A Prescription for Americans Dually Eligible for Medicare and Medicaid

Medicare is the $900 billion program that comes under close scrutiny in discussions about health care outcomes, the nation’s debt, and the lack of substance in 2024 presidential campaigns. If the program goes insolvent in 2031 as projected, payments to health care professionals will be cut by an estimated 20%. This would imperil the abilities of hospitals and physicians to deliver care and make it harder to access services. If the US Congress merely borrows money to address insolvency, it will saddle future generations with crippling debt. Unfortunately, presidential candidates are ignoring the topic.

A way to improve patient outcomes and save money for taxpayers is by addressing the needs of a particularly vulnerable population—those who are “dually eligible.” People who are dually eligible receive both Medicare and Medicaid services. These individuals are lower-income and/or older or have a disability. Only 19% of Medicare beneficiaries are dually eligible, but they account for 34% of total Medicare spending. On the Medicaid side, 14% of enrollees are dually eligible but account for 30% of all Medicaid spending. Despite taxpayers spending more money on persons who are dually eligible, their health outcomes are worse. Dually eligible persons are more likely to be hospitalized and to be readmitted to a hospital within 30 days of discharge compared with Medicare-only beneficiaries, even after controlling for confounding variables.

The root cause of worse outcomes despite spending more money is a lack of coordination of care, which is related to Medicare and Medicaid not coordinating payments. Although Medicare is the primary payer for most physician and hospital services, Medicaid pays for deductibles, co-pays, and long-term care, such as nursing home care. However, it is unclear as to whether Medicare or Medicaid is the primary payer for some services, because in some instances both Medicare and Medicaid can pay. So, at times, each program expects the other to pay.

When combined with Medicare’s mandate to be the payer of last resort, dually eligible individuals seeking health care services often find themselves wedged between 2 programs seeking to push costs to the other. Anyone who has enrolled in Medicare can understand how complicated it is. Think about the difficulty that dually eligible persons, who have a lower income, are older, and perhaps have a disability, have in signing up for 2 programs.

As a physician who worked in a hospital in which patients were uninsured and enrolled in Medicaid services, it was clear how poor payment coordination between the Medicare and Medicaid programs leads to poorly coordinated care and ultimately poor health outcomes. If a patient is eligible for both Medicare and Medicaid but is not enrolled in a managed care program for either, then Medicare and Medicaid services are uncoordinated by definition. But even if the patient is enrolled in a Medicare Advantage plan and is simultaneously enrolled in a Medicaid managed care plan, coordination is not required. This absence of integration inherently increases the possibility of poor coordination of a dually eligible patient from a hospital setting to longer-term care and raises costs.

Integrated programs that combine Medicare and Medicaid exist. They run the spectrum from the Program of All Inclusive Care for the Elderly (PACE) to Fully Integrated Dual Eligible Special Needs Plans and Dual Eligible Special Needs Plans. PACE is the most integrated and has been shown to have demonstrable improvements in health outcomes. Patients enrolled in PACE have 539 hospital admissions per 1000 person-years compared with 962 for a similar patient population not enrolled in PACE. PACE also saves thousands of dollars per participant. Nearly all 60,000 PACE enrollees are Medicare/Medicaid beneficiaries. Fully Integrated Dual Eligible Special Needs Plans are the next degree of integration, but currently enroll fewer than 500,000 people. Dual Eligible Special Needs Plans are “coordination only” and require Medicare Advantage plans to contract with state Medicaid agencies, but provide limited coordination of benefit delivery; the majority of Special Needs Plans fall into this category. Although coordination improves outcomes, less than than 5% of dually eligible individuals are enrolled in a fully-integrated plan (PACE or Fully Integrated Dual Eligible Special Needs Plans).

Disjointed payment should no longer drive uncoordinated care. The federal government should come up with a set of guidelines and require that care be coordinated between Medicare and Medicaid. Specific states can tailor the program to that state’s demographics, health issues, and health infrastructure. As states experiment, they can teach and learn from each other regarding how to better integrate care between Medicare and Medicaid.

There is a working group of 6 US senators on the US Senate Committee on Finance, 3 Republicans and
3 Democrats, who are working to make this transition occur. We realize that there are issues we need to address to achieve full integration. Some issues include the inability of states to supervise a large number of integrated plans, reconciling the fee schedule for common services, and addressing "look-alike" plans that enroll large numbers of dually eligible individuals but do not provide coordinated care.

As a nation, we still have a long way to go to provide quality health care to the most vulnerable Americans. Ensuring that all parts of our government are working together to empower them with tools to live longer, happier, and healthier lives is common sense. When we succeed, not only will patients be healthier, but we will simultaneously make Medicare more sustainable and help address our nation's debt.

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REFERENCES