



Better Integrated Care for Medicare/Medicaid Dual Eligibles Could Lower Costs

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Adults who are dually eligible for both Medicaid and Medicare coverage are among the most chronically ill and costly patients—accounting for close to nearly half of all spending within Medicaid and a fourth of spending within Medicare. However, most of these eight million "duals," as they are often called, frequently are receiving fragmented, uncoordinated, and ultimately high-cost care, according to a new Center for Health Care Strategies (CHCS) [policy brief](#), Supporting Integrated Care for Dual Eligibles.

Dual eligibles represent just 18% of Medicaid enrollees and 16% of Medicare enrollees. But, in spite of recent efforts to try to integrate care Special Needs Plans (SNPs) that would better coordinate their care, more than 80% of dual eligibles remain in fee for service plans, the researchers noted.

Duals often find themselves in "treatment silos" that prevent them from interacting with more than one healthcare provider at a time—even when they already have several physicians. They also may end up getting one prescription at a time—even when they take 15 different prescriptions in any one day, they noted.

By definition, dual eligibles are low income: 60% live below the poverty level, and as many as 94% live below 200% of the poverty level. Compared to the general Medicare population, dual eligibles are three times more likely to be disabled and have higher rates of diabetes, pulmonary disease, stroke, and Alzheimer's disease. In 2005, the total cost to Medicare and Medicaid for care provided to dual eligibles was roughly \$215 billion.

But despite the potential of SNPs for integrating care, only a handful of states operate fully integrated programs. Of the roughly 1.5 million dual eligibles receiving care via Medicare Advantage plans (including SNPs), only about 120,000 are in programs that are fully integrated Medicare and Medicaid services, the study said.

This may be partly due to "a lack of administrative support or to competing state priorities," said the researchers. It may also be linked to questions regarding what "makes SNPs uniquely qualified to care for a high needs population—particularly since many of these organizations have no prior experience caring for dual eligibles."

Integrated programs, the report noted, should include the following elements:

- Strong patient centered primary care base, such as an accountable care home.
- Multidisciplinary care team that is structured to address the full range of a beneficiary's needs (medical, behavioral, and social).

- Comprehensive provider network that meets the needs of the target population and supports the care coordination model.
- Robust data sharing and communications systems that guarantee continuous access to services and promote coordination of care across settings.
- Consumer protections that ensure access to longstanding community providers.
- Financial alignment that addresses fragmented systems of care through blended funding and/or shared gains and risks of providing services.

While there have been a number of attempts to promote more widespread and "scaleable" integration for dual eligibles, progress has been limited in improving the coordination and cost effectiveness of care. To move forward, the researchers suggested that:

- Congress and the Centers for Medicare and Medicaid Services provide greater authority for testing innovative alternatives in states where SNPs are not active and duals are served by the Medicare fee for service system.
- Medicare and Medicaid stakeholders be enabled to share savings generated from the integration of services for dual eligibles.
- Congress and CMS should support mechanisms that would enable states, plans, and the federal government to share savings, such as that realized from reduced emergency department and inpatient use, and from integrating primary, acute, behavioral, and long term supports and provider services.

Janice Simmons is a senior editor and Washington, DC, correspondent for HealthLeaders Media Online. She can be reached at jsimmons@healthleadersmedia.com.

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