ANALYSIS & COMMENTARY

Dx For A Careful Approach To Moving Dual-Eligible Beneficiaries Into Managed Care Plans

ABSTRACT Policy makers are moving rapidly to develop and test reforms aimed at doing a better job of managing the costs and care for people dually eligible for Medicare and Medicaid. This commentary underscores the importance of pursuing new initiatives to address care coordination and spending concerns. It then focuses on key issues raised by proposals that would shift dual-eligible beneficiaries into managed care plans. The paper describes the heterogeneity and complexity of this population, emphasizing the need for approaches closely tied to the needs of particular subgroups of dual-eligible beneficiaries. It warns against moving too quickly, noting the time and resources required to build capacity to serve patients, secure provider networks, and develop an infrastructure for integrating and managing both Medicare and Medicaid services. The commentary cautions that optimistic savings assumptions might not materialize, raises questions about how savings will be allocated, and highlights the need for accountability as new models are being developed and tested to improve care for a population with complex needs.

People who are dually eligible for Medicare and Medicaid have recently captured the attention of federal and state policy makers primarily because they are a frail and costly population that accounts for a disproportionate share of spending under each program. In 2008, dual-eligible beneficiaries represented 20 percent of the Medicare population and 31 percent of Medicare program costs, and 15 percent of the Medicaid population and 39 percent of Medicaid program costs.1,2 Beyond cost, there is concern that care for these beneficiaries with complex medical and long-term care needs is poorly coordinated between the two programs. In response, federal and state policy makers have ramped up efforts to develop new approaches for the dual-eligible population with the objective of obtaining Medicare and Medicaid savings, while also improving the coordination of care and access to benefits across the two programs.

Roughly 9 million low-income Medicare beneficiaries also qualify for Medicaid, including 5.6 million low-income seniors and 3.6 million people under age sixty-five with disabilities.1,2 Medicare, a national program and the primary source of health insurance for dual-eligible beneficiaries, covers hospital, physician, and other medical services, acute and postacute care, prescription drugs, diagnostic and preventive services, and hospice care. But Medicare has high cost-sharing requirements and premiums that are unaffordable for many low-income beneficiaries and does not have coverage for ongoing long-term care. Medicaid, a federal-state partnership in which states operate programs within broad federal rules, supplements Medicare for this population, paying for services that are not covered by Medicare—including long-term care,
dental, and vision—and paying for Medicare premiums and cost sharing.3

Beneficiaries who are dually eligible for Medicare and Medicaid are on average more likely than others enrolled in Medicare to be in fair or poor health and to have multiple chronic conditions, mental impairments, and functional limitations. They are also on average more likely to require both mental health services and long-term care services and supports, for which they rely primarily on Medicaid.

Dual-eligible beneficiaries have higher use rates of Medicare-covered services than other beneficiaries, including inpatient hospital admissions, emergency department visits, and skilled nursing facility admissions. Medicare spending for dual-eligible beneficiaries is primarily for inpatient and other acute care services, whereas the largest share of Medicaid dollars is spent on long-term care (Exhibit 1).4

The Current Landscape: Room For Improvement

Medicare and Medicaid were designed from the beginning as separate but complementary programs, with different eligibility criteria, enrollment pathways, benefits, and program management. Lack of care coordination across the two programs and across providers in a fee-for-service environment can result in dual-eligible beneficiaries’ not getting appropriate care or getting unnecessary care, in cost shifting between providers and programs, and in higher spending under both Medicare and Medicaid.

Only recently have federal and state policy makers committed to improving coordination to create more seamless coverage for dual-eligible beneficiaries across the two programs. However, putting together the services and providers, determining which benefits are covered by each program, and then coordinating coverage across the two programs can be a tall order. Coordinating care is especially difficult for beneficiaries who need a wide range of services or who need access to providers covered under one program or the other, but not always both. For example, an eighty-three-year-old widow discharged from the hospital following hip surgery needed after a fall could require Medicare-covered rehabilitation and other postacute services, followed by home care services, which could also be covered by Medicaid, along with other Medicaid-covered long-term support services to help her manage at home.

For some dual-eligible beneficiaries, a further concern with the current system is the prospect of going without needed care. For example, the availability of home and community-based services remains limited in many states, with hundreds of thousands of people on Medicaid state waiting lists for services.5 Limited access to these services increases the risk that high-need beneficiaries may find themselves readmitted to the

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**EXHIBIT 1**

Distribution Of Spending For Dual-Eligible Beneficiaries, By Service, 2008

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**SOURCES** Kaiser Family Foundation analysis of data from the Centers for Medicare and Medicaid Services (CMS) Medicare Current Beneficiary Survey Cost and Use File, 2008, and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from fiscal year 2008 Medicaid Statistical Information System and CMS Form 64. **NOTES** Average per capita Medicare fee-for-service spending was $13,805 in 2008. Average per capita Medicaid spending was $16,087 in 2008. Home health and dental services constitute less than 1 percent of Medicaid spending. Medicare premiums paid by Medicaid also include cost sharing for Qualified Medicare Beneficiaries only. Prescription drug subsidy payments include both the federal direct subsidy and the low-income subsidy payments.
hospital or admitted to a nursing home after a hospital stay, or without the service needed to function in the community.

The Affordable Care Act of 2010 created a number of new opportunities to improve the delivery of health care benefits and services to those who are dually eligible for both Medicare and Medicaid, and the new Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services (CMS) is moving rapidly to test and implement reforms to improve care and lower costs. Some innovations are designed to improve care in the fee-for-service program, while others would expand the role of managed care plans.

In the fee-for-service environment, CMS is testing delivery system reforms aimed at improving care for high-need Medicare beneficiaries but not exclusively for the dual-eligible population. Examples include the Independence at Home Demonstration to provide care to home-based patients with multiple chronic conditions, the Bundled Payments for Care Improvement initiative to improve care for patients discharged from the hospital, and a new initiative aimed at reducing preventable hospitalizations among dually eligible residents of long-term nursing facilities. On the Medicaid front, initiatives include health homes for beneficiaries with chronic conditions and new financial incentives for states to increase the availability of home and community-based services.

However, the major new effort focused directly on the dual-eligible population involves a federal-state partnership that will test different approaches for integrating and coordinating Medicare and Medicaid financing and services. In April 2011 CMS awarded demonstration planning contracts to fifteen states to design proposals for testing new service delivery and payment models for the dual-eligible population. In July 2011 CMS announced the new Financial Alignment Initiative to integrate the financing and delivery of care for the dual-eligible population through two demonstration models, with the goal of improving the coordination of care across the two programs, reducing unnecessary services and spending, and allowing Medicare and the states to share in the savings.

The first approach is a capitated model under which Medicare and Medicaid would each contribute a capitated payment on behalf of dual-eligible beneficiaries to a managed care plan that provides the full range of Medicare and Medicaid services to enrollees. The second model would test a managed fee-for-service approach that could be structured in a variety of ways. States could, for example, propose to integrate Medicare and Medicaid funds to pay care managers or other providers, with the goal of improving the coordination of care and achieving savings from avoidable medical events, such as hospitalizations and emergency department use.

As of May 2012, twenty-six states were actively pursuing these demonstration programs, the majority of which are proposing capitated, risk-based managed care models. CMS is still negotiating with these states about key elements of their plans.

The following discussion focuses on key issues raised by proposals that rely primarily on managed care strategies for dual-eligible beneficiaries because managed care arrangements are at the forefront of efforts being developed by many states and could represent a major change in the financing and delivery of care for low-income Medicare beneficiaries.

Design And Implementation Considerations

As plans move forward to provide more integration of services for the dual-eligible population while achieving savings, there are multiple design aspects to be considered. Five points to consider in the design and implementation of new approaches are offered below.

**ONE SIZE WILL NOT FIT ALL** Although the dual-eligible population is often described as a single group, there is great diversity in terms of needs, use patterns, and spending profiles. This underscores the importance of developing programs that are well designed for specific subgroups of the population. The dual-eligible population is quite diverse in terms of age (disabled people under sixty-five as well as the elderly), living situation (institution or community), and conditions (Exhibit 2).

The following statistics illustrate the range of needs in the dual-eligible population. Nearly two in five dual-eligible beneficiaries are younger than age sixty-five and qualify for Medicare because of a permanent disability. Almost three in four (73 percent) of these younger dual-eligible beneficiaries have a mental or cognitive impairment, such as a developmental disability, schizophrenia, or depression. As a result, they may require a network of providers with expertise in treating mental or behavioral health needs, access to specific medications to manage their condition, and a range of health services and supports.

About one in ten dual-eligible beneficiaries (13 percent) live in a nursing home or other long-term care facility (Exhibit 2). These beneficiaries account for a disproportionately large share of spending under both Medicare and Medicaid, prompting interest in new programs
that would improve the management of their care, primarily by reducing preventable hospital admissions and reducing churning between the hospital and nursing home. Residents of nursing homes pose unique care management and social support challenges.

Fourteen percent of dual-eligible beneficiaries are age sixty-five or older, live in the community, and have two or more functional limitations. These beneficiaries are likely to have a wide range of medical conditions and to require both medical and social support services so that they can remain in the community.

Additionally, this population displays a wide variation in service use and spending. For example, 8 percent of dual-eligible beneficiaries incurred $40,000 or more in Medicare expenditures in 2008, but 16 percent had Medicare expenditures below $2,500 that year. Medicaid spending on dual-eligible beneficiaries is similarly skewed, with a relatively small share accounting for relatively high average spending. Five percent of dual-eligible beneficiaries had average Medicaid spending in excess of $100,000 in 2008, while 70 percent had less than $4,000 in Medicaid spending.

However, only a small number of dual-eligible beneficiaries are heavy users of services in both programs. This unevenness of medical and long-term care service needs and spending per person underscores the challenge in setting appropriate capitation rates for managed care plans under Medicare and Medicaid.

This variation in service needs among dual-eligible beneficiaries also speaks to the need for highly targeted interventions rather than one-size-fits-all solutions, posing challenges for managed care plans in developing focused approaches and provider networks that are appropriate for different populations. Some of the most successful programs work well because they are targeted to subgroups of dual-eligible beneficiaries who face similar challenges.

For example, the Program of All-Inclusive Care for the Elderly was designed specifically for frail elderly people at risk of entering a nursing home. It has been successful in reducing hospitalization rates and preventing nursing home admissions for this population. However, enrollment is relatively low. As of January 2011 fewer than 22,000 dual-eligible beneficiaries were enrolled in the fully integrated Program of All-Inclusive Care for the Elderly. It remains to be seen whether or how this model can be adapted to other beneficiaries with different needs and circumstances.

**Building Expertise And Plan Capacity Takes Time**

Federal and state policy makers are moving rapidly to establish new programs, and private insurers are expected to play a greater role in providing both Medicare and Medicaid benefits under capitated arrangements for dual-eligible beneficiaries. Several private insurers are gearing up to serve a larger share of the dual-eligible population, leading Wall Street analysts to be optimistic about the potential for enrollment growth and revenue gains as these companies increase their involvement in serving the dual-eligible population.

Yet few plans have experience managing and integrating the full range of services covered by Medicare and Medicaid for the dual-eligible population. Even insurers that operate Medicare and Medicaid plans in the same state may have minimal, if any, experience integrating services across the two programs.

Today, few dual-eligible beneficiaries are enrolled in a plan that provides the full range of benefits covered under Medicare and Medicaid and integrates medical and long-term care benefits. Altogether, about 120,000 dual-eligible beneficiaries are estimated to be enrolled in fully integrated plans, which is a small fraction of the total dual-eligible population. Efforts to build plan capacity, with the appropriate mix of providers for frail or otherwise disadvantaged beneficiaries, require time and experience managing a very frail population.

Some insurers have extensive experience serving the Medicaid population, mainly low-income women and children, but limited experience despite growing interest in serving elderly and disabled beneficiaries. Other insur-
ers have a strong foothold in the Medicare market, although some of these firms are positioning themselves to enroll more Medicaid beneficiaries.

Even insurers with experience serving Medicare beneficiaries tend to have a small number of dual-eligible enrollees. Plans designed specifically for dual-eligible beneficiaries, known as Special Needs Plans for dual eligibles (D-SNPs), account for a relatively small share of total Medicare Advantage enrollment. Very little is known about how these plans manage care for enrollees, the extent to which they provide additional services, or their quality ratings.11,16 Moreover, few of these plans provide the full range of benefits covered under Medicare and Medicaid,17,18 and until 2013 these plans are not required to contract with state Medicaid programs to facilitate the coordination of benefits.

Nonetheless, improvements in care management and associated cost savings could materialize as insurers and plans gain experience integrating Medicare and Medicaid services for dual-eligible beneficiaries. To help achieve these outcomes, performance measures for plans that are appropriate for this population need to be developed to assess the success of these programs in achieving desired outcomes with respect to quality and savings.19 Much work remains to be done and apply these measures to help evaluate programs that provide health and long-term care services and supports for high-need populations.20

A CAUTIOUS APPROACH IS WARRANTED With mixed experience among states and plans in overseeing and managing the full range of Medicare- and Medicaid-covered services for elderly and disabled beneficiaries, policy makers may want to pursue a staged roll-out of new managed care arrangements. In this way, they could make certain that managed care plans under contract with the state can demonstrate capacity to serve high-need beneficiaries and build appropriate provider networks. It is also important that both the federal and state governments involved have time to develop the infrastructure and the resources required for oversight and for educating and preparing beneficiaries for changes that will directly affect their care.

The need for caution is further raised by the process through which beneficiaries will potentially be enrolled in managed care plans. Federal and state policy makers are currently considering a process known as “passive enrollment” with a voluntary opt-out option to enable plans to boost enrollment quickly and to help achieve desired savings. This assignment process could be based on where beneficiaries live, their current health care providers, or their health needs. If, however, dual-eligible beneficiaries are not permitted to opt out of their managed care plan or are locked into a plan for a period of time, there is the concern that they would not have the same choice-of-providers guarantee as all others in Medicare. Even with an opt-out provision, some have expressed concern that this assignment process could disrupt long-standing care arrangements between beneficiaries and providers and that certain patients, such as those with cognitive impairments, might not have the wherewithal to opt out or switch plans.21 Furthermore, it is not clear whether comparable services will be available to those who do opt out.

Some state and federal policy makers have expressed interest in moving rapidly to scale up programs for dual-eligible beneficiaries by moving relatively large segments of this population into managed care plans as part of the new demonstration project. Under the demonstration authority, Massachusetts, for example, proposes to passively enroll all dual-eligible beneficiaries (with an opt-out provision) who are under age sixty-five into managed care plans as of January 2013.22 California is proposing to enroll dual-eligible beneficiaries from the state’s four largest counties into managed care plans in 2013 and to add another six counties in 2014.23

Some have cautioned against moving large numbers of people too quickly into Medicaid managed care plans—a warning that has application for the dual-eligible population.24 In his testimony to the Medicaid and CHIP Payment and Access Commission in November 2011, Darin Gordon, TennCare director and deputy commissioner of the Tennessee Department of Finance and Administration, said, “I have cautioned a lot of states on the time frames that they’re talking about, and I understand why they’re talking that way, but my fear is, again, that people will perceive a failed implementation as a failed concept.”25

Recent experience in California illustrates the challenges associated with moving large numbers of people into managed care plans in a short period of time. As of February 2012 more than 185,750 seniors and people with disabilities, not including dual-eligible beneficiaries, had been shifted into the state’s Medicaid managed care arrangements.26 The transition prompted consumer advocates, including physicians, to raise concerns about moving too quickly and placing patients at risk. The fear is that without sufficient planning and support, patients could experience gaps in care and go without needed services, potentially resulting in adverse outcomes.27 Over time, California’s shift to Medicaid managed care could provide major improvements in care delivery; however, a disruptive transition...
period could undermine support for these improvements.

**DO NOT COUNT SAVINGS BEFORE THEY MATERIALIZ** Numerous claims have been made about the savings that could be achieved through better-coordinated care for the dual-eligible population. In recent years, several studies have raised the prospect of hundreds of billions of dollars in Medicare and Medicaid savings over ten years, with stronger incentives to reduce unnecessary hospitalizations and preventable readmissions, primarily but not exclusively through managed care arrangements.28–30

Through capitated managed care arrangements or improved care management, or both, policy makers hope that beneficiaries will receive better care, while providing savings to both Medicare and Medicaid that can be scored by the Congressional Budget Office. In its guidance to states applying for demonstration projects, CMS has stated expectations that for new initiatives to be approved they must achieve savings for both Medicare and Medicaid.31

Advocates hope that savings will be used to expand the scope of services available to dual-eligible beneficiaries, using savings from reduced Medicare-covered hospital stays to help offset the costs of care coordination and additional home and community-based services.32

Some states are incorporating bottom-line savings into their proposed budgets for the Medicaid program, estimating cost reduction from enrollment of dual-eligible beneficiaries into coordinated care programs. For instance, Gov. Jerry Brown’s California state budget assumes an estimated $663 million in general fund savings (2012–13) that would result from reduced spending on nursing home and hospital admissions as beneficiaries are enrolled in coordinated managed care.33

The expectation of achieving Medicare and Medicaid savings through reforms for the dual-eligible population was also raised in the context of the debt reduction debate, as part of a broader effort to slow the growth in federal entitlement spending. For example, the National Commission on Fiscal Responsibility and Reform, known as the Bowles-Simpson Commission, assumed savings from its recommendation to give Medicaid full responsibility for providing Medicare and Medicaid benefits to dual-eligible beneficiaries and to require mandatory enrollment of the dual-eligible population into a Medicaid managed care plan.34

A review of current programs, however, indicates that caution is warranted before assuming that such savings will materialize. Some of the most successful and highly praised programs, such as the Program of All-Inclusive Care for the Elderly, have had success in reducing hospitalization rates, while providing needed care coordination and highly valued services, but have not been able to demonstrate savings for Medicare.35 Even when programs reduce hospitalization rates, they often incur costs, such as for care coordination teams, that offset savings or ultimately increase total costs, or both.36–38

Moreover, given current levels of unmet need among dual-eligible beneficiaries, particularly for those requiring home and community-based services, an argument could be made for reinvesting the savings to provide greater access to needed services to improve care for dual-eligible beneficiaries,5 assuring that beneficiaries, too, share in any savings. As one option for making this happen, policy makers might consider imposing minimum loss ratio requirements on plans, as will be required for Medicare Advantage plans beginning in 2014. That way, plans would be required to spend a specified portion of revenues received on benefits—in effect, sharing savings with beneficiaries.

**ACCOUNTABILITY MATTERS: WHO WILL BE IN CHARGE?** Federal policy makers are moving toward an approach that would delegate substantial authority to the states for the provision of Medicare services. Some states have developed a solid track record for managing care for high-need beneficiaries, such as those with disabilities, and may have the capacity to build and expand upon their efforts to provide necessary oversight. Others have more limited experience.

Questions also arise as to the capacity of states to take on additional responsibility for overseeing the care provided to beneficiaries at a time when many are dealing with their own budget pressures.39 The capacity of states to assume responsibilities from the federal government and provide the appropriate level of ongoing attention and oversight is not an insignificant issue.

The delegation of authority to states raises fairly fundamental questions for policy makers. Dual-eligible beneficiaries are entitled to coverage under the national Medicare program. The federal government pays for most of their care either directly through Medicare or through the federal share of Medicaid spending.40 The federal government also has a fiduciary interest in determining how savings are calculated and allocated between the federal government (Medicare) and the states (state portion of Medicaid), and between plans and beneficiaries.

As a result, the federal government has a strong interest in ensuring that responsibilities delegated to the states, and then to plans, are carried through, and that federal dollars are used appropriately.40 These efforts are being under-
taken as a demonstration project; therefore, real-time monitoring and evaluation will be essential for ensuring the well-being of beneficiaries receiving services, with built-in opportunities to make adjustments to address problems identified along the way if necessary.

With a more rapid time frame for evaluation, programs that are deemed successful can be quickly identified and expanded, while models that are not working can be replaced. At the same time, full-scale evaluations of demonstration programs are needed to fully assess the impact of the demonstrations in terms of patient outcomes and savings.

Conclusion
The current system of care for some elderly and disabled low-income people who are dually eligible for Medicare and Medicaid is less than ideal from the perspective of care coordination and program spending. New initiatives, launched after the enactment of the Affordable Care Act, seek to address these concerns through new models for financing and delivery of care. Much hope rests on the capacity of these arrangements to improve care and constrain costs through better coordination of services and reductions in unnecessary hospitalizations. Given the complex health needs and frailty of the dual-eligible population, careful planning and preparation for implementation, rigorous oversight and ongoing monitoring, and realistic expectations for savings are central to the success of these efforts.

NOTES
3 For approximately two million dual-eligible beneficiaries, known as “partial duals,” Medicaid pays for Medicare premiums and some cost sharing through the Medicare Savings Program but does not pay for any additional services or benefits.
4 Authors’ analysis of data from the Centers for Medicare and Medicaid Services (CMS) Medicare Current Beneficiary Survey Cost and Use File, 2008, and of data from Urban Institute estimates based on data from the 2008 Medicaid Statistical Information System and CMS Form 64 for the Kaiser Commission on Medicaid and the Uninsured.
9 Authors’ analysis of data from the Medicare Current Beneficiary Survey, 2008.
17 Gold M, Jacobson G, Garfield R. There is little experience and limited data to support policy making on integrated care for dual eligibles. Health Aff (Millwood); 2012;31 (6):1176–85.
18 Examples of D-SNPs that provide the...
full range of benefits under Medicare and Medicaid include Commonwealth Care Alliance Senior Care Options and Senior Whole Health in Massachusetts.


20 California State Senate and Assembly. Committee on Health joint informational hearing [Internet]. Sacramento (CA): California State Senate; 2011 Dec [cited 2012 Apr 17]. Available from: http://shea.senate.ca.gov/informational hearings


20 Tangalos A, Hsu J, Turner J, Ford L (Health Care Alliance Senior Care Services. Managed care implementation for seniors and persons
In this month’s *Health Affairs*, an Analysis & Commentary from Patricia Neuman and colleagues at the Henry J. Kaiser Family Foundation addresses proposed reforms to better managed care and costs for people dually eligible for Medicare and Medicaid. Neuman and her coauthors warn against moving too many, too quickly, in testing these reforms, noting the significant health needs and frailty of the dual-eligible population, and the time and resources required to build capacity to serve patients, among other concerns. They also raise questions about the role and accountability of federal and state policy makers as new care models are developed for this population, with its complex health and social needs.

Neuman is a senior vice president of the Kaiser Family Foundation and director of the foundation’s Program on Medicare Policy. Neuman’s work at the foundation focuses on a broad range of issues pertaining to the Medicare program and the population it serves. She received a doctoral degree in health policy and management and a master’s degree in health finance and management, both from the Johns Hopkins University.

Jennifer Rentas is a senior policy analyst with the Kaiser Commission on Medicaid and the Uninsured and the special assistant to the executive vice president of the Kaiser Family Foundation. She holds master’s degrees in business administration and in public policy from Harvard University.

Barbara Lyons is a senior vice president of the Kaiser Family Foundation and director of the Kaiser Commission on Medicaid and the Uninsured. A major initiative of the foundation, the commission serves as a policy institute and forum for analyzing health care coverage and access for the low-income population and assessing options for reform. Lyons concentrates on issues related to health care coverage, access to care, managed care, and health care financing for Medicaid and low-income populations. She earned her doctoral degree in health policy and management as well as a master’s degree in health finance and management from Johns Hopkins.

Diane Rowland is the executive vice president of the Kaiser Family Foundation and the executive director of the Kaiser Commission on Medicaid and the Uninsured. She is also an adjunct professor in the Department of Health Policy and Management at the Johns Hopkins Bloomberg School of Public Health. She has overseen the foundation’s health policy work since 1993. In December 2009 Rowland was appointed the chair of the Medicaid and CHIP Payment and Access Commission, established to advise Congress on issues affecting Medicaid and the Children’s Health Insurance Program (CHIP). She holds a master’s degree in public administration from the University of California, Los Angeles, and a doctorate in health policy and management from Johns Hopkins.