

Providence College

DigitalCommons@Providence

Annual Undergraduate Conference on Health
and Society

Fourth Annual Undergraduate Conference on
Health and Society

Mar 23rd, 9:30 AM - 10:45 AM

The Danger of Duality: Medicare and Medicaid as a Double Threat

Erica Barnum

Providence College

Follow this and additional works at: <https://digitalcommons.providence.edu/auchs>



Part of the [Health Policy Commons](#), and the [Policy Design, Analysis, and Evaluation Commons](#)

Barnum, Erica, "The Danger of Duality: Medicare and Medicaid as a Double Threat" (2013). *Annual Undergraduate Conference on Health and Society*. 3.

<https://digitalcommons.providence.edu/auchs/2013/panela2/3>

This Event is brought to you for free and open access by the Conferences & Events at DigitalCommons@Providence. It has been accepted for inclusion in Annual Undergraduate Conference on Health and Society by an authorized administrator of DigitalCommons@Providence. For more information, please contact dps@providence.edu.

The Danger of Duality:
Medicare and Medicaid as a Double Threat

Erica Barnum
Senior Seminar—Final Paper
Dr. Agartan
December 10, 2012

“Individuals who are dually eligible for both Medicare and Medicaid have received considerable policy attention in recent years due to their high cost and complex health needs. Research suggests that the dually eligible comprise the sickest, poorest, and most costly cohort of beneficiaries in the nation’s health care system. Although this population is relatively small in number, consisting of approximately 9 million individuals, spending on dually eligible accounts for roughly 36% of Medicare’s total spending and 39% of Medicaid’s spending” (Grabowski 2012, 221).

“All too often, the health care and other support services [dual eligibles] receive are fragmented and uncoordinated—in large part because dual eligibles fall through the cracks of the two very different public programs that finance—and therefore dictate—their care.” (Meyer 2012, 1151)

Introduction

There are well above nine million dual eligible beneficiaries in the American health care system today. Dual eligibles qualify for both government programs of Medicare and Medicaid and they have utilized the services of these two programs in such a way that they have become one of the costliest populations. These sick, vulnerable, frail, elderly, and needy individuals comprise only fifteen percent of total Medicaid enrollment yet are responsible for 39 percent of the program’s expenditures. Similarly, they represent 21 percent of the Medicare population but result in 36 percent of the program’s costs (“Affordable” 2011, 1). It is fair to believe their utilization of services – and, thus, costliness – may be a product of their generally poor health status. “Nearly 60 percent of all dual-eligible beneficiaries have a mental or cognitive problem,

55 percent have three or more chronic conditions, and 50 percent rate their health status as fair or poor” (Brown 2012, 5). However, it seems the spending problems that the federal and state governments are observing are not simply due to the conditions of these dual eligibles, which typically require more extensive, frequent, and expensive care. Rather, there is strong evidence to attribute the problems of the costs and low quality of care within the dual eligible arena to the fragmented and poor coordination between Medicare and Medicaid.

Simply put, the two government programs were implemented as individual entities and were not designed to work together. Medicare is federally funded whereas Medicaid operates on state funding and, therefore, varies across states in regards to program benefits, eligibility criteria, enrollment, costs, etc. Both programs operate in a fee-for-service environment so there has never been an incentive for providers to coordinate care across the programs. Rather, there has been a trend of cost shifting, specifically from states, with the intention of getting services qualified under Medicare since it is federally funded. Medicaid programs have virtually no incentive to “enact policies to lower Medicare-financed hospitalizations because they do not accrue any of the potential savings (Grabowski 2012, 223). However, as a result of the increasing expenditures incurred by this population, federal and state policymakers have been forced to address the issue of fragmented services and payment methods between Medicare and Medicaid. The current approach to financing care for dual eligibles is simply no longer financially sustainable on the federal or state level. Yet, coordination of care for dual eligibles is particularly challenging – beneficiaries may “need a wide range of services or need access to providers covered under one program or the other, but not always both” (Neuman 2012, 1187). But will efforts directed towards integrated care be successful or even feasible?

So far, there have been some steps taken towards better integrating care for dual eligible

beneficiaries so as to reduce costs for federal and state governments while maintaining – and aspiring to improve – care for this population. There have been strides forward to better coordinate care exemplified in the individual state initiatives of Massachusetts, Minnesota, and Wisconsin, to name a few, the creation and implementation of the Program of All-Inclusive Care for the Elderly (PACE), and Dual-eligible Special Needs Plans (D-SNPs). However, although the initiatives thus far may provide slight evidence to improvement in care for dual eligibles, there is no substantial proof of any net savings or cost reductions.

Because efforts to better integrate care for dual eligibles to date have been rather small in magnitude and modest in their outcomes, the Affordable Care Act aspires to achieve drastic results through new policies. Already, the Centers for Medicare and Medicaid Services (CMS) has begun state demonstrations in which twenty-six states are testing new systems and models of payment and delivery for dual-eligibles. Though these demonstrations are works in progress, they are expected to be successful in improving quality of care and care coordination as they are trying radically new approaches. Also, cost reduction is highly anticipated, as “CMS will not approve a demonstration unless the capitated rate provides upfront savings to both CMS and the state” (“Explaining” 2012, 4).

In addition to this current undertaking by the CMS, the ACA contains numerous provisions that will ultimately affect, in some way or another, the dual eligible population. This legislation aspires to provide “better care integration, improved quality measures, and increased access to home and community-based long term services and supports”. It also establishes two new federal entities—The Federal Coordinated Health Care Office (FCHCO or Duals Office) and the Center for Medicare and Medicaid Innovation (CMMI

or Innovation Center)—which will closely be monitoring and studying the quality and delivery of care for dual eligibles (“Affordable” 2012, 1). In addition to an approach directed towards this particular population, the ACA contains numerous provisions specifically directed towards the two separate programs of Medicare and Medicaid. Because dual eligibles access both of these programs, certain provisions unique to each of the two will undoubtedly have an effect on these dual beneficiaries.

Yet, the main question remains: will the ACA be effective in what it proposes regarding dual eligible beneficiaries? In the past, there have been proposals with the same aim – to reduce costs while maintaining, if not improving, the care of dual eligible beneficiaries. The evidence has shown that such implementations - such as PACE and D-SNPs - have not proven effective in achieving this goal. The change required in order to continue providing quality care to this frail, elderly, sickly, and costly population is large in magnitude. Prior attempts to reach reform at this scale have fallen short. Costs will be the ultimate deciding factor in the legislation’s effectiveness and, to this point, studies have projected the ACA will not achieve these desired savings. It seems the only possibility to achieve cost reductions while simultaneously improving care for dual eligibles – or, at least, maintaining a standard level – will involve a tailored approach to address the specific needs of subsets of this population paired with a mandate for state participation in integration efforts.

Who are the dual eligibles?

Dual eligible beneficiaries are those who are enrolled in both Medicare and Medicaid. There are approximately nine million Americans who meet the eligibility requirements for these two government-run programs and, thus, simultaneously receive the respective benefits of each (United States Cong. 2004, 73). This distinct population of Americans has gained a reputation for being the “poorest, sickest, and neediest people” (Clemens-Cope 2011, 1); however, there is much diversity amongst dual eligibles. Some are higher risk with more complex health conditions, incurring high medical and long-term care costs, compared to others who only have fairly limited needs (“Diversity” 2012, 1). Still, many publications provide an overarching view into the overall characteristics of this population. Compared to the general population, dual eligibles are “far more likely to be in poor health and in an institution, not to be white, and not to have completed high school” (Bubolz 2012, 940). In comparison to Medicare beneficiaries, they “tend to have more chronic conditions, cognitive limitations and functional limitations” (Jacobson 2012, 3). One observes these generalizations in the findings of numerous studies. For example, the Kaiser Family Foundation reports that one out of every six dual eligibles lives in a mental institution (“Diversity” 2012, 3). Similarly, MedPAC reported that 38 percent have cognitive or mental impairments, 22 percent have multiple physical impairments, and 23 percent are institutionalized (United States Cong. 2004, 72).

Within the dual enrollee population, it seems there is one there is one main dividing line: those who are “full duals”, and those who are not. The full dual eligibles comprise approximately 76.3% of this population, or about 6.8 million individuals. This eligibility qualifies them for “all Medicaid benefits that provide ‘wrap-around coverage’ to Medicare” (“Diversity” 2012, 1-2). Another 22.5% of the program participants are “partial dual eligibles” who are not eligible for full Medicaid benefits (2). Instead, “partials” receive assistance with

Medicare premiums, deductibles, and other cost-sharing requirements through the Medicare Savings Programs (MSP) (Young 2012, 2). Medicare and Medicaid vary greatly in the services they cover for dual eligibles as well as in their eligibility requirements. In order to qualify for Medicare, dual eligibles, like all other Medicare beneficiaries, must be “age 65 or older or under age 65 with a permanent disability receiving SSDI, or have end-stage renal disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS)” (Jacobson 2012, 2). To qualify for Medicaid, one must “meet the income and asset limits for the Supplemental Security Income (SSI) Program” which is defined as “incomes less than 75% of the federal poverty level (FPL) for individuals (83% for couples) and assets at or below \$2,000 for individuals (\$3,000 for couples)” (12).

Medicare serves as the primary source of health insurance for dual eligibles (Jacobson 2012, 2). Medicare covers acute services, which include inpatient and outpatient care, physician services, diagnostic and preventive services, and outpatient prescription drugs under Part D (Gold, Jacobson, and Garfield 2012, 1177). Coverage also extends to post-acute care and hospice care (Neuman 2012, 1186). Medicaid, on the other hand, covers different needs of the population through a type of “wrap-around” coverage. “The extent of this wrap-around coverage depends upon what services are provided by the state Medicaid program where a dual eligible lives” (“Diversity” 2012, 2). Medicaid essentially fills in the gaps left by Medicare by covering the services Medicare does not (Gold, Jacobson, and Garfield 2012, 1177). Some examples include coverage for long-term care, dental care, vision care, and Medicare’s premiums and cost sharing (Neuman, 2012 1187). Although it seems dual eligibles receive rather extensive care through the combination of both Medicare and Medicaid coverage, there are some gaps. One reason is a result of geographic variation. Two thirds of the Medicaid benefit package is offered at the state’s discretion, so it is each state’s ‘opinion’, which services to provide (United States

Cong. 2004, 84). Also, coverage determinations for both Medicare and Medicaid can be more or less subjective as they are guided by various factors including “statutory definitions of medical necessity, statutory and regulatory parameters of the benefit, judicial decisions, and the judgment of fiscal intermediary staff and administrative law judges (ALJs)” (83). Subjectivity can highly impact the benefits and services a participant receives. For example, Medicare coverage involves the decisions of intermediaries who must interpret laws and regulations – such as whether or not a beneficiary should be in the care of a skilled nursing facility (SNF). Because it is based on interpretation rather than a standard set of guidelines, for instance, intermediaries may vary in their decisions. Coverage decisions made by intermediaries may be appealed to Social Security ALJs; however this subsequent review is yet another subjectively based interpretation (84).

Over the years, dual eligible beneficiaries have grown to become one of the costliest populations—if not the most—for the American health care system. In 2007, Medicare spent \$15,850 per capita on dual eligibles while total Medicaid per capita spending equaled \$14,018. That same year, Medicare and Medicaid spending for the dual eligible population totaled \$265.7 billion (“Diversity” 2012, 5). Last year, in 2011, total spending reached an estimated \$319.5 billion (Meyer 2012, 1151). Compared to non-dual eligible Medicare beneficiaries, the combined average per capita Medicare and Medicaid spending on dual eligibles was more than four times as great, coming in at \$29,868 (Coughlin 2012, 1086). Studies have shown that dual eligible beneficiaries are more likely to use all types of Medicare-covered services than non-dual eligibles (United States Cong. 2004, 72). It is important to note, however, that government spending on dual eligibles is not an even playing field. Some beneficiaries have rather few service needs, resulting in lower costs and others are only eligible for certain Medicaid benefits

(“Diversity” 2012, 9). Thus, much of the spending is concentrated on the beneficiaries with higher needs (Clemens-Cope 2011, 1). In 2007, the “top ten percent of spenders in Medicaid made up nearly one-third of the combined Medicare-Medicaid spending” while the top ten percent of spenders in Medicare were responsible for 35 percent of combined spending (Coughlin 2012, 1089). These two groups alone “accounted for 60.6% of combined Medicaid and Medicare spending on the population”. Yet, there was only a small overlap in the highest spenders of the two programs – less than 1% [of all dual eligible beneficiaries] – and these “high-cost Medicare-Medicaid dual eligibles accounted for only about 4.6% of total spending on the population” (1087). This highlights a crucial take-home:

“The factors that make dual eligibles more expensive than other *Medicare* beneficiaries are not the same factors that make them expensive relative to other *Medicaid* beneficiaries. For Medicare, the reason for high costs among dual eligibles is the elevated need for acute care resulting from the increased prevalence of chronic disease associated with age, disability and poverty. But for Medicaid, the principal reason that dual eligibles tend to be expensive is that they are more likely than other dual beneficiaries to be users of institutional long-term care” (“Diversity” 2012, 9)

One of the main issues behind the costliness of dual eligibles is the inefficiency and poor-coordination between Medicare and Medicaid. The system is perplexed with “skewed incentives for providers and financing fragmented between the federal and state governments” (Clemens-Cope 2011, 1). These two public health insurance programs were simply not designed to work together and “sometimes work at cross-purposes” (“Diversity” 2012, 1). Medicare is a federal

program financed by payroll taxes, general revenues, and beneficiary premiums while Medicaid is a joint federal-state program that varies from state to state (United States Cong. 2004, 85). Because of this, eligibility and benefits can vary greatly and some states may either be under or over spending on health care. The inherent problem behind the spending dilemma is the incentive of both Medicare and Medicaid to “maximize payment from the other program” – essentially known as cost shifting (86). “Some states seek to shift health care services from Medicaid which is funded partially by the states and partially by the federal government, to Medicare, which is wholly federally funded” (Bubolz 2012, 939). For example, states will look to move patients from long-term care into acute care because Medicare incurs the costs of these services (944). Often times, Medicaid views the transfer of services and patients into Medicare as an opportunity due to the fact that “Medicare is a national program administered by the federal government, with broader taxing and borrowing authority” (Grabowski 2012, 229).

Not only does the cost shifting between providers and programs result in higher spending under Medicare and Medicaid but the overall lack of coordination between the programs results in lower quality, and in some instances, rather poor care of dual eligible beneficiaries. Dual eligibles may not get appropriate care or even potentially get unnecessary care (Neuman 2012, 1187). “Fragmentation [in care coordination] can be both wasteful and risky to patients, producing avoidable hospitalizations, emergency department visits, nursing home stays, and unnecessary suffering” (Meyer, 2012 1152). This inefficient delivery of care is beginning to defeat the purposes of the programs and is, instead, becoming a challenge. It is simply too difficult for dual eligibles to navigate between two programs of such distinct procedures, benefits, coverage, eligibility criteria, billing systems, and more (Jacobson 2012, 8). More importantly, the lack of coordination between Medicare and Medicaid has incurred such high

costs for the government that alternative approaches to care delivery must seriously be considered.

What has been done thus far?

The lack of coordination between Medicare and Medicaid for the dual eligible population has simply proven insufficient. Not only has the fragmentation incurred excessive costs for the state and federal governments but also, and perhaps more importantly, these beneficiaries may experience low quality or even poor care. It is estimated that over a ten-year period, the federal government would save \$125 billion and states would save \$34 billion if all dual eligibles were enrolled in “effective, integrated managed care plans” (Meyer 2012, 1151). Also, coordination of care is more than likely to improve elements of access and quality for the beneficiaries (*Report 2012, 67*). The recurring results of the current system have built up a very strong case to move towards a model of integrated care for this elderly, sickly, and needy group. Steps have been taken to do so, as seen in individual state initiatives to better coordinate care, the Program of All-Inclusive Care for the Elderly (PACE), and dual eligible special needs plans (D-SNPs). However, with rather low enrollment in the two programs and the lack of results from the state initiatives, the success and efficacy of these attempts at integrated care is uncertain.

Some states have taken it upon themselves to address the issues arising from poor coordination between Medicare and Medicaid and have done so in innovative ways. Three of these states include Minnesota, Massachusetts, and Wisconsin. Each of them has developed voluntary integration models, which allows for dual eligibles to enroll separately in the same special needs plan or managed care option for their Medicare and Medicaid services. They also all employ the use of combined capitated payments (Grabowski and Bramson 2012, 59).

State Initiatives: Minnesota

In 1997, the Minnesota Senior Health Options (MSHO) was implemented as the first demonstration “designed to improve integrated services to the frail, elderly, dual eligible population” (NHPF 2003, 19). With MSHO, Minnesota was the first state to combine Medicare and Medicaid services through the consolidation of funds from the two programs in a combined capitation payment (Grabowski and Bramson 2012, 55). The payments are integrated at the plan level but Medicare and Medicaid payments are made separately by the state and CMS (Parker 2001, 27). In addition to providing all Medicare and Medicaid services, MSHO also provides in-home and community-based services with the help of a care coordinator who serves as both the gatekeeper and advocate for the beneficiary (28). Enrollment in MSHO is voluntary, although it is an attractive option for dual eligibles because it accepts a wide range of participants regardless of the level of need (NHPF 2003, 19). The principle of integrated capitated financing enables enhanced primary care payments, support of intensive nurse practitioner functions that otherwise are not feasible under Medicare’s fee-for-service arrangement, and flexibility to meet individual needs (Parker 2001, 28).

State Initiatives: Wisconsin

One year following the implementation of MSHO, Wisconsin was granted authority to establish a demonstration in 1998 and it did so in January of 1999 (NHPF 2003, 17). The Wisconsin Partnership Program (WPP) integrates Medicare and Medicaid funding and is at

financial risk for acute and long-term care benefits, giving the program an incentive for efficiency (*Report 2012, 77*). It has a large target population of all dual eligibles 18 years of age and older (Grabowski and Bramson 2012, 56). WPP was the “nation’s first comprehensive managed care plan designed for individuals with disabilities under the age of 65” (NHPF 2003, 17). It follows the PACE model but varies in the sense that it makes less use of day care and allows enrollees to keep their primary care physician (Kane 2002, 315). WPP uses an interdisciplinary team consisting of a registered nurse, nurse practitioner, social worker or social services coordinator to deliver a range of services to a population of primarily dual eligible beneficiaries (*Report 2012, 77*). The program “integrates health and long term support services and includes home- and community-based services, physician services, and all medical care” (NHPF 2003, 18)

State Initiatives: Massachusetts

Just as MSHO combines Medicare and Medicaid benefits, Massachusetts’ Senior Care Options (SCO) follows the same logic. Launched in 2004, the Senior Care Options plan serves dual eligibles as well as Medicaid-only beneficiaries (NHPF 2003, 19). The plan has approximately 4,100 members and provides “round-the-clock care” (Meyer 2012, 1153). Using a team of nurses and social workers, SCO delivers coordinated care and benefits to this population (Grabowski 2009, 139). The multidisciplinary teams have proven useful in keeping patients healthy and preventing hospitalizations, emergency department visits, and institutionalization. These improvements can most likely be attributed to some features of the program which include: medical advice from a care coordinator available 24/7, patient

medication and compliance management, close coordination during transitions between care settings, centralized health records available 24/7 to all providers, and tight integration between care coordinators and primary care and specialty physicians (Meyer 2012, 1154). Massachusetts is able to fund SCO through a waiver that allows for the use of both Medicaid and Medicare funds (Lynch 2007, 14).

The three programs offered by Minnesota, Wisconsin, and Massachusetts have slight differences but all aim to achieve the same goals. The use of coordinated payment systems and the integration of Medicare and Medicaid benefits intend to lower costs “while maintaining, and perhaps improving, the health of beneficiaries” (Grabowski and Bramson 2012, 55). In theory, MSHO, WPP, and SCO all hope to do so but the success has yet to be confirmed. One study found little to no evidence of any savings for any of the three programs because the operational costs of the programs outpaced any potential savings (Brown 2012, 7). Also, MSHO and WPP were found to reduce hospitalizations but did not bring in savings because “the capitated payments were set higher than the amount Medicare would have spent for the dual eligibles under the traditional fee for service program” (2). Despite the improvement of reduced hospitalizations, other studies found that this progress still did not carry much weight. For example, a study found that WPP enrollees had unadjusted mean monthly hospital admission rates of 52.8 per 1,000 enrollees compared with 35.7 for PACE enrollees. Similarly with emergency room visits, there were 82.3 per 1,000 WPP enrollees compared with 62.2 per 1,000 PACE enrollees (*Report 2012, 77*). In order to fully evaluate the efficiency and effectiveness of these three programs, much more data is necessary; however, it seems as though these state initiatives have not found an effective integrated system for dual eligible beneficiaries in which costs are lowered and quality of care is maintained, if not improved.

Program of All-Inclusive Care for the Elderly (PACE)

In addition to the state initiatives, the integrated Program of All-Inclusive Care for the Elderly (PACE) intends to improve the care of dual eligible beneficiaries while controlling costs. PACE coordinates Medicare and Medicaid benefits by providing “all services covered by Medicare and a given state’s Medicaid program” (Gold, Jacobson, and Garfield 2012, 1177). This includes behavioral health services, medical care, and long-term care among others (*Report* 2012, 67). In 2001, more than seventy organizations in thirty states began working on PACE developments (Mui 2001, 60). Today, there are 21,000 enrollees between the 84 different PACE sites spread throughout 29 states. Enrollment in each individual site ranges from twenty to 2,600 but two-thirds of these PACE programs have enrolled fewer than thirty beneficiaries (*Report* 2012, 68). However, once individuals join the program, satisfaction seems rather high, shown in the low numbers of disenrollment and the reenrollment of those who did withdraw from the program at one point or another (69).

“PACE was designed specifically for frail elderly people at risk of entering a nursing home” (Neuman 2012, 1189). In order to participate in the program, members must be 55 years or older and nursing home certifiable. Determining whether or not beneficiaries qualify for a nursing home level of care varies by state but this usually includes having a cognitive impairment or two or more Activity of Daily Living (ADL) problems (*Report* 2012, 68/Lynch 2007, 5). Participants are typically dual eligibles and characteristically white females, age 75 or older (*Report* 2012, 69). The program’s goal is to maintain a sort of involved community life for these participants rather than simply putting them in long term care institutions (68). PACE

intends to encourage the autonomy of the beneficiary while providing quality care for less. In addition to the program's operation in the members' benefit, there is effective integration of acute and long-term care, which reduces fragmentation in the delivery of care (Mui 2001, 59).

This comprehensive system – one of the few fully integrated programs – seems to be tailored to individual needs. PACE “takes into account the elderly person's medical condition, mental functioning, living environment, and the quality and quantity of the person's informal support system” (Mui 2001, 60). Because individual plans are developed for each participant, there have been many positive results. Research has shown that PACE beneficiaries “had fewer hospitalizations and nursing home admissions and lower mortality than similar beneficiaries who were not enrolled in PACE” (*Report 2012*, 76). Likewise, compared with individuals who decline PACE enrollment, those who participate in the program have “lower rates of nursing home utilization and in-patient hospitalization, higher utilization of ambulatory services, better health status and quality of life, and less physical function deterioration” (Lynch 2007, 7). However, there may be a selection bias at work. Evidence has shown that PACE attracts disproportionately healthy enrollees (Grabowski 2009, 138). More importantly, state variations play a major role in this potential “creaming”, or enrolling less costly participants, because states can control the negotiations on important matters such as the Medicaid portion of the capitation payment (Lynch 2007, 8). It is crucial to keep in mind these factors, because cream skimming ultimately affects the validity of the results and outcomes.

Despite the overall encouraging outcomes (although the veracity of them remains uncertain), cost has continued to be an issue. It has been suggested that the “established capitation rates for both Medicare and Medicaid have been set too high for this intensive program to generate net cost savings”. Although there was a reduction in hospitalizations, a

study by Foster et al. (2007) found that “the Medicare capitation rate yielded total expenditures under PACE that were very similar to what enrollees would have incurred had they been in Medicare FFS (Medicaid costs were substantially higher under PACE than what enrollees would have cost had they remained in Medicaid FFS)” (Brown 2012, 10).

More importantly, 21,000 enrollees is an extremely low number when considering the dual eligible population of well over nine million beneficiaries. This is less than 1% of total beneficiaries who enroll in PACE (*Report 2011*, 133). One problem could potentially be utilization management. PACE programs “receive separate capitation payments from Medicare and Medicaid and blend those funds” to cover a multitude of health services (*Report 2012*, 68). However, although these payments are large, the needs of the PACE population are very high in number. Hence, in order to better function and attract participants, as well as to ensure financial security, the program must closely manage utilization among varied services (Lynch 2007, 6). There also seems to be significant enrollment barriers, starting with the most obvious: the criteria for eligibility – 55 or older and nursing home certifiable (*Report 2012*, 62). Additional enrollment barriers include Medicare regulations, state processes, methods for certifying beneficiaries as eligible for a nursing home level of care, enrollees having to change their primary care physician to the PACE physician, the need to attend the day care center and the restriction of enrollment to only the first day of each month (due to the fact that PACE providers receive a prospective per enrollee payment from Medicare and Medicaid at the beginning of each month) (74). PACE also has to maneuver between each individual state’s “willingness to process PACE applications or negotiate the Medicaid portion of the capitation payment, given concerns about the high cost of providing the benefit” (Lynch 2007, 8). Although PACE has remained rather small in magnitude, most likely because of enrollment barriers, it is considered

to be a successful one-stop, integrated program that provides a range of services from both Medicare and Medicaid (Mui 2001, 60).

Dual-eligible Special Needs Plans (D-SNPs)

Another attempt at integration has been the Dual-eligible Special Needs Plans. Dual-eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage plan that specifically enrolls dual eligible beneficiaries (*Report 2012*, 62). D-SNPs intend to “combine Medicare and Medicaid managed care contracting for dually eligible beneficiaries” and “encourage a more efficient production of health care services across the two programs” through a model of capitated payment (Grabowski 2009, 137). In 2005 there were forty-two D-SNPs; this increased to 439 in 2008, when approximately 854,877 dual eligibles were enrolled (140). In 2011, about 11% of dual eligibles were part of D-SNPs (*Report 2011*, 128); today there are approximately 320 D-SNPs that enroll 1.16 million dual eligibles, or about 10% of the dual eligible population (*Report 2012*, 82).

D-SNPs are technically not integrated but they can be if a plan also has a contract with a state to provide Medicaid benefits. “Most D-SNPs are not integrated programs because they do not also receive a Medicaid payment to manage Medicaid benefits” (*Report 2011*, 124).

Although the majority of D-SNPs are currently not integrated, they will be required to have a state contract to cover Medicaid benefits by 2013, which is a step in the right direction for integration. Still, even if D-SNPs do have a state contract, integration of Medicare and Medicaid benefits is not guaranteed because, paradoxically, states are not required to enter into contracts with D-SNPs (*Report 2012*, 82). Because of the high dependency on state Medicaid policies,

enrollment varies throughout the nation. In 2011, 43% of Arizona's dual eligibles were enrolled in D-SNPs, Minnesota D-SNPs enrolled 33% of its duals, and Hawaii enrolled 31%. "In contrast, in 18 states, less than 2% of dual eligibles [were] enrolled in SNPs" (Gold, Jacobson, and Damico 2011, 4). Enrollment is highly dependent on Medicaid benefits offered within each D-SNP and, because it is at each state's discretion what to include and provide within their Medicaid program, there is much variation. Although D-SNPs lack in Medicaid benefits coverage due to state differences, there are plans that contract with states to cover most or all of Medicaid services. These subsets of D-SNPs, or fully integrated dual eligible special needs plans (FIDE-SNPs), have contracts to provide a wider range of the services – if not complete – that D-SNPs do not cover, such as long term care (*Report 2012*, 62). However, in 2010, "fewer than 2% of dual eligibles were in integrated SNPs that provided both Medicare and Medicaid benefits" (Gold, Jacobson, and Garfield 2012, 1178)

It is important to note that enrollment in D-SNPs relies heavily on the benefits and value the plan offers to the beneficiary (Grabowski 2009, 138). D-SNPs may not necessarily give certain dual eligibles an incentive to join, especially with the existing system they currently find themselves in, characterized by low out-of-pocket costs and unrestricted access to services and benefits. More importantly, because the dual eligible population is so heterogeneous with specific and varying needs – "ranging from younger beneficiaries with debilitating mental disabilities to older enrollees, with physical and cognitive impairments, living in nursing homes or trying to maintain their independence at home" – D-SNPs encounter much difficulty in providing all necessary and fitting services (Gold, Jacobson, and Damico 2011, 5). D-SNPs also face other barriers in regards to coordinating and providing benefits and services to enrollees including the alignment of incentives, inability to coordinate care due to conflict between federal

and state approaches for managed care, and the lack of data sharing across Medicare and Medicaid (Grabowski 2009, 139). Uncertainty seems to exist in regards to “how well benefits and services are in fact being coordinated for most dual-eligible SNP enrollees” (138). Although 2013 will bring about changes with the requirement of state contracts, the effectiveness of this modification in coordinating care, services, and benefits is unclear (Gold, Jacobson, and Damico 2011, 5). It appears D-SNPs need to focus their attention on partnerships with states in order to move forward (Grabowski 2009, 142).

Although there have been – and there continues to be – varied proposals and efforts to integrate and better coordinate care for dual eligibles, the efforts thus far seem to fall short. One of the main contributing factors is that dual eligibles’ participation in managed care plans cannot be mandated (United States Cong. 2004, 82). Hence, it is not surprising that “more than 80% of dual eligibles remain in traditional fee-for-service Medicare, fee-for-service Medicaid, and a “stand-alone” Medicare prescription drug plan” (Clemens-Cope 2011, 2). Dual eligibles simply do not have sufficient incentives to move into managed care, which explains why fewer than 2% of all dual eligible beneficiaries are in “some type of integrated care program that coordinates some or all services” (*Report* 2011, 124). Even worse, only 12,000 dual eligibles are enrolled in fully integrated plans (Neuman 2012, 1189).

These attempts to coordinate care have plenty of potential to improve, access to, quality of, and costs of care but these programs are small in number and enrollment (*Report* 2011, 119). There are also numerous barriers to the development of integrated programs. Some barriers include but are not limited to “lack of experience with managed care for long term care services, resistance from providers and other stakeholders, states wanting to share in savings that accrue to the Medicare program, and separate Medicare and Medicaid administrative procedures” (*Report*

2012, 68). Past and current attempts offer lessons for policy implementation such as the importance of alignment between and support from states. Not only are regional differences critical in making policy decisions, but also differences among this high-risk, sickly, and costly population demonstrate the difficulty in addressing the specific needs of each individual. Integrating and coordinating care for dual eligibles will undoubtedly remain a challenge but there is certainly a strong case to be made for a continued push in this direction.

What has the ACA done so far? What does it plan to do?

The Affordable Care Act was proposed in 2010 and contains many provisions targeted at the costly and sickly population of dual eligible beneficiaries. The main goal of these new policies – some of which are currently in the works as well as some which have later implementation dates – is to reduce costs while trying to better coordinate and improve the care of this population. As discussed, this special group of government beneficiaries accesses services from both Medicare and Medicaid; consequently many provisions of the ACA strictly and/or predominantly directed towards each of these distinct programs will also affect costs, care, access, benefits, etc. of dual eligible beneficiaries.

One of the first steps taken towards integrating care for the dual eligible population is the ACA's authorization of a new Medicare-Medicaid Coordination Office within the Centers for Medicare and Medicaid Services (CMS). This office carries the responsibility of ensuring that dual eligible beneficiaries receive coordinated care that meets their health care needs. Specifically, the office must develop and, furthermore, implement new models of care and financing in order to meet this responsibility (Gold, Jacobson, and Garfield 2012, 1176). CMS in general is working on innovations to improve care in the fee-for-service program as well as

focusing on expanding the scope of managed care plans through improvement of existing models all while bringing new ideas to the table (Neuman 2012, 1188).

One of the most noted efforts of the CMS thus far has been the state demonstrations, which are currently still works in progress. In July 2011, CMS announced the new Financial Alignment Initiative “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” (Neuman 2012, 1188). Fifteen states were awarded design contracts to develop service delivery and payment models to integrate care for dual eligibles (“Explaining” 2012, 2). These states were California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. The proposals submitted to CMS from each state will vary in “service delivery models, target populations, benefits packages, financing, beneficiary protections, and stakeholder involvement” (Grabowski 2012, 226). It is crucial to note “CMS will not approve a demonstration unless the capitated rate provides upfront savings to both CMS and the state” (“Explaining” 2012, 4). The demonstrations will be tested under two approaches: a capitated model and a managed fee-for-service approach. The capitated approach involves a three-way contract between the CMS, the state and a health plan in which they will negotiate capitation rates (*Report* 2012, 63). “CMS and the state will jointly select and monitor participating plans. Plans will receive a prospective blended rate for all primary, acute, behavioral health, and long-term services and supports. The Medicare and Medicaid payment rates under the capitated model are intended to allow both CMS and the state to share savings” (“Explaining” 2012, 2). This model will essentially test financial and administrative alignment between Medicare and Medicaid (*Report* 2012, 86). In the managed fee-for-service approach,

“states will recognize care delivery and retrospectively receive a share of savings reaped by Medicare” (Meyer 2012, 1153). “The state will be eligible for a retrospective performance payment if a target level of Medicare savings, net of increased federal Medicaid costs, and specified quality thresholds are met” (“Explaining” 2012, 2).

As of April 2012, additional states - other than the original fifteen that were awarded funding by the CMS - released proposals for demonstrations. Nine states released proposals for the capitated model for a 2013 start date, another nine states released proposals for the capitated model for a 2014 start date, and five states released proposals for the managed fee-for-service model for a 2013 start date (*Report* 2012, 86). Washington, California, Colorado, Oklahoma, Iowa, Illinois, Wisconsin, Michigan, Ohio, New York, North Carolina, Massachusetts and Connecticut are among the states that have proposed a 2013 start date; Oregon, Idaho, Arizona, Texas, Hawaii, Tennessee, South Carolina, Virginia, Vermont, and Rhode Island propose to start in 2014 (“Explaining” 2012, 1). These demonstrations “are an opportunity to test how to encourage care coordination, improve quality of care, and reduce spending by reducing some of the conflicting financial incentives between Medicare and Medicaid” (*Report* 2012, 86-87). However, once again, the dual eligible population is heterogeneous, which is a crucial factor that must be taken into consideration. This is essentially an experiment with a specific population’s health care so it is important that dual eligibles receive quality care and have alternatives if their needs are not met during the demonstrations (87). Although cost control of the dual eligible population is one of the main concerns, these state demonstrations must also maintain a focus on the quality of care while testing these financial models.

While these state demonstrations remain in progress and the results will be inconclusive for the next few years to come, the ACA intends to continue forward with other changes outlined

in additional provisions. Firstly, it will establish new federal entities targeted at the dual eligible population, including the two prominent ones of a Federal Coordinated Health Care Office (FCHCO or Duals Office) and a Center for Medicare and Medicaid Innovation (CMMI) – both within CMS. The FCHCO aims to improve access and care coordination while simultaneously increasing quality of care and decreasing costs. They plan to do this by “integrating various services in order to eliminate redundancy and friction between Medicare and Medicaid” (Grabowski 2012, 225-226). FCHCO will be responsible for providing relative entities (those involved in the care of dual eligibles) with all necessary resources to help develop programs that will better align benefits (“Affordable” 2011, 1). In order to track the efficacy of this objective, annual reports will be required, “containing recommendations for improving care coordination and benefits for dual eligibles” (2). Meanwhile, the CMMI will test and assess new payment models in order to determine the best methods for improving quality and lowering costs of the care provided to dual eligible beneficiaries (Grabowski 2012, 226).

In addition to the establishment of these entities, there are plenty of provisions directed at the problems of costs and quality of care for dual eligibles. Some include “integration of hospital and physician care (Section 2704), value-based payment modifier for physicians (Section 3007), accountable care organizations (Section 3022), bundled payment demonstration (Section 3023), hospital readmissions reduction program (Section 3025), support for medical homes (Section 3502), medication management (Section 3503)” (Grabowski 2012, 227). Many of these are radically new approaches, such as accountable care organizations (ACOs). ACOs intend to simultaneously improve care and reduce costs by “encouraging better care coordination (for example, provider communication across care settings); providing incentives for prevention and management of chronic diseases (for example, increased focus on primary care; disease

management programs); and reducing overutilization (for example, emergency department use)” (Lewis 2012, 1777).

There are also a handful of provisions that will work more specifically with addressing the quality and costs of care within each of the programs of Medicare and Medicaid. For example, Section 2703 establishes health homes for the chronically ill, which “could be a first step toward more integrated care for duals” (“Affordable” 2011, 1). These health homes will essentially be an extension of the medical home models currently present in many Medicaid programs, intending to “[enhance] coordination and integration of physical and behavioral health care, and acute and long-term care, and [build] linkages to community-based social services and supports”. The health homes aim to improve health outcomes and patient experiences while providing cost-effective care (“How” 2012, 7). Similar to this Medicaid option, there is also an at home Medicare demonstration project for “Medicare beneficiaries with at least two chronic conditions, at least two function dependencies and a non-elective hospital stay within the past year” (“Affordable” 2011, 3). Apart from these provisions, there are additional ACA components specific to the two programs of Medicare and Medicaid. Regarding Medicare, there will be changes to Medicare Part D and Medicare Advantage plans such as elimination of cost sharing and extending the authority for MA plans for SNP individuals (5). Concerning Medicaid, long-term care provisions will be implemented such as the Community Living Assistance Services and Supports (CLASS) Program which will “allow individuals to make voluntary payroll deductions” and help them move towards independence in the community (6).

What does the future hold?

Although the ACA is taking steps in the right direction, that may be the extent of its success in addressing the complex problems within the dual eligible population. All of the provisions mentioned – along with numerous ones that were not discussed – will most certainly tackle various aspects of the difficulties in caring for this elderly and sickly population. Yet, on an aggregate level, accomplishing the goal of reducing costs while improving – or, at least, maintaining – the care of dual eligible beneficiaries seems dismal.

Much has been learned from previous reform efforts and attempts for the integration of care for dual eligibles. They have all led to the same conclusion: to achieve this level of change, a different approach needs to be taken. One of the main challenges within this population is the diversity of this group regarding their conditions and needs. Because of this, policymakers must take into account the fact that “one size does not fit all” (Neuman 2012, 1188). It has been suggested that, if programs are designed to meet specific needs of different types, there will be improved efficiency, value, and access for the dual eligibles (Coughlin 2012, 1090). For example, PACE was designed specifically for the elderly who would potentially be entering a nursing home. Although it was successful in improving quality of care – i.e., reducing hospitalizations – it still proved costly, which provides a subsequent lesson: policymakers must not guarantee savings before they materialize (1191). Grabowski argues that most of the ACA provisions target “either care delivery or payment, but not both” (Grabowski 2012, 227). It is believed that if targeted care was established for specific subsets of this population then there exists much potential to achieve savings (Brown 2012, 3).

In addition to the need to tailor care efforts for dual eligibles, it seems a mandate for state participation in integration plans and programs may be necessary to get this population into better-managed, coordinated and integrated care. As of right now, dual eligibles cannot be

mandated into managed care, which is a huge cost factor (United States Cong. 2004, 82). These beneficiaries do not have any incentives to shift over from the current uncoordinated care between Medicare and Medicaid because they are able to unrestrictedly access services at low out-of-pocket costs. Many also fear a switch may restrict their networks, force them to switch providers, go to new locations for care, or take away their independence in regards to choice (*Report 2011*, 125-126). As mentioned, only 2% of dual eligibles are currently enrolled in fully integrated plans, which is simply not sufficient for this population nearing ten million individuals. As learned from the implementation of the PACE program, “collaboration and cooperation among all planners and clinicians are keys to success” (Mui 2001, 63). In a similar manner, D-SNPs proved more effective in states that had the capacity to coordinate with these plans (Grabowski 2009, 142). With this being said, it seems a key feature to moving forward will be a mandate for state participation. When considering switching out of the tradition fee-for-service models of Medicare and Medicaid, the dual eligibles placed a heavy emphasis on the benefits they would receive in comparison to their current benefits – specifically Medicaid benefits. Until this point, it has been extremely difficult to bring about state participation, which determines the scope of Medicaid benefits offered by any type of integration plan. Although D-SNPs will be required to have a state contract to cover Medicaid benefits by 2013, integration of Medicare and Medicaid benefits is not guaranteed because, paradoxically, states are not required to enter into contracts with D-SNPs. It is assumed that, with greater state participation – and, consequently, increased Medicaid benefits – in integrated programs, beneficiaries will be more likely and willing to move away from the traditional fee-for-service system given this new appeal of coordinated care.

Conclusion

Efforts to reform and make changes within the health care system of dual eligibles have continually proven very difficult for a variety of factors. Some of these challenges include lack of experience, resistance from participants – both on the provider side and consumer side – low enrollment in these reform efforts, and simply the lack of coordination between Medicare and Medicaid that continues to persist (*Report 2012*, 68). Although there have been many problems concerning the integration of care among dual eligible beneficiaries, it is not an impossible task. Previous efforts such as PACE and D-SNPs, have provided valuable lessons in moving forward. The ACA does address certain aspects of this population and problematic areas; however, it is unclear how successful it will be in simultaneously improving care while reducing costs. In order to generate modest savings within these two programs, tailoring, targeting, and monitoring will be required (Brown 2012, 4). Also, in order for integration to truly be effective in achieving these goals, there must be a bigger effort and contribution on the states' parts, which, it seems, will require a mandate for state participation. Until reform efforts and model designs focus more narrowly on the diverse needs of this heterogenic population and get states more actively involved, policymakers may find themselves at an impasse for successful reform.

Policymaking is no easy task, which is why reforming care for dual eligibles continues to be a difficult battle and most likely will remain so for years to come. Some challenges policymakers will encounter in integrating care for the dual eligible population include “the pairing of payment and delivery reforms, the need to engage Medicaid, the feasibility of federalizing Medicaid (or de-federalizing Medicare), and compulsory enrollment in managed care” (Grabowski 2012, 230). More importantly, policymakers must consider the potential

outcomes of new approaches such as whether or not the quality of care will improve or be adversely affected, the types of restriction and regulations that will be put into effect, what steps will be taken to maintain the patient-provider relationship, how will savings be achieved for Medicare and Medicaid, and how the new approaches will be monitored and evaluated for effectiveness (Jacobson 2012, 8).

There is no doubt this task will come with many obstacles, for uncertainty is the biggest challenge in policy making. Ultimately, no one knows which approach will work best for integrating care for dual eligible beneficiaries. However, policymakers must push forward; this vulnerable, sickly, frail, and needy population has simply become too costly. It is indisputable that savings are possible with the right reform. With a tailored approach to address the diverse needs of these individuals, along with a mandate for state participation, there may be hope after all for improvements in care for dual eligible beneficiaries while simultaneously reducing the costs of this population.

Bibliography

- “Affordable Care Act Provisions Relating to the Care of Dually Eligible Medicare and Medicaid Beneficiaries.” Washington, DC: Kaiser Family Foundation Focus on Health Reform, May 2011.
- Brown, Randall and David R. Mann. “Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence.” Washington, DC: Kaiser Family Foundation Medicare Policy, October 2012.
- Bubolz, Thomas, Constance Emerson, and Jonathan Skinner. "State Spending on Dual Eligibles under Age 65 Shows Variations, Evidence of Cost Shifting from Medicaid to Medicare." *Health Affairs* 31.5 (2012): 939-947. Health Policy Reference Center. Web. 29 Sept. 2012.
- Clemans-Cope, Lisa, and Timothy Waidmann. "Improving Care for Dual Eligibles through Innovations in Financing." *New England Journal of Medicine* 365.11 (2011): N.PAG. Health Policy Reference Center. Web. 30 Sept. 2012
- Coughlin, Teresa A., Timothy A. Waidmann, and Lokendra Phadera. "Among Dual Eligibles, Identifying the Highest-Cost Individuals Could Help in Crafting More Targeted and Effective Responses." *Health Affairs* 31.5 (2012): 1083-1091. Health Policy Reference Center. Web. 30 Oct. 2012
- “The Diversity of Dual Eligible Beneficiaries: An Examination of Services and Spending for People Eligible for Both Medicaid and Medicare.” Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2012.
- “Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries.” Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2012.

Gold, Marsha, Gretchen Jacobson, Tricia Neuman, and Anthony Damico. "Special Needs Plans: Availability and Enrollment." Washington, DC: Kaiser Family Foundation Program on Medicare Policy, September 2011.

Gold, Marsha R., Gretchen A. Jacobson, and Rachel L. Garfield. "There Is Little Experience and Limited Data to Support Policy Making on Integrated Care for Dual Eligibles." *Health Affairs* 31.6 (2012): 1176-1185. Health Policy Reference Center. Web. 27 Sept. 2012.

Grabowski, David C. "Care Coordination For Dually Eligible Medicare-Medicaid Beneficiaries Under The Affordable Care Act." *Journal Of Aging & Social Policy* 24.2 (2012): 221-232. Health Policy Reference Center. Web. 28 Nov. 2012

Grabowski, David C. "Special Needs Plans and the Coordination of Benefits and Services for Dual Eligibles." *Health Affairs* 28.1 (2009): 136-146. Health Policy Reference Center. Web. 21 Oct. 2012.

Grabowski, David C., and Jeffrey Bramson. "State Initiatives to Integrate the Medicare and Medicaid Programs for Dually Eligible Beneficiaries." *Generations* 32.3 (2008): 54-60. Health Policy Reference Center. Web. 4 Oct. 2012.

"How is the Affordable Care Act Leading to Changes in Medicaid Today? State Adoption of Five New Options." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2012.

Jacobson, Gretchen, Tricia Neuman, and Anthony Damico. "Medicare's Role for Dual Eligible Beneficiaries." Washington, DC: Kaiser Family Foundation Medicare Policy, April 2012.

Kane, Robert L., Patty Homyak, and Boris Bershady. "Consumer Reactions to the Wisconsin Partnership Program and its Parent, the Program For All-Inclusive Care of the Elderly (PACE)." *Gerontologist* 42.3 (2002): 314. Health Policy Reference Center. Web. 30 Oct. 2012.

Lewis, Valerie A., Bridget Kennedy Larson, Asha Belle McClurg, Rebecca Goldman Boswell, and Elliott S. Fisher. "The Promise And Peril Of Accountable Care For Vulnerable Populations: A Framework For Overcoming Obstacles." *Health Affairs* 31.8 (2012): 1777-1785. Health Policy Reference Center. Web. 28 Nov. 2012

Lynch, Marty, Mauro Hernandez, and Carroll Estes. "PACE: Has It Changed the Chronic Care Paradigm?" *Social Work In Public Health* 23.4 (2007): 3-24. Health Policy Reference Center. Web. 29 Sept. 2012.

Meyer, Harris. "The Coming Experiments in Integrating and Coordinating Care for 'Dual Eligibles'." *Health Affairs* 31.6 (2012): 1151-1155. Health Policy Reference Center. Web. 14 Oct. 2012.

Mui, Ada C. "The Program of All-Inclusive Care for The Elderly (PACE): An Innovative Long-Term Care Model in the United States." *Journal Of Aging & Social Policy* 13.2/3 (2001): 53. Health Policy Reference Center. Web. 30 Sept. 2012.

NHPF Issue Brief: "Serving Complex Populations: Program Options". NHPF No. 794 (2003). Health Policy Reference Center. Web 4 Nov. 2012.

Neuman, Patricia, Barbara Lyons, Jennifer Rentas, and Diane Rowland. "Dx For a Careful Approach to Moving Dual-Eligible Beneficiaries into Managed Care Plans." *Health Affairs* 31.6 (2012): 1186-1194. Health Policy Reference Center. Web. 12 Oct. 2012.

Parker, Pam, and Amy Sander. "Coordinated Care for Dual-Eligibles: Minnesota Senior Health Options." *Policy & Practice of Public Human Services* 59.4 (2001): 26. Health Policy Reference Center. Web. 27 Oct. 2012.

Report to the Congress: Medicare and the Health Care Delivery System. Washington, DC: Medicare Payment Advisory Commission (MedPAC), June 2011.

Report to the Congress: Medicare and the Health Care Delivery System. Washington, DC: Medicare Payment Advisory Commission (MedPAC), June 2012.

United States Cong. The Medicare Payment Advisory Commission (MedPAC). *MedPAC: Advising the Congress on Medicare Issues.* Cong. Rept. N.p., June 2004. Web. 29 Sept. 2012. <http://www.medpac.gov/publications/congressional_reports/June04_ch3.pdf>.

Young, Katherine, Rachel Garfield, Marybeth Musumeci, Lisa Clemans-Cope, and Emily Lawton. "Medicaid's Role for Dual Eligible Beneficiaries." Washington, DC: Kaiser Commission on Medicaid and the Uninsured, April 2012.