MILLIMAN WHITE PAPER SERIES

Navigating the Intersection of Medicare and Medicaid – Dual-Eligible Beneficiaries

Paper 1: Overview of the dual-eligible ecosystem

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We are excited to introduce a white paper series, "Navigating the Intersection of Medicare and Medicaid – Dual-Eligible Beneficiaries." This series is designed to provide an in-depth exploration of the complexities and challenges faced by states and payers related to individuals who are eligible for both Medicare and Medicaid, known as dual-eligible beneficiaries.

Over the course of this white paper series, we will delve into the intricacies of the dual-eligibility system, its implications for payers, and potential strategies for improving care coordination and health outcomes. We aim to shed light on the unique healthcare needs and complex healthcare programs serving dual-eligible beneficiaries, with the goal of informing policy and practice improvements.

This series is intended for a wide range of readers, including policymakers, actuaries, healthcare providers, researchers, and advocates. The overarching goal of this series is to educate stakeholders on dual-eligible beneficiaries. Join us as we navigate the complexities centered around the intersection of Medicare and Medicaid and explore opportunities to better serve dual-eligible beneficiaries.

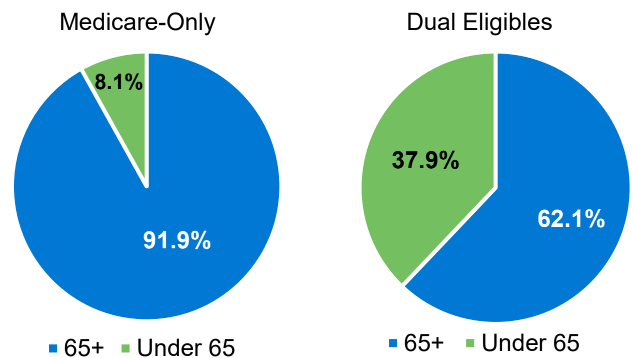
As the first of the series, the primary focus of this paper is to provide definitions and context to support the topics to be discussed in the future papers. Here we will focus on understanding certain fundamentals of dual-eligible enrollment, including its history, eligibility criteria, and the benefits available to dual-eligible beneficiaries.

Eligibility and benefits

Dual-eligible beneficiaries are individuals who are entitled to both Medicaid and Medicare benefits.

In general, Medicaid provides health coverage for certain low-income individuals, while Medicare provides coverage for those age 65 and over. However, Medicare eligibility is not strictly age-based; individuals entitled to Social Security Disability Insurance (SSDI) benefits for at least 24 months, individuals with the neurodegenerative disease amyotrophic lateral sclerosis (ALS), and individuals with end-stage renal disease (ESRD) may all qualify for Medicare benefits prior to 65 years of age. As shown in Figure 1, based on calendar year (CY) 2019 data from the Centers for Medicare and Medicaid Services (CMS), being over age 65 is the most common qualifier for Medicare eligibility overall, but dual-eligible beneficiaries under age 65 qualify for Medicare benefits for other reasons, such as disability or disease, more frequently than Medicare-only beneficiaries. [1]

FIGURE 1: PERCENTAGE OF DUAL-ELIGIBLES/MEDICARE-ONLY BY AGE



1 CMS (November 2020). Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 Through 2019. Retrieved April 9, 2024, from https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf.

When it comes to understanding the scope of coverage for dual-eligible beneficiaries, there are two different categories of dual eligibility: full and partial. Full-benefit dual-eligible beneficiaries are fully entitled to both Medicaid and Medicare benefits. Partial-benefit dual-eligible beneficiaries lack access to benefits that are exclusively Medicaid-covered, but are eligible for assistance with Medicare premiums (paid by the Medicaid program) and, in some cases, assistance with cost sharing through the Medicare Savings Programs (MSPs).

Medicare Savings Programs

While MSPs do not provide Medicare-covered services on their own, they do assist certain beneficiary groups with paying for Medicare services. MSPs are federally regulated state Medicaid programs designed to help low-income individuals by covering some or all of the out-of-pocket costs they incur, including Medicare premiums and cost sharing.

MSPs have the following eligibility classes based on income and disability status:

- Qualified Medicare Beneficiaries (QMBs)
- Specified Low-Income Medicare Beneficiaries (SLMBs)
- Qualified Individuals (QIs)
- Qualified Disabled and Working Individuals (QDWIs)

The beneficiary populations eligible for benefits under the QMB and SLMB designations are further segmented into “Only” or “Plus,” where “Plus” refers to full-benefit dual-eligible beneficiaries and “Only” refers to partial-benefit dual-eligible beneficiaries. Figure 2 describes eligibility, benefits, and financing for the different MSPs. When Medicaid is required to cover beneficiary cost sharing, the state may limit the provider reimbursement to the Medicaid fee schedule. In instances where the Medicare payment, prior to the application of the beneficiary cost sharing, exceeds the Medicaid fee schedule, Medicaid would not make an additional payment.

FIGURE 2: FEDERAL ELIGIBILITY, BENEFITS, AND FINANCING REQUIREMENTS OF MSPS

	QMB ONLY	QMB PLUS	SLMB ONLY	SLMB PLUS	QI	QDWI
Percentage of Overall MSP Enrollment	16.9%	63.5%	10.1%	3.6%	5.9%	0.0%
Eligibility Requirements						
Monthly Income Limit	$ 1,275	$ 1,275	$ 1,526	$ 1,526	$ 1,715	$ 5,105
Federal Asset Limit	$ 9,430	$ 9,430	$ 9,430	$ 9,430	$ 9,430	$ 4,000
Eligible for Medicare Part A	Yes	Yes	Yes	Yes	Yes	Yes
Benefits						
Medicare Part A Premiums	Required	Required	Not Allowed	Not Allowed	Not Allowed	Required
Medicare Part A Cost Sharing	Required	Required	Not Allowed	Optional	Not Allowed	Not Allowed
Medicare Part B Premiums	Required	Required	Required	Required	Required	Not Allowed
Medicare Part B Cost Sharing	Required	Required	Not Allowed	Optional	Not Allowed	Not Allowed
Medicare Part C Premiums	Optional	Optional	Not Allowed	Optional	Not Allowed	Optional
Eligible for Full Medicaid	No	Yes	No	Yes	No	No
Financing						
Responsible for Premium Payments	Federal/State	Federal/State	Federal/State	Federal/State	Federal	Federal/State

Notes:

“Monthly Income Limit” and “Federal Asset Limit” represent CY 2024 individual amounts.
“Percentage of Overall MSP Enrollment” based on December 2022 quarterly MSP enrollment report from CMS. [2]
“Optional” means that coverage is at the discretion of the state Medicaid agency.

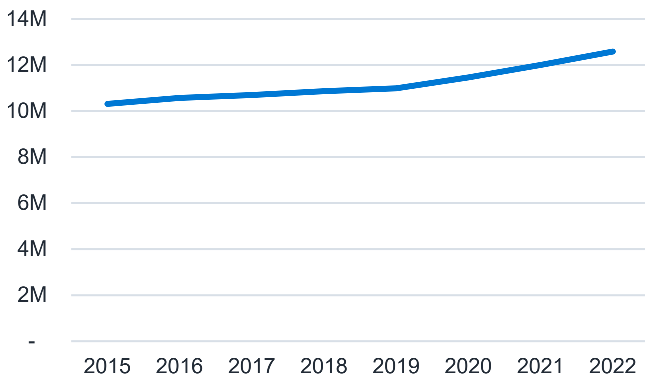
[2] CMS. MMENRO-2. Retrieved April 9, 2024, from https://www.cms.gov/files/zip/mmenrolleestatecountyqtrly.zip (ZIP file download).

It is important for state Medicaid agencies to appropriately assign beneficiaries to the correct MSPs. If beneficiaries are inappropriately assigned, the state Medicaid agency may lose federal match opportunities and, as a result, pay more through state general funds. Inappropriate assignments may also result in beneficiaries not receiving the appropriate levels of support.

Membership and cost growth

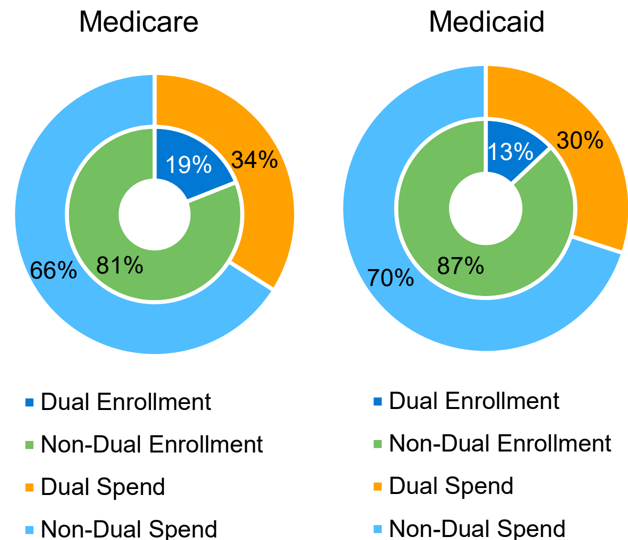
As discussed above, dual-eligibles are qualifying low-income individuals who are elderly (over the age of 65), disabled, and/or have ALS or ESRD. The number of individuals and the percentage of the total population in the United States over the age of 65 has increased over time due to medical advances that allow individuals to live longer, coupled with the Baby Boomer generation entering the age 65+ population starting in 2011.[3] Similarly, dual-eligible enrollment increased by 22% from 2015 to 2022. Figure 3[4] shows the total number of dual-eligible beneficiaries from 2015 through 2022, based on quarterly MSP enrollment reports from CMS.

FIGURE 3: NUMBER OF DUAL-ELIGIBLE BENEFICIARIES



Dual-eligible beneficiaries often have complex medical needs that require access to specialized services and are more expensive than the average Medicare or Medicaid beneficiary. In 2019, dual-eligible beneficiaries accounted for 19% of total Medicare enrollment and 34% of Medicare spending. In the same year, dual-eligible beneficiaries accounted for 13% of total Medicaid enrollment and 30% of Medicaid spending, as illustrated in Figure 4.

FIGURE 4: MEDICARE AND MEDICAID DUAL/NON-DUAL SPEND[5]



Medicaid pays Medicare premiums

Federal law requires state Medicaid agencies to cover certain Medicare premiums based on the beneficiary's dual-eligibility status, as illustrated in the benefits section of Figure 2 above. The original Medicare program consists of three parts, with varying premium requirements: Part A (inpatient, skilled nursing, home health, and hospice services), Part B (outpatient and professional services), and Part D (prescription drugs). In 2022, Medicaid state agencies spent approximately $37.6 billion to cover Medicare premiums for dual-eligible beneficiaries. Medicare Parts A and B may also be provided by a health plan, if CMS approves the plan's bid, which is commonly referred to as Medicare Advantage (MA) or Part C.

Medicare Advantage organizations may offer specialized plans that are limited to dual-eligible beneficiaries, called dual special needs plans (D-SNPs). It is optional for states to provide Medicaid coverage for the premiums of beneficiaries enrolled in the Medicare Advantage plan.[6] Additional information on D-SNPs is provided in the Dual Managed Care Programs section of this paper below.

PART A

Medicare Part A covers inpatient hospital services, limited skilled nursing facility (SNF) care after three days of a covered hospitalization, home healthcare, and hospice care. For individuals who have "aged in" to Medicare, the premium for

[3] Vespe, J. (March 13, 2018). The U.S. Joins Other Countries With Large Aging Populations. U.S. Census Bureau: The Graying of America. Retrieved April 9, 2024, from https://www.census.gov/library/stories/2018/03/graying-america.html#:~:text=Americans%20are%20having%20fewer%20children,aging%20is%20the%20baby%20boomers.

[4] Ibid.

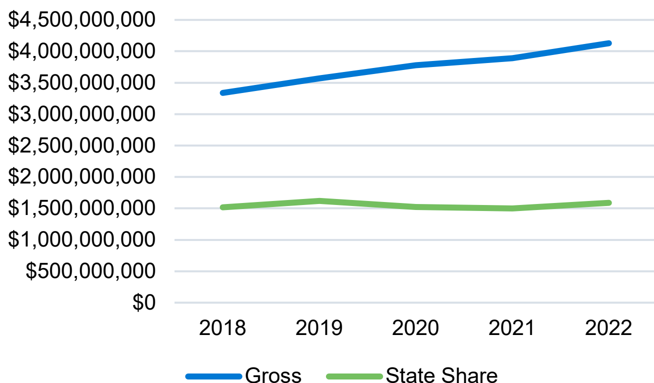
[5] MedPAC & MACPAC (January 2024). Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid. Retrieved April 9, 2024, from https://www.macpac.gov/wp-content/uploads/2024/01/Jan24_MedPAC_MACPAC_DualsDataBook-508.pdf.

[6] See Social Security Act §1905(p)(3)(D).

Medicare Part A is dependent on the number of quarters that the individual or their spouse, parent, or child have worked and paid Medicare taxes. If the individual or their spouse, parent, or child has paid Medicare taxes for 40 quarters, or 10 years, and the individual now qualifies for Social Security or Railroad Retirement benefits, then there is no premium for Medicare Part A. This is typically referred to as “premium-free Part A.” Most Medicare-eligible individuals qualify for premium-free Part A. Different requirements apply for individuals eligible for Medicare due to disability, ALS, or ESRD.

As illustrated in Figure 5, the gross amount (state funds and federal matching funds) that state Medicaid agencies paid for Medicare Part A premiums on behalf of dual beneficiaries has increased from $3.3 billion in 2018 to $4.1 billion in 2022.[7] The amount paid by the state general fund (state share) stayed relatively flat from 2019 through 2022 as a result of the increased federal match rate during the COVID-19 public health emergency.

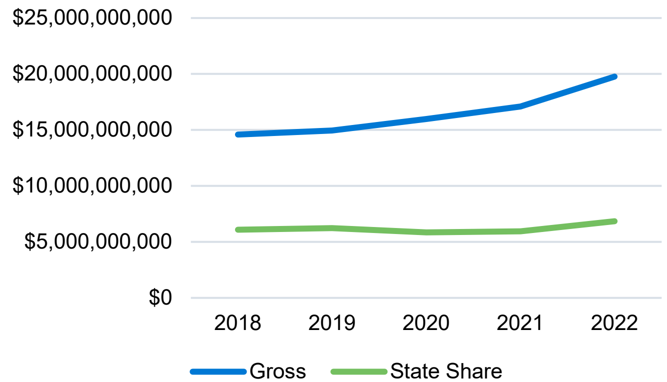
FIGURE 5: NATIONAL MEDICAID PAYMENT – MEDICARE PART A PREMIUMS



PART B

Medicare Part B covers outpatient and professional services. Medicare Part B always requires a monthly premium, though some Medicare Advantage plans may include a buy-down or “giveback” with rebate dollars to subsidize a portion of this premium for their enrollees. Medicaid state agencies cover the Medicare Part B premium for all individuals enrolled in MSPs with the exception of Qualified Disabled and Working Individuals (QDWIs). As illustrated in Figure 6, the gross amount (state funds and federal matching funds) that state Medicaid agencies paid for Medicare Part B premiums on behalf of dual beneficiaries has increased from $14.6 billion in 2018 to $19.8 billion in 2022. The amount paid by the state general fund (state share) stayed relatively flat from 2019 through 2022 as a result of the increased federal match rate during the COVID-19 public health emergency.

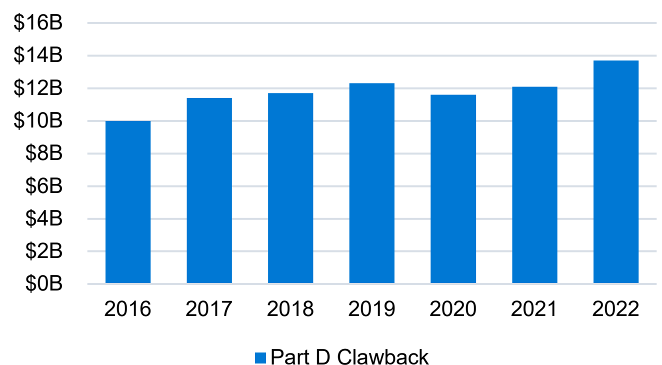
FIGURE 6: NATIONAL MEDICAID PAYMENT – MEDICARE PART B PREMIUMS



PART D

Medicare Part D covers prescription drug benefits. The Medicare Part D program covers the prescription drug cost for low-income individuals with reduced or eliminated cost sharing and premium subsidies. In return, the state Medicaid agencies pay a fixed amount per month to Medicare, commonly referred to as the “clawback.” The clawback was designed to help finance Medicare Part D and to allow Medicare to share the prescription drug savings experienced by the state Medicaid agencies. The amount each state Medicaid agency must pay is based on the number of dual-eligibles in the state and the state's drug costs for these individuals in 2003 trended for inflation. As illustrated in Figure 7, the amount that state Medicaid agencies paid for the Part D clawback on behalf of dual beneficiaries has increased from $11.7 billion in 2018 to $13.7 billion in 2022.

FIGURE 7: PART D CLAWBACK



[7] Medicaid. Expenditure Reports From MBES/CBES. Retrieved April 9, 2024, from https://www.medicaid.gov/medicaid/financial-management/state-expenditure-reporting-for-medicaid-chip/expenditure-reports-mbescbes/index.html.

Dual managed care programs

Some policymakers have promoted the managed care delivery system as a way to increase coordination and integration of healthcare services while incentivizing beneficiaries to receive care at the appropriate time and location.[8] The goal of managed care is to optimize the beneficiaries' interactions with the healthcare system to ensure that health issues are identified and treated as appropriately and efficiently as possible.[9]

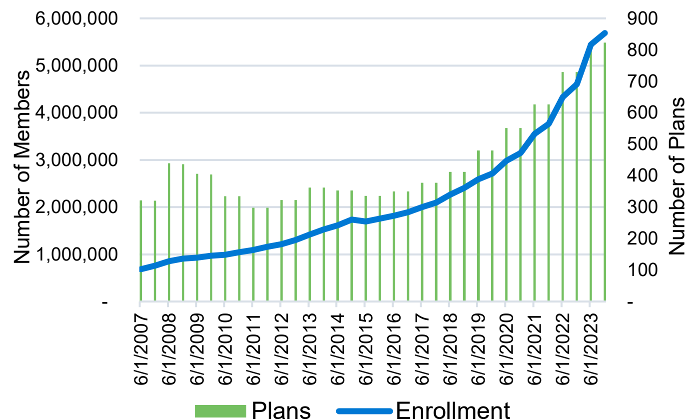
When Medicare and Medicaid were initially created in 1965, neither program anticipated the emergence of managed care in 1973. Since then, changes to both programs have been implemented to allow managed care. In the early 1980s, Medicaid regulations were amended to allow states to develop managed care programs that could include mandatory enrollment options through a 1915(b) waiver.[10] The Balanced Budget Act of 1997 allowed for the creation of Medicare managed care programs, but states could only include voluntary enrollment options.[11] Dual-eligible beneficiaries are in a unique situation because they are covered by both Medicare and Medicaid and, therefore, two sets of federal regulations must be followed to create a fully integrated managed care program for dual-eligible beneficiaries.

> As of December 2023, there are approximately 12.6 million dual-eligible beneficiaries in the United States, with approximately 6.1 million beneficiaries (48%) enrolled in one of the following three types of managed care programs: the D-SNP, the Program of All-Inclusive Care for the Elderly (PACE), and the Financial Alignment Initiative (FAI) model.

DUAL SPECIAL NEEDS PLAN (D-SNP)

D-SNPs are a type of Medicare Advantage plan offered by Medicare Advantage organizations (MAOs) and designed to cover individuals who are eligible for both Medicare and Medicaid. D-SNPs were created in 2006 following the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.[12] As illustrated in Figure 8, the number of D-SNP beneficiaries has doubled since December 2019, and the number of D-SNP plans available in the market has nearly doubled since 2018.

FIGURE 8: D-SNP ENROLLMENT AND NUMBER OF PLANS[13]



D-SNPs are required to contract with states, but states are not required to contract with D-SNPs. As a result, states have the authority to selectively contract with MAOs to align with their policy objectives. Additionally, states may mandate that D-SNPs implement care coordination programs and/or provide additional services to further integrate care between Medicare and Medicaid. Based upon current regulations, D-SNPs can offer three levels of integration (listed from lowest to highest levels of integration): Coordination Only (CO), Highly Integrated Dual-Eligible Special Needs Plan (HIDE SNP), and Fully Integrated Dual-Eligible Special Needs Plan (FIDE SNP).

As of December 2023, approximately 5.7 million dual-eligibles were enrolled in a D-SNP.[14] Figure 9 provides a summary of the percentage of individuals enrolled in a D-SNP by level of integration as of December 2023.

[8] Walsh, E.G. & Clark, W.D. (2002). Managed Care and Dually Eligible Beneficiaries: Challenges in Coordination. *Health Care Financ Rev*. Retrieved April 9, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194785/.

[9] DeMarzo, A. (December 29, 2020). What Is Managed Care? ACMA. Retrieved April 9, 2024, from https://www.priorauthtraining.org/what-is-managed-care/#:~:text=The%20purpose%20of%20managed%20care,cost%2C%20utilization%2C%20and%20quality.

[10] Ibid.

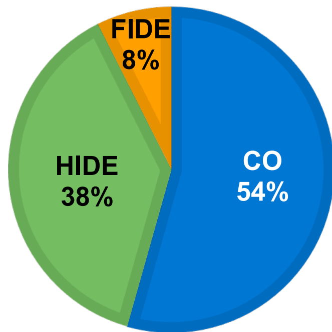
[11] Ibid.

[12] MACPAC. Medicare Advantage Dual Eligible Special Needs Plans. Retrieved April 9, 2024, from https://www.macpac.gov/subtopic/medicare-advantage-dual-eligible-special-needs-plans-aligned-with-medicaid-managed-long-term-services-and-supports/.

[13] CMS. Special Needs Plan (SNP) Data. Retrieved April 9, 2024, from https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/special-needs-plan-snp-data.

[14] Ibid.

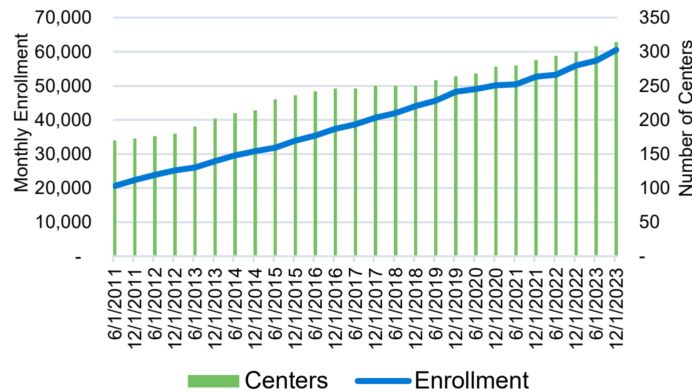
FIGURE 9: DECEMBER 2023 D-SNP ENROLLMENT BY LEVEL OF INTEGRATION



PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

PACE is a unique healthcare program designed to provide comprehensive medical and social services to individuals over the age of 55 who meet the state's nursing facility level of care criteria but wish to remain in their own homes for as long as possible. Under this model, a designated PACE center coordinates, and is at risk for, all covered services related to the beneficiary. The PACE center can also provide additional medically necessary services not covered by Medicare and Medicaid. For individuals who are eligible for both Medicaid and Medicare, PACE is a fully integrated program.

FIGURE 10: PACE ENROLLMENT AND NUMBER OF PACE CENTERS



As illustrated in Figure 10, as of December 2023 approximately 60,500 individuals were served by the PACE model in 32 states, including the District of Columbia,[15] most of whom are dual-eligible individuals.

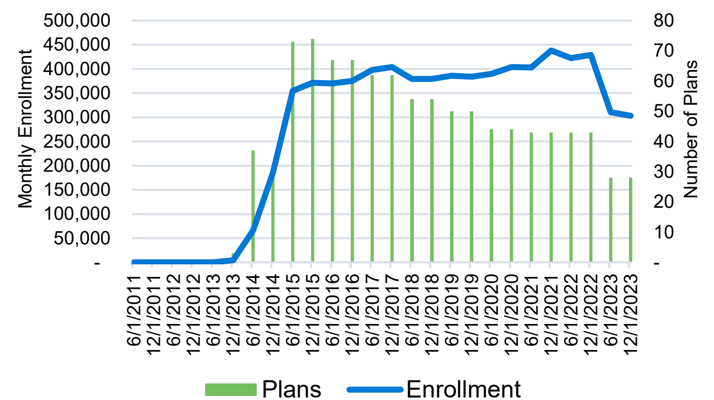
Because PACE organizations primarily deliver care through PACE centers, beneficiaries tend to live in very close proximity to the PACE facilities. As a result, the number of individuals who enroll in this program is limited by the number and locations of PACE centers.

FINANCIAL ALIGNMENT INITIATIVE (FAI)

The FAI is a collaborative effort by CMS to provide a coordinated, person-centered care experience for individuals who are dually eligible for Medicare and Medicaid. Launched in 2011, the FAI capitated model is a time-limited demonstration that aims to remove barriers to high-quality healthcare for dual-eligible beneficiaries by promoting health plan innovations that align the financial incentives of the Medicare and Medicaid programs and improve coordination. Medicare-Medicaid Plans (MMPs) provide integrated Medicare and Medicaid services to dual-eligibles through a three-way contract with CMS, the state, and the health plan. One of the goals of this program is to encourage the use of waiver services to allow beneficiaries with mobility concerns to remain in the community for longer periods of time by making their homes safer and providing extra help with activities of daily living (ADLs). A unique aspect of this model is an explicit cost savings assumption that is incorporated into the Medicare and Medicaid capitation rates paid to MMPs.

As shown in Figure 11, as of December 2023 approximately 302,900 individuals were served by the FAI capitated model in eight states.[16] CMS announced in 2022 its intent to end the demonstration and to work with states to convert MMPs to integrated D-SNPs by the end of 2025. Three states have already ended their FAI demonstrations, with the most recent termination being California on December 31, 2022.

FIGURE 11: FINANCIAL ALIGNMENT INITIATIVE ENROLLMENT AND NUMBER OF PLANS



[15] CMS. Monthly Enrollment by Plan. Retrieved April 9, 2024, from https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-advantagepart-d-contract-and-enrollment-data/monthly-enrollment-plan.

[16] Ibid.

Due to the limited number of states participating in the demonstration, and with the gaining popularity of D-SNPs, there has been limited new enrollment in the FAI demonstration.

MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)

In 1981, Congress added Section 1915(c) to the Social Security Act, allowing state Medicaid programs to provide long-term services and supports (LTSS) in home- and community-based settings as an alternative to institutional care.[17] As a result, states began to establish MLTSS systems to provide LTSS through capitated Medicaid managed care programs. Under this model, managed care organizations (MCOs) contract with states to deliver LTSS and receive reimbursement for the cost of the services they provide each month per enrollee, known as the "capitation payment."[18] In 2021, a total of 24 states were operating MLTSS programs under various federal authorities, 10 of which utilized the FAI capitated model demonstrations to provide LTSS for dual-eligible beneficiaries, with the state of Indiana planning to implement an MLTSS program beginning in the summer of 2024.[19,20]

The MLTSS model is designed to cover LTSS for Medicaid beneficiaries who require assistance with ADLs due to chronic illness, disability, or the aging process, many of whom are dual-eligible individuals. By encouraging MCOs to streamline LTSS delivery using existing home- and community-based services (HCBS) programs, the MLTSS model promotes person-centered care coordination with the goal of improving both quality of care and the efficiency of service delivery for MLTSS beneficiaries.[21] There has been a significant growth in MLTSS expenditures in recent years, reflecting that more states are using MLTSS and more beneficiaries are receiving LTSS through these programs.[22] As of 2021, there are approximately 1.9 million individuals enrolled in MLTSS programs.[23] Please note that the information reported from Data.Medicaid.gov excludes PACE enrollment in its MLTSS enrollment estimates.

To summarize, the dual eligibility system is a complex yet vital aspect of the U.S. healthcare system that allows certain individuals, known as dual-eligible beneficiaries, to access both Medicaid and Medicare benefits. This system provides essential health coverage to low-income individuals who are typically elderly, disabled, or both. The coordination of healthcare between Medicaid and Medicare is an intricate process involving numerous eligibility categories, benefits, and managed care programs. These various moving parts have significant implications for healthcare providers, policymakers, and beneficiaries.

The dual-eligible population has seen recent growth, driven primarily by an aging population and increased national life expectancy. We expect the growth of this population to continue, which is why it is crucial to understand and support the improvement of this system now.

What's coming up next?

The next white paper in our series "Navigating the intersection of Medicare and Medicaid" will dive deeper into the future of managed care programs for dual-eligible beneficiaries. As the FAI comes to a close during calendar year 2025, many states are exploring new options to provide comprehensive, integrated care for their dual-eligible populations with the goal of increasing coordination between Medicare and Medicaid. This upcoming white paper will examine the innovative strategies, opportunities, and challenges that states are encountering as they navigate the evolving healthcare landscape for dual-eligible beneficiaries.

[17] Medicaid (June 9, 2023). Medicaid Section 1915(c) Waiver Programs Annual Expenditures and Beneficiaries Report: Analysis of CMS 372 Annual Reports, 2018-2019. Retrieved April 9, 2024, from https://www.medicaid.gov/sites/default/files/2023-10/cms-372-report-2018-2019.pdf?utm_source=NASBO&utm_campaign=ab5ab1ad93-EMAIL_CAMPAIGN_2023_10_24_05_57&utm_medium=email&utm_term=0_-ab5ab1ad93-%5BLIST_EMAIL_ID%5D.

[18] Medicaid (June 9, 2023). Medicaid Long-Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2020. Retrieved April 9, 2024, from https://www.medicaid.gov/sites/default/files/2023-10/ltssexpenditures2020.pdf?utm_source=NASBO&utm_campaign=ab5ab1ad93-EMAIL_CAMPAIGN_2023_10_24_05_57&utm_medium=email&utm_term=0_-ab5ab1ad93-%5BLIST_EMAIL_ID%5D.

[19] Downard, W. (October 2, 2023). Managed care transition set to go live July 2024. News From the States. Retrieved April 9, 2024, from https://www.newsfromthestates.com/article/managed-care-transition-set-go-live-july-2024.

[20] Medicaid Long-Term Services and Supports Annual Expenditures Report, op cit.

[21] Cacchione, P.Z. (June 1, 2020). Managed Long-Term Services and Supports for Medicaid Only and Dually Eligible Individuals. J Gerontol Nurs. Retrieved April 9, 2024, from https://pubmed.ncbi.nlm.nih.gov/32453434/.

[22] Ibid.

[23] Data.Medicaid.gov. Open Data: Managed Long-Term Services and Supports (MLTSS) Enrollees. Retrieved April 9, 2024, from https://data.medicaid.gov/dataset/5394bcab-c748-5e4b-af07-b5bf77ed3aa3.

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