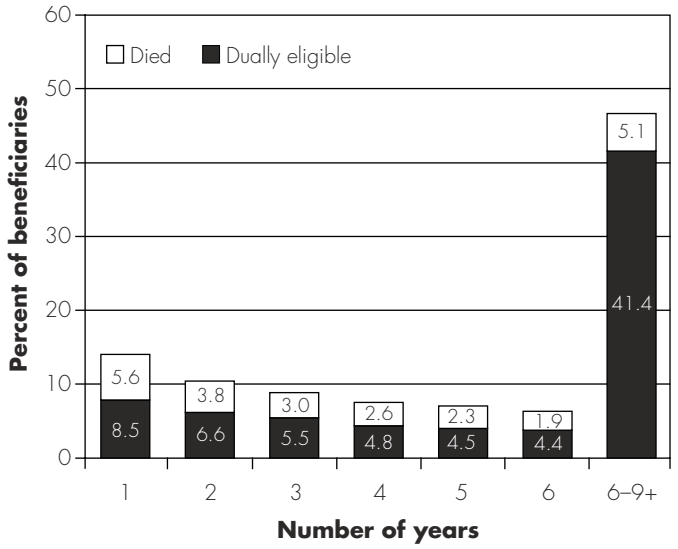
- over 40 percent have less than two ADL limitations and no mental or cognitive impairments,
- about 38 percent have mental or cognitive limitations, and
- 22 percent have difficulty with two or more ADLs but do not have cognitive or mental limitations.

One important subgroup of dual eligibles resides in institutional settings, such as nursing homes. Of these, the majority (60 percent) were aged and mentally or cognitively impaired in 2001, followed by aged with physical impairments (19 percent), and disabled with cognitive or mental impairments (15 percent).

The composition of dual eligibles has changed somewhat in the last decade. A larger percentage of dual eligibles are under 65 and disabled (34 percent compared with 28 percent), and a smaller percentage of dual eligibles are institutionalized (25 percent compared with 29 percent).

FIGURE 3-1

Beneficiaries who became eligible for Medicaid in 1994–1996 were often still eligible 6–9 years later



Note: Some beneficiaries likely remained dually eligible beyond the nine year time period we analyzed.

Source: MedPAC analysis of 5 percent Denominator files, 1993–2002, from CMS.

What are their spending and care patterns?

Higher Medicare, Medicaid, and total spending for dual eligibles compared to nondual eligibles (Table 3-4) provokes a number of questions. Why are dual eligibles more costly? Are all dual eligibles equally costly or is there variation? What services do they tend to use more of? Answers to these questions may yield insight into how to target policy interventions and evaluate dual eligibles' access to care. This section focuses primarily on Medicare spending.

Why are dual eligibles more costly for Medicare?

That per capita Medicare spending for dual eligibles is higher than for nondual eligibles is not surprising given the criteria for eligibility. Some become eligible because they are sick; others become eligible because they are poor, a characteristic often associated with lower health status. One analysis found that differences in health status explain the majority of the difference in Medicare spending for dual and nondual eligibles, but not all (Liu et al. 1998). Other factors that could contribute to higher spending for dual eligibles include:

- presence of supplemental coverage (i.e., Medicaid),
- socio-economic factors that may lead them to delay care until they require more services in more costly settings,
- lack of an informal care network or environment, and
- separate sources (i.e., Medicare and Medicaid) of coverage that may inhibit coordination of their care.

We look more closely at the sources of Medicare spending (Table 3-5) by comparing the average per capita Medicare payment for dual eligibles and other beneficiaries by service.[10] For each type of service, average Medicare per capita payments are higher for dual eligibles than nondual eligibles. The most striking difference between the two groups is in SNF and hospice services, for which Medicare spends over twice as much on dual eligibles as on nondual eligibles.

Higher average per capita spending for dual eligibles is a function of both a higher proportion of dual eligibles using services than nondual eligibles as well as greater volume or intensity of use among those who do use services. A higher proportion of dual eligibles than nondual eligibles use at least one Medicare-covered service, but the difference is relatively small—92 versus 89 percent. They are also more likely to use each type of Medicare-covered service than nondual eligibles. For example, dual eligibles are more than twice as likely to use SNF services.

Among beneficiaries with payments for each type of service, Medicare spending is significantly higher for dual eligibles in the categories of physician, outpatient hospital, and hospice care, but higher for nondual eligibles in inpatient hospital, home health, and SNF care.

TABLE 3-4 **Dual eligible beneficiaries are more costly than others, 2001**

Source of spending	Nondual eligibles	Dual eligibles
Total	$10,054	$20,844
Medicare	5,399	8,559
Medicaid	85	8,603
Other	4,570	3,682

Note: Total spending includes Medicare, Medicaid, and out-of-pocket spending in addition to spending from other sources of supplemental insurance and public programs (e.g., the Department of Veterans Affairs, the Department of Defense). We count beneficiaries as dual eligibles if the months they qualify for Medicaid exceed the number of months they qualify for other supplemental coverage. Thus, some nondual eligibles have Medicaid coverage for some portion of the year.

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

Are all dual eligibles equally costly?

Annual Medicare spending is concentrated among a small number of dual eligibles (Figure 3-2, p. 80). The costliest 5 percent of dual eligibles account for over 40 percent of total Medicare spending for this population, and the costliest 20 percent account for 80 percent of total Medicare spending on dual eligibles. In contrast, the least costly 50 percent of dual eligible beneficiaries account for only 3 percent of Medicare spending on dual eligibles. This wide distribution in annual spending underscores the diversity of the dual eligible population.

TABLE 3-5

Differences in spending and service use for nondual and dual eligible beneficiaries, 2001

Service	Nondual	Dual	Percent difference
Average Medicare payment for all beneficiaries			
Total Medicare payments	$5,399	$8,559	59%*
Inpatient hospital	2,486	3,974	60*
Physician[a]	1,720	2,278	32*
Outpatient hospital	523	965	85*
Home health	241	338	40*
Skilled nursing facility[b]	322	727	126*
Hospice	98	199	104*
Percent of beneficiaries using service			
Any Medicare service	89.1%	92.2%	3.5%*
Inpatient hospital	15.3	26.8	75.6*
Physician[a]	70.7	90.5	28.0*
Outpatient hospital	51.7	71.6	38.6*
Home health	5.5	8.0	43.9
Skilled nursing facility[b]	3.2	7.7	143.5*
Hospice	1.3	2.5	89.4
Average Medicare payment for beneficiaries using service			
Any Medicare service	$6,059	$9,284	53%*
Inpatient hospital	16,281	14,824	–9*
Physician[a]	2,432	2,517	3*
Outpatient hospital	1,012	1,348	33*
Home health	4,348	4,243	–2*
Skilled nursing facility[b]	10,224	9,473	–7*
Hospice	7,405	7,973	8*

Note: [a] Includes a variety of medical services, equipment, and supplies.
[b] Individual short-term facility (usually skilled nursing facility) stays for the Medicare Current Beneficiary Survey population.
* Indicates a statistically significant difference between dual eligibles and nondual eligibles, at a 95% confidence level ($p<0.05$).

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey, which updates the previous analysis by Liu et al. in 1998.

A similar pattern exists for all Medicare beneficiaries (see Chapter 2). However, because the average Medicare spending on the most costly dual eligibles is higher than on the most costly nondual eligibles, dual beneficiaries are a disproportionate share of the overall most costly beneficiaries. Of the 1 percent of beneficiaries for whom Medicare spending is the highest, one-third are dual eligibles. Similarly, of the costliest 5 percent of beneficiaries, 25 percent are dual eligibles.

On average, total spending (which includes primarily Medicare, Medicaid, and out-of-pocket spending) for dual eligible beneficiaries is more than twice as high as that for nondual eligibles—$20,840 compared to $10,050. The distribution of total spending for dual eligibles is similar, but slightly less concentrated, than the distribution of Medicare spending. For example, the top 5 percent of dual beneficiaries account for 27 percent of total spending (compared with 40 percent of Medicare spending).

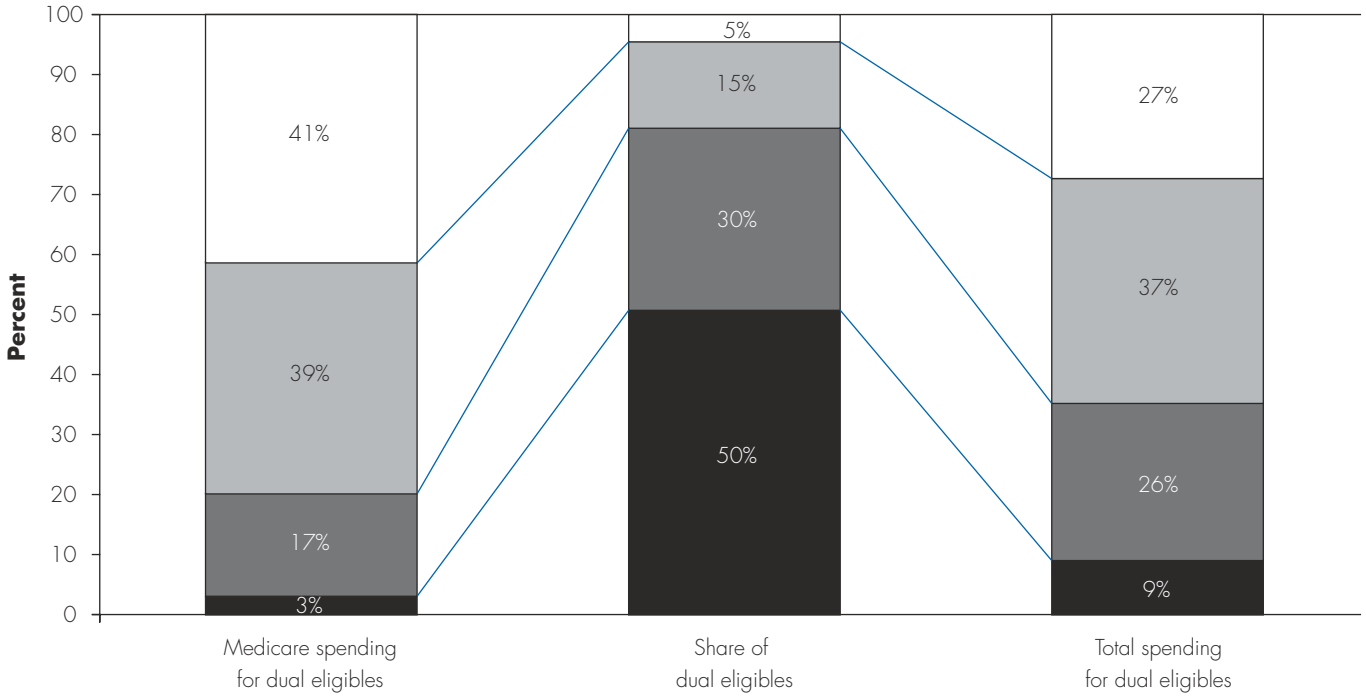
What type of dual eligibles are more costly?

To better understand the underlying diversity of the dual eligible population, we examine spending data using the same subgroup classifications we used earlier in the chapter (page 76). In this analysis, we compare spending patterns among subgroups of dual eligibles as well as across dual eligibles and nondual eligibles (Table 3-6, p. 80).

We find that, on average, the most costly subgroup of dual eligibles for Medicare are aged with mental and cognitive problems ($12,370), followed by the aged with physical impairments ($9,603) and the disabled with physical impairments ($7,299). Not surprisingly, dual eligibles with less than two ADL limitations cost Medicare much less ($3,425–$4,415).

Comparing dual eligibles and nondual eligibles, we find that all categories of *disabled* dual beneficiaries are significantly more costly to Medicare than their nondual counterparts. In contrast, Medicare spending for *aged* dual eligibles is about the same as for their nondual counterparts. While Medicare spending on these two populations is relatively close, total spending is much higher for dual eligibles. This disparity reflects the increased likelihood of dual eligibles receiving care in long-term care facilities, which is not covered by Medicare.

FIGURE 3-2 **Both Medicare and total spending are concentrated among dual beneficiaries, 2001**



Note: Columns may not sum due to rounding. Total spending includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending.

Source: MedPAC analysis of Cost and Use file, 2001 Medicare Current Beneficiary Survey.

TABLE 3-6 **Aged mentally or cognitively impaired dual eligibles are most costly**

	Medicare spending	
Subgroup	**Dual eligibles**	**Nondual eligibles**
Disabled		
Mentally or cognitively impaired	$6,405*	$3,657
Limitations in two or more ADLs	7,299*	4,416
Limitations in fewer than two ADLs	3,425*	2,605
Aged		
Mentally or cognitively impaired	12,370	11,864
Limitations in two or more ADLs	9,603	8,933
Limitations in fewer than two ADLs	4,415	3,992

Note: ADL (activity of daily living).
*Indicates statistically significant difference in spending between dual and nondual eligibles.

Source: MedPAC analysis of Cost and Use file, 1999–2001 Medicare Current Beneficiary Survey.

How is Medicare spending distributed by service for dual eligibles? Has it changed over time?

While Medicare spending for both dual and nondual eligibles living in the community is concentrated on hospital and physician services, the distribution of Medicare spending across services for dual eligibles differs from that of nondual eligibles. A greater portion of Medicare spending is devoted to home health care for dual than nondual eligibles, while a greater portion of spending is devoted to physician care for nondual eligibles, as compared to dual eligibles (Table 3-7).

The distribution of Medicare spending has changed somewhat over time for dual eligibles. The portion spent on home health care declined and the portion spent on physician and outpatient hospital care increased. The portion spent on SNF or inpatient care remained unchanged. Dual and nondual eligibles experienced

TABLE 3-7

Medicare spending by service, 1993–1995 and 1999–2001

	1993–1995		1999–2001	
Service type	**Dual**	**Nondual**	**Dual**	**Nondual**
Inpatient hospital	48.7%	52.2%	49.8%	49.1%*
Physician	26.4	28.8	30.8*†	33.3*
Outpatient hospital	7.8	7.6	9.6*	8.4*
Home health	14.4	8.7	6.3*†	4.5*
SNF	2.0	2.0	2.1†	3.4*

Note: SNF (skilled nursing facility).
* Indicates statistically significant change in the portion of spending for a service between the two time periods.
† Indicates statistically significant difference in the portion of spending for a given service between the dual and nondual eligible populations.

Source: MedPAC analysis of Cost and Use file, 1993–1995 and 1999–2001 Medicare Current Beneficiary Survey.

similar changes in the distribution of spending, except that the portion spent on SNF care for nondual eligibles increased, while the portion spent on inpatient care for this group decreased.

How is their access to care?

Are dual eligibles able to access the health care they need? This question is particularly relevant for this population because these beneficiaries often possess characteristics that are associated with needing care (e.g., ADL limitations, poor health status) as well as having difficulty obtaining care (e.g., poor, less educated).

Because the question of access is difficult to answer definitively, we examine a number of different indicators. In the previous section, for example, we examined spending patterns over time and found that dual eligibles appear to be accessing fewer of certain types of services than they did before, pointing to possible access problems. However, spending patterns alone do not reveal whether the care beneficiaries are receiving is medically necessary or whether beneficiaries have unmet needs.

Thus, we examine beneficiaries' own evaluation of their access to care and find mixed results. We analyze two surveys, both of which are administered by CMS: the CAHPS and the MCBS.[11] Although survey data are limited in that they do not measure the clinical appropriateness of care and can be influenced by factors such as education level, they provide us with an important indication of how beneficiaries perceive their own ability to access care.[12]

The results indicate that most dual eligibles rate their access to care positively, higher in some cases than Medicare-only beneficiaries but generally lower than beneficiaries with other sources of supplemental insurance. Between 75 and 93 percent of dual eligibles rate their access to care highly, depending on the measure of access. This compares with about 83 to 99 percent of beneficiaries with other sources of supplemental coverage—Medigap or employer-sponsored insurance, for example.[13] Medicare-only beneficiaries may or may not report better access to health care than dual eligibles. The results depend on the aspect of access being measured: Dual eligibles have a slightly more difficult time getting immediate and regular care, but are more likely to have a usual source of care and less likely to delay care due to cost (Table 3-8). Both groups rate their health care and providers highly.

TABLE 3-8

Dual eligible beneficiaries report generally good access to care

	Percent reporting positively	
Question	**Dual eligible**	**Medicare only**
Do you have one person you think of as your personal doctor or nurse?	84.0%	74.6%
Did you delay seeking medical care because you were worried about the cost?	9.7	22.5
Did you usually or always get care as soon as you wanted when you needed care right away?	88.1	90.3
Did you usually or always get an appointment for regular or routine care as soon as you wanted?	86.5	90.7

Source: MedPAC analysis of the Cost and Use file and the Access to Care file, 2001 Medicare Current Beneficiary Survey; and the 2001 Consumer Assessment of Health Plans Survey.

On some measures, dual eligibles' access to care appears to be relatively good. Dual eligibles report having a usual source of care—a particular doctor or nurse—more often than Medicare-only beneficiaries (84 percent versus 75 percent). Dual eligibles also report that they delay care due to cost less often than Medicare-only beneficiaries (10 percent versus 23 percent). This makes sense, since dual eligibles have little out-of-pocket liability: The majority have Medicaid coverage for both services that Medicare does not cover and the cost sharing associated with Medicare-covered benefits. However, beneficiaries with other sources of supplemental coverage report better access to care on these measures than either dual eligibles or Medicare-only beneficiaries: Between 89 percent and 93 percent have a usual source of care, and between 1 percent and 5 percent delay care due to cost. These differences may reflect differences not only in coverage but also in the underlying characteristics of the populations.

Dual eligibles may have slightly more difficulty accessing immediate and routine care than do Medicare-only beneficiaries. Dual eligibles were less likely than Medicare-only beneficiaries to report that they "usually" or "always" received immediate or routine care when they or their doctor felt they needed it. A higher percentage of beneficiaries with other supplemental coverage (about 93 percent) responded "usually" or "always" to the same questions.

We find conflicting results regarding the broad, overarching question of whether beneficiaries had difficulty getting needed care. Using MCBS data, we find no difference between dual eligibles and Medicare-only beneficiaries. However, using CAHPS, we find that dual eligibles have slightly more problems obtaining necessary health care than Medicare-only beneficiaries. On both surveys, beneficiaries with other sources of supplemental coverage report fewer problems than either of these groups in accessing needed health care.

Both dual eligibles and Medicare-only beneficiaries appear equally able to access a specialist: Between 75 and 77 percent report they are able to see a specialist when needed (compared with 87 percent of those with other sources of coverage). Both groups appear satisfied with their personal doctor, specialist, or overall health care: 78 to 84 percent rate their health care providers or the health care they receive highly.

How do coverage and payment policies work for dual eligibles?

Attempts to coordinate benefits and payments for services used by dual eligibles illustrate the complex interrelationship of the two programs and the challenges involved in managing care, improving access, and containing systemwide costs. The dynamics in the system differ somewhat depending upon whether a dual eligible is in Medicare fee-for-service (FFS) or in a Medicare Advantage (MA) plan (formerly known as a Medicare+Choice plan).

The vast majority of dual eligibles are enrolled in FFS. Unlike other Medicaid recipients, dual eligibles' enrollment in managed care cannot be mandated by states. They are considered to be Medicare beneficiaries first and, as such, are afforded freedom of choice in enrolling in managed care.

In some states, however, dual eligibles' enrollment in MA plans is significant. Eleven percent of dual eligibles in California are enrolled in Medicare managed care, 14 percent in Florida, and 28 percent in Oregon (Walsh and Clark 2002). Other types of Medicare managed care arrangements, such as the Program of All-Inclusive Care for the Elderly (PACE), Evercare, and state waiver plans, are also available to dual eligible beneficiaries, depending on where they live. In addition, recent legislation authorized specialized Medicare managed care plans in order to allow greater regulatory flexibility and encourage development of plans that focus on the dual eligible population, among other special needs populations.

The problem of coordinating benefits

Medicare is the primary insurer for dual eligibles and covers medically necessary acute care services, including physician, hospital, hospice, SNF, and home health services, and durable medical equipment. As the secondary payer, Medicaid generally covers:

- Services not covered by Medicare, such as transportation, dental, vision, and until 2006, most outpatient prescription drugs.
- Wrap-around services, such as cost sharing for services covered by Medicare as well as acute care services that are delivered after the Medicare benefit is

exhausted or if certain Medicare criteria are not met. These services include inpatient hospital, SNF, and home health care.

- Long-term care, including custodial nursing facility care, home and community-based services, and personal care services.

After 2006, Medicare will include a prescription drug benefit. Its design is a significant departure from that of other Medicare benefits for dual eligibles. Whereas Medicare's cost-sharing requirements for all other benefits are uniform regardless of the beneficiary's income, cost-sharing requirements for the drug benefit are dramatically reduced for beneficiaries with low income. The extent of the reduction varies by income and asset level.

Under the new prescription drug benefit, dual eligibles with incomes less than 100 percent of the poverty level pay no premium if they select an average—or lower—cost plan. They also pay no deductible, and institutionalized dual eligibles are not responsible for any copays. Dual eligibles living in the community pay nominal copays, the exact amount of which depends on their income.[14] These subsidies are also available to dual eligibles and other low-income beneficiaries with incomes between 100 and 135 percent of poverty who meet a federal asset test. For those who meet the asset test but have incomes between 135 and 150 percent of poverty, the premium subsidy is adjusted on a sliding scale. Their deductible and coinsurance percentages are also reduced.

Although states can supplement the Medicare drug benefit, they cannot receive federal Medicaid matching funds to do so. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) provides an exception to this for states that choose to cover a class of drugs not required under the Medicare drug benefit. In this case, Medicaid programs would be allowed to cover this class of drugs and receive the federal match. Certain situations may motivate states to provide coverage even though they do not receive the federal match. For example, if plan formularies do not include drugs important to some dual eligibles, states may choose to provide supplemental coverage. Also, if not all eligible beneficiaries enroll in the program during the limited enrollment period, states may choose to cover these beneficiaries. However, to the extent that states find that they are unable to provide coverage in these situations without the federal match, dual beneficiaries may face barriers in obtaining prescription drugs.

As under FFS, Medicare is the primary insurer for dual eligibles enrolled in managed care plans participating in the MA program. Medicaid is the secondary insurer, responsible for covering certain wrap-around benefits and acute and long-term care services not covered by Medicare. However, the boundaries between Medicare and Medicaid coverage are less clear for enrollees in MA plans than in FFS because MA plans can offer additional benefits, such as outpatient prescription drug coverage, preventive services, and vision and dental care—all services that Medicaid often covers. In addition, plans generally have a different cost-sharing structure than FFS Medicare. Plans tend to require less cost sharing at the time of service delivery (though more than Medicaid requires) and may charge a premium in addition to the Part B premium. The benefit structure has evolved as Medicare payment and market dynamics have changed. In the last few years, plans increased cost sharing and premiums, and many reduced the scope of additional benefits they offer. However, with the recent payment increases to plans, premiums and cost-sharing levels may once again decline.

Gray areas of benefit definitions

Defining the boundaries of coverage between the two programs can be imprecise and subjective, particularly when similar services are covered by both programs. Coverage determinations are guided by a combination of factors, including statutory definitions of medical necessity, statutory and regulatory parameters of the benefit, judicial decisions, and the judgment of fiscal intermediary staff and administrative law judges (ALJs).

The two programs have a significantly different coverage mandate in statute. Medicare pays for covered services that are medically "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (Social Security Act Section 1863(1)(A)). Hence, its coverage tends to be oriented toward acute care services. By contrast, Medicaid pays for "necessary medical services and . . . rehabilitation and other services to help . . . individuals attain or retain capability for independence or self-care" (Frye 2003). This emphasis leads to broader Medicaid coverage of durable medical equipment, home care services, and long-term care than Medicare.

In addition, Medicare has specific eligibility criteria for each benefit. For example, to qualify for home health care, beneficiaries must be homebound and need skilled care, and the care must be part time or intermittent and prescribed via a physician's order. To qualify for SNF care, a beneficiary must first have a three-day hospital stay.

These eligibility criteria can be further defined by judicial decisions. Perhaps the best known is the 1988 court case Duggan vs. Bowen, in which the court reinterpreted the "part time or intermittent" criteria in a way that allowed more beneficiaries to access home health and increased the number of visits that were covered by Medicare.

Medicare coverage decisions are made by fiscal intermediaries, carriers, and durable medical equipment regional contractor (DMERC) staff who review individual claims. Determining whether someone is homebound or in need of skilled care, for example, can require interpretation of law and regulation, and intermediaries can vary in their interpretation of these definitions. The ALJs provide another layer of review. Intermediary denials of these coverage decisions can be appealed to Social Security ALJs, who, in the past, tended to be more lenient than intermediary staff and reverse some of the intermediaries' decisions (Anderson et al. 2003).[15]

Gaps in coverage for dual beneficiaries

Medicaid covers many important services that Medicare does not cover, but neither program covers some services. Medicaid has a core set of required services that each state must cover (e.g., physician, hospital), but about two-thirds of the Medicaid benefit package is offered at the state's option. As a result, significant geographic variation in coverage prevails. Some states do not cover certain services, such as dental, vision, and therapy services; some limit the number of hospital days and prescriptions per month covered; others limit coverage by narrowing their medically necessary criteria. Overall, however, the types of benefits covered are fairly comparable to what many private insurance plans offer.

Given recent state budget pressures, many state Medicaid programs have been reducing or eliminating coverage for optional services. For example, in fiscal year 2004, seven states reduced adult dental services, seven states reduced chiropractic services, and five states reduced vision or eyeglass coverage. Other cuts included podiatric and psychological services as well as occupational, physical, speech, and mental health therapies (Kaiser Family Foundation 2003b).

In addition, Medicaid may not cover services if they are delivered by non-Medicaid approved providers. This may occur in cases where Medicaid coverage is provided through a managed care plan and a non-network provider delivers care. In addition, some Medicaid programs do not recognize certain types of providers, such as long-term care hospitals or some rehabilitation facilities.

Paying for fee-for-service

When Medicaid coverage wraps around Medicare coverage of a service, Medicare pays providers according to its payment methods and rates. In theory, Medicaid pays the associated cost sharing. However, the extent of a state's liability has evolved since passage of the Balanced Budget Act of 1997 (BBA). The BBA clarified that state Medicaid programs are not required to pay the full cost-sharing amount so long as their payment policies are written in their state plan. States are free to cap their liability so that providers receive no more than the state would have paid if the beneficiary only had Medicaid (Table 3-9). Because so many states' Medicaid payment rates are lower than the total Medicare payment rates (program payment plus coinsurance), and often below the program payment alone, providers caring for dual eligibles frequently do not receive the full coinsurance. In general, providers cannot bill the dual eligible for any portion of the coinsurance unless the state charges a nominal Medicaid copayment for the service.

TABLE 3-9

Illustration of Medicaid payment of Medicare coinsurance for most services

	Medicare		Medicaid	
Scenario	Payment	Coinsurance	Rate	Payment for coinsurance
A	$80	$20	$75	$0
B	80	20	90	10
C	80	20	≥100	20

Note: A (Medicaid is lower than Medicare payment), B (Medicaid is higher than Medicare but less than combined payment plus coinsurance), C (Medicaid rate is greater than or equal to the combined payment plus coinsurance).

For outpatient mental health services, dual eligibles' liability for cost sharing is a special case and, depending on the state's reimbursement rate, is potentially higher than for other services. Medicare's payment is, in effect, 50 percent of the allowed rate; however, it is technically calculated as 80 percent of 62.5 percent of the allowed amount. The maximum coinsurance a state may pay is therefore calculated as 20 percent of 62.5 percent of the total allowed amount (Table 3-10). As with other services, a state may opt to pay nothing if the Medicaid rate is below the Medicare program payment (i.e., 50 percent of the allowed amount) as long as the policy is stipulated in its state plan. Although not permitted for other types of services, mental health practitioners may bill the Medicare beneficiary for the 37.5 percent not reimbursed by either the Medicare program or the state for outpatient mental health services (Thompson 2003).

The degree of flexibility in Medicaid payment for cost sharing was subject to judicial review and decisions in various states before being clarified in the BBA. Prior to this law, about 12 states are estimated to have limited Medicaid payment of Medicare coinsurance. One study found that, between 1997 and 1999, about 18 states reduced their provider payment rates for dual eligibles and aligned them more closely with Medicare payment rates, thereby limiting Medicare coinsurance payments (Nemore 1999, Thompson 2003). Additional states have likely since amended their state plans to pay a smaller portion of Medicare cost sharing.

TABLE 3-10 **Illustration of Medicaid payment of Medicare coinsurance for outpatient mental health services**

	Medicare			Medicaid	
Scenario	Allowed amount	Payment*	Coinsurance**	Rate	Payment for coinsurance
A	$100	$50	$12.50	≤$50	$ 0
B	100	50	12.50	>50	≤12.50

Note: A (Medicaid is lower than or equal to Medicare payment), B (Medicaid is higher than Medicare but less than combined payment plus coinsurance).
*Calculated as 50% of allowed Medicare rate.
**Per statute, the amount of Medicare coinsurance is calculated as 20% of 62.5% of the total allowed Medicare rate.

Even if Medicaid and dual eligibles do not pay the cost sharing, facilities do not have to fully absorb these amounts. Instead, a portion of this reduction is offset by increased Medicare payments. Medicare pays facility-based providers for uncollected cost sharing, otherwise known as "bad debt." Facility-based providers may be reimbursed by Medicare between 70 and 100 percent of bad debt, depending on the type of facility. Part B providers—such as physicians and other ambulatory care providers—do not receive Medicare payments for bad debt. Bad debt reimbursement is limited for dialysis facilities.

When a dual eligible in FFS Medicare is also in a Medicaid managed care plan, determining wrap-around payment is complicated further. A Medicaid managed care plan may maintain that its payment rate (separate from the FFS rate) is lower than Medicare's payment and therefore it owes the Medicare provider no coinsurance. In addition, in some states, if the service is not provided by a Medicaid plan network provider, the plan is not required to pay the provider. In other states, the plan is expected to pay cost sharing for out-of-network providers (Walsh and Clark 2002).

The implications of coverage and payment rules

The coverage rules, payment rules, and different financing mechanisms of the Medicare and Medicaid programs create a complex environment for dual eligibles to obtain care. While Medicare—as a federal program—is predominantly financed by federal payroll taxes, general revenues, and beneficiary premiums, Medicaid is a joint federal and state program, with states financing up to 50 percent of costs.

Spending

Each program's actions can shift costs from one program to the other. In some cases, this shifting of costs increases systemwide administrative costs.

- *Medicare cost sharing and benefit changes.* If Medicare reduces beneficiary cost-sharing requirements, Medicaid spending usually decreases. Similarly, if Medicare expands its benefit package to include a service already covered by Medicaid, Medicaid savings could result. For example, but for the "clawback" provision of the MMA, states would have saved money by having Medicare expand its

coverage for outpatient prescription drugs. In this case, the savings to states are largely eliminated by the requirement that they refund much of the estimated savings to the federal government.

Conversely, if Medicare increases cost sharing or otherwise reduces the scope of a benefit that is also covered by Medicaid, Medicaid spending would increase. For example, recent enactment of a higher Part B deductible or proposals to add a beneficiary copayment for home health services have been estimated to increase Medicaid spending (CBO 2003). In addition, to the extent that increasing Medicare payment rates increases the Part B premium, Medicaid spending for dually eligible beneficiaries also increases.

- *Medicaid payment and Medicare bad debt payments*. Medicare's bad debt payment policy means that Medicare's spending for bad debt payments will rise when states lower their cost-sharing payments.
- *Medicare maximization programs for home health.* Many states have noted the inconsistency of coverage decisions and, facing budget pressures, have undertaken "Medicare maximization programs" to increase the number of decisions requiring Medicare to cover home health services. In their most aggressive form, the state Medicaid program files claims on behalf of beneficiaries and pursues their appeals if denied by the intermediaries. Indeed, the payoff for some states has been well worth the effort. Eight states have adopted this strategy since 1988 (although only five of these states pursue appeals to ALJs), and only one state discontinued its use because the costs turned out to be higher than the returns. Ratios of recovered expenditures to costs incurred under this strategy in Connecticut, New York, and Massachusetts have been between 5:1 and 7:1 (Anderson et al. 2003). The states that adopt this approach tend to be the ones with high Medicaid home care spending.

  About 36 other states have adopted less aggressive Medicare maximization strategies, whereby they educate providers on billing techniques that increase the likelihood that Medicare, rather than Medicaid, will pay the claim. Such programs may require providers to submit proof of Medicare denial before Medicaid will pay the claim. This approach generally does not rely on appealing intermediary decisions.

Quality of care

The tension between the two programs over which program will pay may lead to poorer quality of care. Instead of having the incentive to improve the overall efficiency and coordination in the delivery of care, each program has an incentive to maximize payment from the other program. As a result, the incentive of one program to invest in initiatives that would improve quality of care will be undermined if the financial payoff is realized by the other program.

One illustration of this is the disincentive the system provides for state Medicaid programs to finance case and care management services for their dual eligibles. Because these services are primarily intended to reduce hospitalizations covered by Medicare, Medicare would recoup most of the savings. Medicaid programs may choose to provide these services for other reasons, but the current structure of the system provides little incentive for them to do so. (See Chapter 2 for discussion of CMS's new policy on sharing the cost of disease management programs for Medicaid recipients.)

Other care coordination barriers exist as well. One state interested in providing disease management to dual eligibles reports that its Medicaid disease management program has had difficulty identifying Medicare providers caring for dual eligibles because the state does not have access to Medicare claims information. Even when it can identify the providers, the disease management program has had limited success in inducing Medicare providers to cooperate.

Providers have incentives to maximize payment between the two programs in ways that may not best serve the dual eligibles. For example, nursing home providers may have little incentive, at the margin, to avoid hospitalizing dual eligible patients whose nursing home care is paid for by Medicaid. If patients remain in the hospital at least three days (a requirement for SNF care), the hospitalization can trigger a Medicare-covered SNF stay (up to 100 days) that is paid at a higher rate than if the stay were covered only by Medicaid. Offsetting this financial incentive is the requirement that nursing homes report their hospital readmission rates, which are then made available to consumers as one measure of the facilities' quality of care.

Lack of coordination between Medicare and Medicaid may also affect the type of post-acute care patients receive when they are discharged from a hospital and the overall spending for that care. In some cases, dually eligible

patients needing long-term care are discharged to a SNF because the SNF care is covered by Medicare. Eventually, the 100 days of Medicare coverage expire or the patients' needs shift from skilled care to a lower level of care, and Medicaid becomes the primary payer. However, if Medicaid had been the primary payer from the beginning, the patients might have been advised about noninstitutional options at the outset of the stay, potentially leading to a better outcome for the patient and lower costs to Medicaid (Ryan and Super 2003).

Access to care

Payment and coverage rules can affect access to care for dual eligibles in different ways. First, although Medicaid provides many services not available through Medicare, variation in Medicaid benefits across states means that not every dual eligible has access to the same benefits. For example, some states may cover dual eligibles for dental and hearing services; other states may not. Lack of coverage reduces access, particularly for low-income populations.

Second, Medicaid's role as a supplemental insurer in promoting access to care for dual eligibles may be diminished as a result of the BBA clarification that allows Medicaid to pay providers less than the full Medicare cost sharing amount. Because of this, total payments to providers for dual eligibles may be considerably below that for other beneficiaries.

As a supplemental insurer, Medicaid provides financial assistance to dual eligibles by paying beneficiaries' Part B premiums and limiting providers' ability to bill beneficiaries for cost sharing. In addition, Medicaid coverage—on top of Medicare coverage—may improve access to care for dual eligibles by generally paying providers more than they would have received if the beneficiaries had been covered by Medicare or Medicaid alone. Research indicates that physicians segment their potential patient pool based on insurer type and prefer to treat higher-paying patients first. Higher payments, therefore, encourage physicians to treat more dual eligible patients and, conversely, lower payments may discourage providers from caring for dual eligibles (Thompson 2003).

A study of nine states by the Department of Health and Human Services found that lowering the Medicare cost sharing paid by Medicaid decreased the likelihood that a dual eligible would have an outpatient physician visit and reduced the total number of visits the person would have. A 10 percent reduction in cost sharing decreased the probability of having an outpatient visit by 3 percent. This effect was more significant for outpatient mental health treatment than for other outpatient care. Indeed, the probability of an outpatient mental health visit decreased by 21.3 percent in the study state with the highest payment reduction (Thompson 2003).

Third, conflicting payment and coverage rules may cause complications for providers. For example, a dual eligible who is receiving nursing home care (not SNF care) is eligible for Medicare coverage of durable medical equipment. However, if a nursing home has all of its beds certified for Medicare (which is increasingly the case), the DMERC will assume the patient is covered under the Medicare SNF benefit (which includes full payment for durable medical equipment) and will, therefore, deny the claim. The problem is that the DMERC does not now receive information about the patient's source of coverage, so the only information it has is the certification of the bed.

Another example of the coordination problem stems from state Medicare maximization programs that require home health providers to submit proof of Medicare denial before they can submit a claim to Medicaid for payment. Providers complain that this step delays receipt of payment.

Paying MA plans

In general, MA plans are paid a capitated rate per enrollee based on the rate for the beneficiary's county of residence multiplied by a risk-adjustment factor that is intended to reflect the relative health status of the enrolled beneficiary. CMS has recently implemented a new risk-adjustment method—called the CMS hierarchical condition category model—that pays more accurately for patients' clinical needs. The method of payment for dual eligibles is not different than for other beneficiaries. However, because dual eligibles often have more health problems than nondual eligibles, the payments generated for dual eligibles by the new risk-adjustment formula would likely be higher than for nondual eligibles.

The risk-adjustment method includes an additional adjustment for beneficiaries enrolled in a PACE or demonstration plan—such as Minnesota Senior Health Options and Disability Health Options, Massachusetts Senior Care Options, or the Wisconsin Partnership Program (WPP)—which tend to have more frail dually eligible enrollees. This frailty adjuster, phased-in beginning in 2004, is intended to capture predictable

differences in costliness but with less administrative burden for plans than the previous method.

The frailty adjuster is calculated for each plan based upon a weighted average of the number of limitations in ADLs among each plan's enrolled beneficiaries over 55 and living in the community. The frailty adjustment amount is added to the individual risk score to produce a total risk-adjustment factor. In turn, this factor is multiplied by a base payment amount to produce a total payment amount. Table 3-11 provides an illustration of payment to plans for an aged dual eligible male.

Generally, this additional adjustment results in higher payment for the same frail beneficiary in a PACE or one of the demonstration plans than in a regular MA plan. The intent of this higher payment is to compensate these plans for enrolling such a high percentage of frail beneficiaries, compared with MA plans. In theory, MA plans that enroll a smaller percentage of frail beneficiaries may be better able to offset these beneficiaries' higher costs with payments plans get for much lower-cost beneficiaries.

Cost sharing

Although Medicaid is the secondary payer for dual eligibles enrolled in managed care, Medicaid payment for beneficiaries' cost sharing is inconsistent and complicated by a number of factors:

- States have had difficulty informing plans which beneficiaries are dually eligible, so MA plans may not be aware that a beneficiary is also Medicaid eligible. As a result, the plan bills the beneficiary for cost sharing rather than billing Medicaid. Beneficiaries who are billed are often unaware that they are not liable for the expense and may pay the premium or cost sharing (or avoid care).
- The state may claim that the plan payment to the provider for cost sharing exceeds Medicaid payment for the same service and that Medicaid is therefore not required to pay.
- Physicians and other Medicare providers in the MA network may not be participating Medicaid providers and may not have billing systems compatible with Medicaid.

Payment for cost sharing may be further complicated by variations in state policy. Although most dual eligibles are in Medicare plans that are supplemented by Medicaid FFS, some beneficiaries are in Medicaid health maintenance organizations (HMOs) for their Medicaid-covered services. States may allow, encourage, or forbid enrollment in Medicaid managed care if the beneficiary is in an MA plan; the rules may even vary by market area within a state. In particular, complications arise if beneficiaries receive care from providers that are not in the Medicaid HMO's network. Similarly, if Medicare provides a service that requires preauthorization from the Medicaid HMO, but fails to obtain that preauthorization, the HMO, depending on the state, may not be required to pay the associated cost sharing (Walsh and Clark 2002).

Furthermore, states are not required to pay MA plan premiums on behalf of their dual eligibles (Walsh and Clark 2002). This policy has become more significant recently given the decline in zero premium options that were available in many areas in the early- to mid-1990s. Some states, including California and Texas, have negotiated with plans so that they pay premiums in exchange for an MA benefit package that includes services, such as prescription drugs, that Medicaid would otherwise have to cover.

Special managed care programs for dual eligibles

Several programs integrate the financing and delivery of care for the full range of health care needs of dual eligibles and thereby avert some of these coordination-of-benefit issues. By aligning incentives, this integrated payment approach is also intended to facilitate coordination of care for dual eligibles. The following three programs combine Medicare and Medicaid capitated payments to integrate care for the dual eligible population.

PACE The Program of All-Inclusive Care for the Elderly serves frail elderly beneficiaries, age 55 and older, who meet states' standards for nursing home placement and reside in areas served by the PACE organizations. Most enrollees are dually eligible.

These plans receive separate capitated payments from Medicare and Medicaid. Until now, the Medicare rate was equal to 2.39 times the Medicare county rate amount for MA plans, but, as noted earlier, this adjustment is being replaced with a frailty adjuster based on limitations in ADLs among enrollees in the plan. The PACE plan negotiates the Medicaid rate with the state Medicaid agency. Separate contracts mean that plans still have to deal with two payers and the inefficiencies that result.

TABLE 3-11 **Payments to PACE or demonstration plans are often higher than to MA plans**

Plan	Base rate	Individual risk score	Frailty adjustor	Total risk adjustment factor	Total payment
Medicare Advantage	$550	1.18	0	1.18	$649
PACE or demonstration (with average of 3–4 ADL limitations)	550	1.18	.34	1.52	836

Note: ADL (activity of daily living), PACE (Program of All-Inclusive Care for the Elderly), MA (Medicare Advantage). This example is based on a male age 65 or older. Frailty factor varies between –.14 and 1.09 depending upon the weighted average number of ADLs with which enrollees have difficulty.

PACE plans feature a comprehensive medical and social service delivery system, a multidisciplinary team that provides services in an adult day health center setting, and in-home and referral services in accordance with participants' needs. The BBA allowed states to implement nonprofit PACE plans without applying for a federal waiver. For-profit PACE plans still must apply for a waiver.

An evaluation of the PACE program found that its enrollees had much lower rates of home health use and inpatient hospitalization and higher rates of ambulatory care than a comparison group. The differences persisted after two years of enrollment, but to a smaller extent. PACE enrollees also reported better health status and quality of life, and, holding other factors constant, they showed a lower mortality rate. Those with the most ADL limitations experienced the most marked decreases in hospital use, decreases in nursing home days, and improvements in self-reported quality of life (CMS 1998).

State demonstration waivers Several state programs operate under the Medicare demonstration authority, including:

- Minnesota Senior Health Options and Disability Health Options, in which Medicare and Medicaid each pay a capitated rate for their respective benefits, including home- and community-based care and nursing facility services (except for those provided beyond 180 days, which are paid on an FFS basis). Enrollment is offered to dually eligible seniors and disabled persons—both those that qualify for nursing home care ("nursing home certified") and those that do not—as a voluntary option to Minnesota's mandatory managed care program. The state oversees a single contract with plans to provide Medicare and Medicaid services. It is therefore able to create a single point of accountability, avoid regulatory duplication, and resolve differences between Medicare and Medicaid. It has merged enrollment processes, membership materials, grievance procedures, and data reporting requirements. However, reflecting CMS's stance against granting states control over Medicare funds, Medicare and Medicaid capitation payments are always pooled at the plan and not the state level (Miller and Weissert 2003).
- Wisconsin Partnership Program, in which four community-based organizations enter into a Medicaid managed care contract with the Wisconsin Department of Health and Family Services and a Medicare contract with CMS. They receive monthly capitated payments for each participant, from which they pay for all participant services. WPP serves both seniors over 55 and physically disabled dual eligibles. Qualifying beneficiaries must be nursing home certified.

Evercare This demonstration plan largely serves a dual eligible population. In Texas, an Evercare plan accepts capitated payments from both Medicare and Medicaid and offers an integrated product that manages the full range of long-term care services.

The Evercare model provides case management for nursing home residents to reduce the need for hospital and emergency room care. Evercare employs a cadre of nurse practitioners who work cooperatively with residents' primary care physicians. The physicians are paid more

generously than under FFS Medicare. Evaluations have found that Evercare resulted in reduced hospitalizations compared with control groups and that care is at least comparable with what is available in the FFS environment (Kane et al. 2003, 2002). It currently operates in 11 states and has 24,000 enrollees, about 75 percent of whom are dually eligible.

The implications of payment rules for MA

Coordination of benefits is confusing and threatens the protection intended by dual coverage

As noted above, Medicaid payment of MA plan cost sharing is inconsistent. Many beneficiaries are confused about their benefits and, so, cannot be effective advocates for themselves when they are inappropriately billed for cost sharing. As a result, many dual eligibles are paying for MA plan cost sharing. This situation undermines the protection that Medicaid coverage was intended to provide if, as a result, beneficiaries spend more out-of-pocket and avoid needed care.

MA plans that charge premiums may be a less viable option for dual eligibles

States are not required to pay the MA plan premium on behalf of dual eligibles, and after three consecutive months of nonpayment, plans may disenroll a beneficiary. Plans can elect to charge a premium but not collect it from some members, such as dual eligibles. While nothing prohibits plans from doing this, they are not allowed to advertise that they do. Thus, the policy may keep dual eligibles from enrolling in plans that charge a premium.

If MA enrollment does not provide added value to dual eligibles in terms of enhanced benefits or improved quality, then policies that discourage enrollment of dual eligibles in MA plans may be acceptable. On the other hand, if dual eligibles are disadvantaged by not having the option to enroll in an MA plan, policymakers may want to consider policies that encourage more states to allow dual eligibles to enroll in plans with premiums. (At a minimum, it would appear that QMBs who were not also eligible for full Medicaid benefits would particularly benefit from enrollment if plans covered non-Medicare services.)

Opportunities to integrate benefits for dual eligibles are limited

A variety of factors limit the ability of managed care plans to integrate care effectively. First, the failure of Medicaid programs to notify plans promptly of accurate enrollment information may limit access to benefits. For example, dual eligibles are able to access additional durable medical equipment, home health, pharmacy, and long-term care benefits, but only if plan staff, providers, or beneficiaries are aware of that coverage (Walsh et al. 2003).

Second, having beneficiaries enrolled in one managed care plan for Medicare benefits and another for Medicaid benefits raises a variety of problems for coordination of care. For example, a Medicaid HMO often has no opportunity to provide case management or direct its members to in-network providers. Similarly, the Medicare HMO does not have an incentive to manage beneficiaries' care to avoid long-term care spending.

Third, case studies suggest that even when beneficiaries are enrolled in Medicare and Medicaid managed care plans (but not an integrated plan) offered by the same managed care organization, coordination of care is challenging. Beneficiaries have two separate membership cards and different points of contact for their Medicare and Medicaid benefits. Plans may not be equipped to coordinate across the requirements of the two programs. Also, most Medicaid managed care plans are not responsible for long-term care services. Additional coordination with state long-term care agency personnel is necessary (Walsh et al. 2003).

Integrated financing and care delivery have unrealized potential

Many of these coverage and payment issues are generally alleviated if the dual eligible is enrolled in the same plan for both Medicare- and Medicaid-covered services, and if that plan is committed to integrating benefits. This integration can occur under the various Medicare and Medicaid integrated plans (e.g., PACE, WPP) as well as, in rare instances, in MA plans that also participate in Medicaid. However, these integrated plans serve only a small fraction of dual eligibles. Recent legislation authorizing specialized plans partly addresses this limitation by removing regulatory barriers for plans that would like to offer a product exclusively to dual eligibles. But, for MA plans that prefer to serve a more diverse population, barriers still exist. ■

Endnotes

1 The range in the estimated number of dual eligibles reflects differences in whether someone is counted as a dual eligible if Medicaid was their predominant source of supplemental coverage for the year or if they had just one month of Medicaid coverage in a year. The analyses in this chapter are based on the former, which corresponds to the lower figure.

2 Beginning in 2006, prescription drug coverage will be included in the Medicare benefit package. (This is discussed in the section, "Coverage and coordination of benefits.")

3 Beneficiaries in nursing homes qualify for this benefit if they have incomes less than or equal to 300 percent of the Supplemental Security Income level and have assets no greater than $2,000 (individual) or $3,000 (married).

4 In states that have opted to provide full Medicaid benefits up to 100 percent of poverty, beneficiaries may be QMBs who also receive Medicaid coverage for the wrap-around benefits.

5 Participation among those who are only eligible for the QMB program (and not for full Medicaid coverage) is likely lower than 78 percent.

6 The federal poverty level was $8,494 for people living alone and $10,715 for married couples in 2001.

7 The definitions of the subgroups of dual eligibles draw directly upon the approach developed by Sandy Foote and Chris Hogan in their analysis of the Medicare disabled population (Foote and Hogan 2001).

8 Beneficiaries were assigned to subgroups using a hierarchy that first assigned beneficiaries to the mental and cognitive impairments category based on diagnosis codes as well as prescription drug use. These people may also have physical limitations. The other two categories include all beneficiaries who do not have a mental or cognitive impairment.

9 This finding is based upon a separate MedPAC analysis of the 5 percent Denominator file for 2001.

10 This analysis updates work by Liu and others based on 1993 MCBS data (Liu et al. 1998).

11 CAHPS was originally developed for use with private health plans by a consortium including Harvard Medical School, RAND, Inc., and Research Triangle Institute, with support from the Agency for Healthcare Research and Quality and CMS. It was subsequently adapted for surveying beneficiaries in Medicare Advantage plans and fee-for-service Medicare. It does not include institutionalized beneficiaries. CMS has administered CAHPS to between 168,000 and 178,000 fee-for-service beneficiaries annually since 2000. With response rates of 70 to 80 percent, the CAHPS surveys are the largest surveys of Medicare beneficiaries.

12 One bias that can affect survey responses is socially desirable response set bias, which is the tendency of respondents to answer in a way that they perceive to be consistent with societal norms rather than based on their own personal experience. Another possible bias is acquiescent response set bias, which is the propensity of respondents to agree with a question regardless of its content. Studies have shown that survey participants with lower income or education levels exhibit these biases (Ross et al. 1995, Ross and Mirowsky 1984, Ware 1978), and older respondents have also been shown to acquiesce or respond in a perceived socially desirable way (Klein 1972, Ross et al. 1995).

13 The exception is beneficiaries with public supplemental insurance, such as that from the Department of Veterans Affairs: These beneficiaries do not rate their access to care as significantly different than dual eligibles.

14 Those with income below 100 percent of poverty level pay $1 per generic and $3 per brand name drug. Those with income over 100 percent of poverty pay $2 per generic and $5 per brand name drug.

15 The MMA requires that the ALJ function be transferred from the Social Security Administration (SSA) to the Department of Health and Human Services for Medicare appeals by October 2005. This change addresses criticism that SSA ALJs were not sufficiently knowledgeable about Medicare.

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