Dual Eligibles: Integrating Medicare and Medicaid

A Briefing Paper

Although almost all older Americans are covered through Medicare, forty-five percent of Medicare beneficiaries (16 million) are poor or low-income[1]. While Medicare covers major medical expenses, it requires co-pay and deductible requirements that many older Americans cannot afford. In contrast, Medicaid offers expanded health and long term care coverage, including prescription drug coverage, but qualifying for Medicaid is much more difficult than qualifying for Medicare. Those who qualify for both Medicare and Medicaid – the dual eligibles – are the most vulnerable of Medicare beneficiaries. They are more likely to be female, live in a nursing home, have a serious disease or chronic condition, suffer from serious functional limitations, have less access to a regular source of care or preventive services, and make greater use of emergency room services.[2]

Nationwide, close to 97% of Medicare beneficiaries receive their care through the original Medicare plan. It is not uncommon for dual eligibles to receive their Medicare and Medicaid services through different health plans or different providers. This can lead to fragmented services, both duplication of coverage and Medicare beneficiaries falling through the cracks. For dual eligibles, the states bear the administrative burden of coordinating coverage and services, and the financial burden of covering through Medicaid services not covered by Medicare, such as prescription drugs.

This report briefly summarizes eligibility for Medicare and Medicaid, outlines current efforts to blend Medicare and Medicaid funding, and identifies challenges to policy-makers to integrate the two programs.

Medicare

Medicare is a federal health insurance program, financed by a combination of payroll taxes, beneficiary premiums, general revenue and interest on trust fund assets. Generally, eligibility for Medicare is automatic if someone, or their spouse, worked for at least 10 years in Medicare-covered employment *and* is at least 65 years old *and* a citizen or permanent resident of the United States. Medicare coverage is determined at the federal level, and all enrollees are entitled to the same core benefits. Younger persons with a disability or chronic kidney disease might also qualify for coverage. Medicare covers an estimated 35.6 million beneficiaries, including close to 500,000 Oregonians as of July 1999.[3]

Medicare has two parts:

- **Part A** (Hospital Insurance) covers hospital stays, skilled nursing care, home health care, hospice, and blood products needed during a covered hospital or skilled nursing facility stay. Most beneficiaries get Part A without having to pay a premium.

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[1] Kaiser Commission on Medicaid and the Uninsured, Medicaid Eligibility for the Elderly, May 1999.
[2] General Accounting Office, Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging. August 2000.
[3] HCFA, Medicare County Enrollment as of July 1, 1999. Retrieved from http://www.hcfa.gov/stats/enroll December 2000.

- **Part B** (Medical Insurance) covers doctors' services, outpatient medical and surgical services and supplies, diagnostic testing, durable medical equipment, outpatient physical and occupational therapy, mental health services, clinical laboratory tests and x-ray, home health care, outpatient hospital services, and blood needed as part of a Part B covered service. Part B also covers preventive services such as bone mass measurements, colorectal cancer screening, diabetes monitoring, mammogram screening, pap smear and pelvic exams, prostate cancer screening and vaccinations (flu, pneumonia, hepatitis B). Most beneficiaries pay a premium for Part B.

Medicare beneficiaries receive covered services either through the 1) original Medicare plan, where beneficiaries may go to any doctor, specialist, or hospital that accepts Medicare, or 2) through Medicare+Choice plans, which fall into three categories:

1. **Coordinated care plans,** which include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law.
2. **Private, unrestricted FFS plans,** which allow beneficiaries to select certain private providers. For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk, nor does it vary payment rates based on utilization.
3. **Medical savings account (MSA) plans,** which provide benefits after a single high deductible is met. Medicare makes an annual deposit to the MSA, and the beneficiary is expected to use the money in the MSA to pay for medical expenses below the annual deductible. MSAs are currently a test program for a limited number of eligible Medicare beneficiaries.

Except for MSA plans, all Medicare+Choice plans are required to provide at least the current Medicare benefit package, excluding hospice services. Plans may offer additional covered services and are required to do so (or return excess payments) if plan costs are lower than the Medicare payments received by the plan.

It is important to note what Medicare does not cover – services such as long-term nursing care, custodial care, and certain other health care needs such as dentures and dental care, eyeglasses, hearing aids, and most prescription drugs, unless they are part of a private health plan under Medicare+Choice.

Medicaid and "Dual Eligibles"

Medicaid, Title XIX of the Social Security Act, became law in 1965. The program provides medical assistance for certain individuals and families with low incomes and resources. Medicaid is jointly funded between the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people. Within broad national guidelines, which the Federal government provides, each of the States:

- establishes its own eligibility standards;
- determines the type, amount, duration, and scope of services;

- sets the rate of payment for services; and
- administers its own program.

The Medicaid program varies considerably from State to State, as well as varying within each State over time.

Certain Medicaid programs pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain low-income people who are entitled to Medicare. The term "dual eligible" most commonly refers to low-income Medicare beneficiaries who also qualify for full Medicaid benefits, but there are varied groups of dual eligibles, as shown in the next section. Medicaid fills in some of the gaps that fee-for-service Medicare does not cover; such as prescription drugs and long term care either in a nursing facility or in the community. Since the range of Medicaid services covered varies from state to state, some beneficiaries have duplicate coverage for services while others have significant gaps in coverage. Although the elderly make up a substantial portion of Medicare beneficiaries, approximately 30 percent of dual eligibles were younger than age 65 in 1992.[4]

Dual Eligible Programs

For each program listed, the client's resources cannot exceed twice the limits of SSI eligibility and the federal match for each program is equal to the Medicaid match. The Medicaid programs for Medicare beneficiaries are:

- QMB (Qualified Medicare Beneficiaries) for those at or below 100% FPL, which covers premiums, deductibles and coinsurance.
- SLMB (Specified Low-Income Medicare Beneficiaries) for those between 100% and 120% FPL, which covers the Part B premium.
- SLMB Plus (Specified Low-Income Medicare Beneficiaries) for those between 100% and 120% FPL, which covers Part B premium and coinsurance.
- QDWIs (Qualified Disabled and Working Individuals) for those at or below 200% FPL who lost their Medicare Part A benefits due to their return to work and are not otherwise eligible for Medicaid. Medicaid pays the Medicare Part A premiums only.
- QI-1 (Qualifying Individuals) for those between 120% and 135% FPL, which covers Part B premium.
- QI-2 (Qualifying Individuals) for those > 135 FPL up to 175%, which partially covers the Part B premium.
- Medicaid Only Dual Eligibles, for those who are either > 200% FPL or spend down.

With this wide range of available programs there are still reports indicating that outreach is needed to assure that Medicare beneficiaries are aware of their eligibility for Medicaid.[5] In a 1998 report, Families USA listed estimated that between 3.3 and 3.9 million low-income elderly

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[4] Kaiser Commission on Medicaid and the Uninsured, Medicare and Medicaid for the Elderly and Disabled Poor. May 1999.

[5] Families USA 1998. Shortchanged: Billions Withheld from Medicare Beneficiaries. Washington, DC: The Families USA Foundation.

and disabled Medicare beneficiaries are eligible for Medicaid assistant with Medicare premiums and cost sharing but are not receiving these benefits.

Federal Demonstrations

Since the early 1990s, the Health Care Financing Administration and individual states have tried to experiment with managed care approaches to integrate services for Medicare beneficiaries who are also eligible for full Medicaid benefits. Demonstrations have tried to address issues such as:

- Identifying potential cost savings
- Addressing fragmentation in delivery systems
- Ensuring access to primary care and preventive services
- Improving accountability for health outcomes
- Explore incentives for appropriate use of medical services
- Reduce administrative differences and barriers between Medicare and Medicaid.

States have generally sought federal waivers from certain Medicare and/or Medicaid requirements. There are two key federal waiver authorities. Section 222(b) of the Social Security Act Amendments of 1972 allows demonstrations to experiment with Medicare payment methodology, while Section 1115 of the Social Security Act authorizes demonstrations to test Medicaid program innovations. There is standing federal policy within the Office of Management and Budget that requires that waiver requests be budget neutral. Two states have obtained approval to establish Medicaid/Medicare integrated care demonstrations – Minnesota and Wisconsin.

The states' efforts have built upon knowledge gained through national demonstrations, the Program for All-Inclusive Care for the Elderly (PACE), two generations of the Social Health Maintenance Organization (S/HMO and S/HMO II), and Evercare.[6]

1. **Program for All-Inclusive Care for the Elderly (PACE)**

   The Program for All-Inclusive Care for the Elderly (PACE) program is a capitated managed care benefit for the frail elderly, modeled after the On Lok program in San Francisco's Chinatown. PACE features comprehensive medical and social service delivery system, use of a multidisciplinary team in an adult day health center, supplemented by in-home and referral services in accordance with participants' needs. In 1999, 6,000 enrollees participated in 25 PACE sites in 13 states. The Balanced Budget Act of 1997 allows states to implement PACE without applying for a special demonstration waiver. PACE focuses on the frail elderly, 55 and older, who meet states' standards for nursing home placement and reside in the area served by the PACE organization. Health and long-term care services are paid for on a capitated basis and provided primarily in adult day health centers, participants' homes or inpatient facilities as needed.

[6] General Accounting Office.

2. **Social Health Maintenance Organization (S/HMO, S/HMO II)**

   Congress established the first Social Health Maintenance Organization (S/HMO) demonstration in 1984 to determine whether investing in some long-term care benefits for Medicare HMO enrollees would save money by coordinating care and providing services that might prevent more costly medical expenses in the future. In 1990, Congress authorized an extension of the demonstration authority and established the second-generation S/HMO demonstration, known as S/HMO II. One purpose of S/HMO II is to test the effects of linking chronic care case management services with acute care providers. The primary components of S/HMO II include an expanded case management system, with acute and long-term care linkages, a long-term care benefit package, and a risk-adjusted payment methodology.

   S/HMO demonstrations provide standard Medicare benefits, such as hospital, physician, skilled nursing home, and home health services; together with limited long-term care benefits to Medicare beneficiaries who voluntarily enroll. In addition, expanded benefits, such as eyeglasses and prescription drugs, personal care aides, homemakers, medical transportation, adult day health care, respite care, and case management are provided.

   Eligibility to enroll in the S/HMO is limited to elderly Medicare beneficiaries living within a defined S/HMO coverage area. The S/HMO II also enrolls disabled individuals under age 65. Funds from Medicare, Medicaid, member premiums and co-payments are pooled to finance each program, and S/HMOs are paid on a capitated basis. As of April 2000 there were 81,718 enrollees at three S/HMO sites (Portland OR, Brooklyn NY, Long Beach CA), and one S/HMO II site (Las Vegas NV).

3. **EverCare**

   EverCare is a demonstration designed to study the effectiveness of managing acute care needs of nursing home residents by pairing physicians and geriatric nurse practitioners, who function as primary medical caregivers and case managers. The major goals of the program are to reduce medical complications and dislocation trauma resulting from hospitalization of permanently placed nursing home patients, and to save the expense of hospital care when patients could be managed safely in nursing homes. EverCare is a subsidiary of United HealthCare. There is no expansion beyond the standard Medicare benefit. Even though all enrollees are in nursing homes, the costs of nursing facility care are not covered. EverCare receives a capitated rate from Medicare to provide Medicare-covered services. EverCare does not pool Medicaid and Medicare funds; it simply provides Medicare covered services in a case management setting.

State Waiver Efforts

Oregon is one of fifteen states funded by the Robert Wood Johnson Foundation's (RWJ) Medicare/Medicaid Integration Program (MMIP). The purpose of MMIP is to encourage states to test models of integration of Medicaid's long-term care services with Medicare's acute care services within managed care settings. Oregon's RWJ grant was made to Senior and Disabled Services Division for eighteen months, ending 3/31/01. The other funded states include Colorado, Florida, Minnesota, New York, Texas, Washington and a consortium of New England states (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont). An

advisory committee to Oregon's Medicare/Medicaid Project outlined characteristics that an integrated model should include:

- a focus on health and quality of life;
- a comprehensive continuum of services;
- accountability for outcomes;
- an emphasis on simplicity for the consumer; and
- solutions to the problems of cost shifting between Medicare and Medicaid programs.[7]

Four states have applied for waivers to test integration models but only two are operational – Minnesota and Wisconsin. New York has applied, is approved but not yet operational, while Massachusetts is still awaiting approval.

1) Minnesota Senior Health Options (MSHO)

Development of Minnesota's model was funded by the Robert Wood Johnson Foundation. Minnesota's demonstration facilitates the integration of primary, acute and long-term care services for persons over age 65 who are dually eligible for both Medicare and Medicaid, approximately 46,000 people. MSHO is authorized under Minnesota Statutes 256B.69 subd.23. Minnesota received federal Medicare Section 222 and Medicaid Section 1115 waivers in 1995 from the Health Care Financing Administration (HCFA) to put this demonstration into practice. The project became operational in 1997. In addition, the federal waivers granted Minnesota a Medicare risk adjustment payment for frail elderly dual eligibles in the community as an incentive to prevent unnecessary institutionalization. The demonstration is being implemented in the seven county Minneapolis-St. Paul metropolitan area and will cover a five-year period.

Under Minnesota Senior Health Options, enrollees are entitled to receive all Medicaid services provided, plus all Medicare services under Parts A and B. In addition, health plans will provide services available under the current home and community based waiver (Elderly Waiver), which consists mainly of extended home care benefits to frail elderly eligible for nursing home care. A unique feature of Minnesota Senior Health Options also requires health plans to be responsible for the first 180 days of care in a nursing facility for those who enroll in Minnesota Senior Health Options while living in the community. This feature maximizes the opportunity for innovation in non-institutional care and prevention of early institutional placement, especially for those who have chronic care needs.

There is a single enrollment process for both Medicare and Medicaid. Projected enrollment over the life of the project was estimated to be 4,000 but MSHO has served about 5,700 enrollees in its three years of existence.[8]

Minnesota has received approval to switch from its 1115 waiver to a combination of section 1915(a) authority and section 1915(c) waiver. The section 1915(c) waiver allows states to provide home and community-based services to individuals at risk of nursing

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[7] Medicare/Medicaid Integration Program, University of Maryland Center on Aging, 1998. retrieved January 2000 from website http://www.inform.umd.edu/EdRes/Colleges/HLHP/AGING/MMIP
[8] General Accounting Office.

home placement and permits Minnesota to access some special eligibility provisions such as protection against spousal impoverishment. Section 1915(a) authority is not subject to OMB's budget-neutrality policy.

2) **Wisconsin Partnership Program**

The Wisconsin Partnership Program was originally designed as two models of an integrated care program – one for the frail elderly aged 55 or older and one for people with disabilities ages 18 to 65, focused on those at risk of nursing home placement who are Medicare only or dual eligible. In practice, the separation of the two groups proved to be largely unnecessary. In fact, one of Wisconsin's Partnership organizations operates the program from the same model for both target groups.

The Wisconsin Partnership Program was first implemented as a partially capitated Medicaid pre-paid health plan in December 1995. Wisconsin received waiver approval in October 1998, and in January 1999, the Program began operating under a fully-capitated, dual Medicaid and Medicare (1115/222) waiver that combined Medicaid and Medicare funds into one funding stream. The Partnership operates in five counties – two urban and three rural.

The model being used is similar to the PACE model, but without restrictions on choice of primary care physician or use of adult day health care as the site of care. The goal is to enroll 2,400; 782 were enrolled as of March 2000.[9]

Conclusion

The impetus to develop strategies to integrate Medicare and Medicaid is driven by a need to address fragmentation of care for a vulnerable population. Twenty-nine percent of dual eligibles qualify for Medicare because they are disabled, while nearly a quarter (24%) are in nursing homes. The population is in poorer health, have physical and cognitive limitations, and account for a substantial share of spending under both Medicare and Medicaid.[10] Those eligible for both Medicare and Medicaid need a system of coverage and care that can adequately address their complex medical, social and long-term care needs. As long as the two programs are not integrated administratively and financially, those most in need of coordinated care will continue to have poor quality of care, even though they are covered by a rich combination of Federal and State programs.

Despite the availability of federal waivers to experiment with Medicare and Medicaid integration there is very little experience to draw upon from other states to find a proven direction that addresses administrative fragmentation, access, or improved outcomes. Oregon can apply for a waiver to allow administrative and fiscal integration of Medicare and Medicaid through Medicaid Sections 1115, 1915(a) or 1915(b); and/or Medicare Section 222 but it takes a substantial time investment, typically several years, between the time a state applies for a waiver and the possible time of implementation. Several states began the waiver process and withdrew, instead choosing to focus on integration of health care financing and delivery for Medicaid services only (Texas, Florida and Colorado).

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[9] General Accounting Office.
[10] Kaiser Commission on Medicaid and the Uninsured, Medicare and Medicaid for the Elderly and Disabled Poor, May 1999.

Oregon has local experience in its work with the RWJ funded Medicare/Medicaid Integration Program, the Social/HMO (Kaiser Permanente, Portland) and PACE (Providence Health Plan, Portland) demonstrations and could build on these experiences, partnering to design pilot projects that integrate funding for dual eligibles. Whether small community pilot sites or a larger statewide program effort are potential next steps, the need to improve care for dual eligibles, a vulnerable population, is significant.

This is one of a series of papers discussing issues related to universal health coverage for low-income uninsured Oregonians. This work is supported by a grant from the Health Resources and Services Administration. As more information is gathered, the papers will change. Views and ideas expressed within these papers are not intended to reflect those of any particular group, unless so noted, but are intended to inform and stimulate discussion and debate on critical health care coverage strategies. For the most recent revision, please visit the grant team's Web site: http://www.ohppr.org/hrsa/index_hrsa.htm, or call 503/418-1067 to request the paper in an alternate format.