Dual Eligibles: Integrating Medicare and Medicaid

Executive Summary

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.

Medicaid and "Dual Eligibles"

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.[3]

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.

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

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

services within managed care settings. Oregon's RWJ grant was made to Senior and Disabled Services Division for eighteen months, ending 3/31/01. 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.[4]

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.

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.[5] 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).

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.

[4] 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

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