



**U.S. House Committee on Energy & Commerce  
Subcommittee on Health**

**Dual-Eligibles: Understanding This Vulnerable Population and  
How to Improve Their Care  
June 21, 2011**

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, thank you for the invitation to discuss the Center for Medicare & Medicaid Services' (CMS) efforts to integrate care for individuals who are enrolled in both the Medicare and Medicaid programs (Medicare-Medicaid enrollees). The Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office, was established by Section 2602 of the Affordable Care Act to more effectively integrate the Medicare and Medicaid benefits and to improve the coordination between the Federal and State governments for individuals enrolled in both the Medicare and Medicaid programs. A Federal Register notice officially establishing the Medicare-Medicaid Coordination Office was published on December 30, 2010.

**Background**

The Medicare and Medicaid programs were originally created as distinct programs with different purposes. Not surprisingly, the programs have different rules for eligibility, covered benefits, and payment. Over the past 40 years, the Medicare and Medicaid programs have remained separate systems despite a growing number of individuals who utilize both programs for their health care. Many individuals become eligible for Medicare first, and then qualify for Medicaid as a result of an income-changing event. Others qualify for Medicaid initially and then in turn qualify for Medicare because of their age or disability. As the number of individuals who rely on both programs for their coverage grows, there is an increasing need to align these programs so that they better serve enrollees.

Today, more than 9 million Americans are enrolled in both the Medicare and Medicaid programs; two-thirds are low-income elderly, and one-third are under 65 and are disabled.<sup>1</sup> Additionally, Medicare-Medicaid enrollees include higher proportions of female, African-American, and Hispanic individuals than in the Medicare-only population. Medicare-Medicaid enrollees must navigate two separate programs for their care—Medicare for coverage of basic acute health care services and drugs, and Medicaid for coverage of supplemental benefits such as long-term care supports and services. Medicaid also provides help with Medicare premiums and cost-sharing for those who need additional financial assistance. A lack of alignment and cohesiveness between the programs can lead to fragmented or episodic care for Medicare-Medicaid enrollees and misaligned incentives for both payers and providers, resulting in reduced quality and increased costs to both programs and to enrollees.

People enrolled in both Medicare and Medicaid tend to have the most complex, chronic illnesses, and therefore they are some of the highest cost individuals within the Medicare and Medicaid programs. Total annual spending for their care is estimated at \$300 billion annually across both programs. In the Medicaid program, these individuals represented 15 percent of enrollees and 39 percent of all Medicaid expenditures. In Medicare, they represented 16 percent of enrollees and 27 percent of program expenditures.<sup>2,3</sup> Compared to all other Medicare enrollees, Medicare-Medicaid enrollees' health costs are nearly five times greater. Compared to all other Medicaid enrollees, Medicare-Medicaid enrollees' health costs are nearly 6 times greater. They are three times more likely to have a disability, and overall these individuals have higher rates of diabetes, pulmonary disease, stroke, Alzheimer's disease, and mental illness.<sup>4</sup> These statistics demonstrate the tremendous opportunities available to improve the individual care experience by raising quality, and to lower costs through improved health outcomes for this population.

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<sup>1</sup> Based on the Centers for Medicare & Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office for Research, Development and Information, July 2010.

<sup>2</sup> The Medicare Payment Advisory Committee (MedPAC), A Data Book: Healthcare spending and the Medicare program, June 2010. Available at: [http://www.medpac.gov/documents/Jun10\\_EntireReport.pdf](http://www.medpac.gov/documents/Jun10_EntireReport.pdf).

<sup>3</sup> Kaiser Family Foundation, The Role of Medicare for the People Dually Eligible for Medicare and Medicaid. January 2011. Available at: <http://www.kff.org/medicare/upload/8138.pdf>

<sup>4</sup> Chronic Disease and Co-Morbidity among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured, 1. Kaiser Family Foundation. July 2010. Available at: <http://www.kff.org/medicaid/upload/8081.pdf>

Too often, the care journey for these individuals is fragmented and uncoordinated. Therefore, this population could benefit the most from integrated systems of care that ensure all their needs – primary, acute, long-term care, behavioral and social – are met in a high quality, cost effective manner. Better alignment of the administrative, regulatory, statutory, and financing aspects of these two programs promises to improve the quality and cost of care for this complex population.

The Medicare-Medicaid Coordination Office’s mission is to address and improve the beneficiaries’ experiences, access to care, quality of care, and cost of benefits for individuals enrolled in both the Medicare and Medicaid programs. To that end, the Medicare-Medicaid Coordination Office is engaged in ongoing discussions with key internal and external stakeholders, including beneficiary advocates, provider organizations, MedPAC, MACPAC and State Medicaid agencies, to work together to advance high quality, seamless care for Medicare-Medicaid enrollees. The Office is also working to improve collaboration and communication between Medicare and Medicaid program offices within CMS and across other Federal agencies.

### **The Need for Coordinated Care**

#### ***Partnerships with the States***

The 9 million Medicare-Medicaid enrollees accounted for approximately \$120 billion in combined Medicaid Federal and State spending in 2007 – almost twice as much as Medicaid spent on all 29 million children it covered in that year.<sup>5</sup> While spending on Medicare-Medicaid enrollees varies by State, it accounts for more than 40 percent of all combined Federal and State Medicaid spending in 26 States, more than half of such spending in 4 States (Connecticut, New Hampshire, North Dakota and Wisconsin) and not less than a quarter of total spending in any State.

States alone spent more than \$50 billion in 2007 to support the health and long-term care costs of people enrolled in Medicare. The average Medicaid spending per beneficiary on Medicare-Medicaid enrollees was \$15,459 in 2007, more than six times higher than the comparable cost of

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<sup>5</sup> Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. December 2010. <http://www.kff.org/medicaid/7846.cfm>

a non-disabled adult covered by Medicaid (\$2,541).<sup>6</sup> This spending mostly reflects the significant costs associated with a population with low income and high health care needs; however, there are opportunities for savings through improved care coordination, simplification, and alignment of some Medicare and Medicaid rules. In 2007, roughly 5 percent of Medicaid spending for Medicare-Medicaid enrollees went to acute care services. This is a relatively low figure, compared to the 70 percent of Medicaid spending for Medicare-Medicaid enrollees' long-term care services, which are mostly not covered by Medicare or private insurance.

Too often, the current approach to financing care for those eligible for Medicare and Medicaid provides a financial incentive to push costs back and forth between the States and the Federal government. Better coordination and partnerships between the two levels of government will eliminate these incentives and focus on finding the care setting that is most appropriate for the beneficiary, independent of who is paying for it. This is a complex problem and not something that CMS can fix on its own. We are relying on collaboration with our partners in the States to find real solutions that, through better care coordination, will improve the experience and quality of care for beneficiaries and reduce costs. The Medicare-Medicaid Coordination Office is working to facilitate innovation by nurturing these vital State-Federal relationships.

### ***Better Care for People***

The Medicare-Medicaid Coordination Office has been working to improve Medicare-Medicaid enrollees' satisfaction, program awareness, health, functional status, and well-being. Most individuals enrolled in both Medicare and Medicaid are not receiving coordinated care. Our goal is to assure that Medicare-Medicaid enrollees are receiving high quality and person-centered acute, behavioral, and long-term care services and supports.

To further this mission, our Office has worked in concert with the Center for Medicare and Medicaid Innovation, the Center for Medicaid, CHIP and Survey & Certification and the Center for Medicare within CMS to foster significant reforms across the health care delivery system that will improve the coordination of care for all patients, including low-income beneficiaries, many

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<sup>6</sup> Kaiser Family Foundation, Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007. December 2010. <http://www.kff.org/medicaid/7846.cfm>

of whom are Medicare-Medicaid enrollees. One example of such an initiative is the Partnership for Patients, an investment of up to \$1 billion in patient safety initiatives that are designed to improve coordination of care and reduce preventable hospital-acquired conditions. The Partnership for Patients hopes to take these safety efforts to scale, which could save tens of thousands of lives, avoid millions of preventable injuries, and save Medicare and Medicaid billions of dollars over time.

The Partnership for Patients, which aims to prevent hospital readmissions and hospital-acquired conditions will help drive better care for Medicare-Medicaid enrollees. In a recent CMS study, 27 percent of the Medicare-Medicaid enrollees were hospitalized at least once during the year, totaling almost 2.7 million hospitalizations.<sup>7</sup> More than a quarter of these hospital admissions may have been avoidable, either because the condition itself could have been prevented (e.g., a urinary tract infection), or the condition could have been treated in a less costly and more appropriate setting (e.g., adult asthma). The study projects that the total costs for potentially avoidable hospitalizations for Medicare-Medicaid enrollees will be between \$7 and \$8 billion for 2011.<sup>7</sup> Providing appropriate, coordinated and integrated care may be able to prevent unnecessary hospitalizations, which would allow these individuals to remain independently at home while saving scarce health care resources.

### ***Benefits of Integrated Care***

A real-life example of the significant benefits of integrated care for people enrolled in both Medicare and Medicaid is a 77 year old woman named Mattie. Mattie is a fiercely independent woman who lives alone but requires significant personal assistance to maintain independence. She has diabetes, depression, and hypertension, and over the years has suffered three strokes, resulting in left-side weakness and limited mobility. Before receiving integrated care, she fell frequently, had inadequate food intake, and had three potentially avoidable hospitalizations that resulted from poorly controlled diabetes. In addition, she faced difficulties making her medical appointments because of mobility limitations, challenges accessing and managing personal care

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<sup>7</sup> Centers for Medicare & Medicaid Services, Center for Strategic Planning, Policy and Data Analysis Group Policy Insight Report: Dual Eligibles and Potentially Avoidable Hospitalizations, 2011. Available at: [http://www.cms.gov/reports/downloads/Segal\\_Policy\\_Insight\\_Report\\_Duals\\_PAH\\_June\\_2011.pdf](http://www.cms.gov/reports/downloads/Segal_Policy_Insight_Report_Duals_PAH_June_2011.pdf).

attendant services, and problems obtaining mental health services. In order to receive routine medical care, Mattie had to navigate and manage three separate health care systems, with three different benefit structures and three different identification cards—one for Medicare, one for her prescription drug coverage, and one for Medicaid. She had multiple providers that rarely communicated with one another, and her health care decisions were rarely coordinated and were not made from a patient-centered perspective. As a result of all these challenges, her care was fragmented and she was considering nursing home care.

Fortunately, Mattie was able to enroll in a special program that integrates her Medicare and Medicaid covered services and which has at its core a multi-disciplinary care team that assumes full responsibility for all of her care needs. She now has access to the full range of services to meet her needs and keep her at home, including necessary nutrition support, mental health services, and durable medical equipment. In this program, Mattie only has to manage one set of benefits, and has a single insurance card. One year after enrolling in this program her health has improved, and her care costs have been reduced: she has had no falls, achieved diabetic control, improved her mobility, reduced her personal care attendant support needs, and has had no hospital or emergency department contacts since enrollment in the program. Coordinated care has meant that Mattie can maintain her independence and receive high quality care, while Medicare and Medicaid have avoided the high costs of preventable hospitalizations and nursing home care. These outcomes are the care we want to make available to everyone.

### **Initiatives to Date**

The Medicare-Medicaid Coordination Office has already launched a variety of initiatives to meet its Congressional charge to improve access, coordination and cost of care for Medicare-Medicaid enrollees. Our work falls into the following broad areas:

- Program Alignment
- Data and Analytics
- Models and Demonstrations

### ***Program Alignment***

On May 11, 2011, the Medicare-Medicaid Coordination Office launched the Alignment Initiative, an effort to more effectively integrate benefits under the Medicare and Medicaid programs. As stated previously, the lack of alignment between the programs too often leads to fragmented or episodic care for people enrolled in Medicare and Medicaid, which can reduce quality and raise costs. For example, Medicare and Medicaid have different coverage standards for those accessing durable medical equipment. These differences can lead to fragmented care and coverage gaps that could result in patients losing access to the treatments and equipment that help them live at home or in the community. Even temporary coverage gaps can be disruptive and potentially even life-threatening if patients no longer have coverage for wheelchairs or other medical care.

The Alignment Initiative is not simply an effort to catalogue the differences between Medicare and Medicaid, or to make the two programs identical. Rather, it is an effort to advance beneficiaries' understanding of, interaction with, and access to seamless, high quality care that is as effective and efficient as possible. Better alignment of the two programs can reduce costs by improving health outcomes and more effectively and efficiently coordinating care.

The first step in the Alignment Initiative is to identify opportunities to align potentially conflicting Medicare and Medicaid requirements. The Medicare-Medicaid Coordination Office compiled a wide-ranging list of opportunities for legislative and regulatory alignment on areas identified through numerous stakeholder discussions. Those areas fall into the following broad categories: care coordination, fee-for-service benefits, prescription drugs, cost sharing, enrollment, and appeals. We published our list in the Federal Register on May 16, 2011 and are seeking public comment through July 11, 2011.

The Medicare-Medicaid Coordination Office will continue to engage with stakeholders on the Alignment Initiative through regional listening sessions, which are intended to supplement the Federal Register Notice by engaging stakeholders, including beneficiaries and providers, in an open discussion about how to improve care for these individuals. The first of these listening sessions was held for New York and New Jersey on June 1, and the second one took place

yesterday (June 20, 2011) for California, Arizona, Hawaii, Nevada, and several Territories. We are committed to being open and transparent in our efforts to better streamline these programs to ensure more efficient and effective care, and will continue to engage the States and the public as we move forward on this Initiative.

### ***Data to Support Goals***

On May 11, 2011, the Medicare-Medicaid Coordination Office also announced a new process to provide States access to Medicare data to support care coordination for individuals enrolled in both Medicare and Medicaid. Access to Medicare data is an essential tool for States seeking to coordinate care, improve quality, and control costs for their highest cost beneficiaries. For example, a State that wants to expand its long-term care and behavioral health care management program to serve low-income seniors and people with disabilities needs data on its Medicare-covered hospital, physician, and prescription drug use. With Medicare data, States can identify high risk and high cost individuals, determine their primary health risks, and provide comprehensive individual client profiles to their care management contractors to tailor interventions. The ability to access the entire spectrum of information on clients enables States to better analyze, understand, and coordinate a person's experience within the Medicare and Medicaid programs.

The Medicare-Medicaid Coordination Office has been focused on understanding the utilization profiles and care experience of individuals eligible for Medicare and Medicaid. As a foundation for this goal, we will be preparing brief profiles of individuals eligible for Medicare and Medicaid in each State, including demographics, service utilization, and availability of benefits. Our Office also seeks to go beyond data and actually speak with beneficiaries to gain a better understanding of their experiences from their perspectives. To build on ongoing efforts to better understand the needs of Medicare beneficiaries under the age of 65, we are in the process of conducting focus groups across the country with individuals with disabilities enrolled in both Medicare and Medicaid to understand the impact of integrated care on beneficiary experience and health outcomes. Finally, the Medicare-Medicaid Coordination Office will monitor and report on issues from a national viewpoint, including annual total expenditures, health outcomes, and access to benefits for individuals enrolled in Medicare and Medicaid.

### *Models and Demonstrations*

The Medicare-Medicaid Coordination Office is also supporting State efforts to coordinate and align Medicare and Medicaid acute and long-term care benefits. Partnering with the Center for Medicare and Medicaid Innovation (Innovation Center), the Medicare-Medicaid Coordination Office has awarded contracts of up to \$1 million each to 15 States to design person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports and services for Medicare-Medicaid enrollees.<sup>8</sup> The 15 States selected for the design contracts are: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin. The overall goal of this contracting opportunity is to identify delivery system and payment integration models that can be rapidly tested and, upon successful demonstration, replicated in other States. CMS will work with the States to develop and design models and interventions that can be implemented in future phases. The primary “deliverable” of the initial design period will be a demonstration proposal that describes a State's methods for structuring, implementing, and evaluating a model aimed at improving the quality, coordination, and cost effectiveness of care for individuals enrolled in Medicare and Medicaid. Beyond these contracts, technical assistance will be available to all States through a State Resource Center, which will support our State partners as they develop models that better integrate care for Medicare-Medicaid enrollees.

It is important to note, however, that a CMS contract with a State to design a coordinated care model does not confer authority to implement, or endorsement of, the particular model. Only after a State has submitted a coordinated care model design that meets CMS’ specifications and is consistent with its contract will the model receive further consideration by CMS for implementation. We will also take recommendations that the Medicare Payment Advisory Commission (MedPAC) has shared with us into consideration. These include testing capitated payment models, collecting consistent quality and cost data across demonstrations, assessing ways to increase enrollment, preserving beneficiary protections, and promoting the appropriate use of Federal funds. We will assess

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<sup>8</sup> [http://www.cms.gov/medicare-medicaid-coordination/04\\_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage](http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage)

State proposals with these concerns in mind to ensure models that are tested improve the quality of care while ensuring appropriate use of program funding.

### *Collaborative Efforts*

The Medicare-Medicaid Coordination Office is also facilitating a collaborative effort across the Medicare and Medicaid programs, and with external partners, to evaluate and promote the development of quality measures to better assess beneficiary access to care to reflect the unique circumstances of individuals eligible for Medicare and Medicaid. CMS will engage partners to review the availability of appropriate quality and access measures, and assist in the development of measures which accurately reflect the quality of care received by individuals eligible for Medicare and Medicaid. Our partners will move forward in strategic development of such measures in a manner that streamlines quality measurement across Medicare and Medicaid for individuals receiving care under both programs.

As noted above, the Medicare-Medicaid Coordination Office is also working collaboratively with the Innovation Center to design unique opportunities for integrated care through payment and delivery system reform for individuals eligible for Medicare and Medicaid. These State and provider-based demonstrations will complement the work underway in the Innovation Center on Medicare Accountable Care Organizations and other payment and delivery system demonstrations (for example, Medicare care transitions or Medicaid health homes), which will improve coordination of care for a number of individuals eligible for Medicare and Medicaid.

Finally, the Medicare-Medicaid Coordination Office has consulted and coordinated with both the MedPAC and the Medicaid and CHIP Payment and Access Commission (MACPAC), including presenting at the MACPAC public meeting in October 2010. The Medicare-Medicaid Coordination Office will continue to collaborate with staff and members of both Commissions on important issues related to data analysis, care model demonstrations, and policy alignment opportunities for Medicare-Medicaid enrollees.

## **Conclusion**

CMS, through the Medicare-Medicaid Coordination Office, is working to ensure better health, better care, and lower costs through improvement for individuals that are enrolled in both Medicare and Medicaid. Over the years, a lack of coordination for this population has led to fragmented and episodic care, which can lead to lower quality and higher costs for this population. With the creation of the Office, we have a tremendous opportunity to better integrate the programs and better serve this population. With your continued support, we will keep working as partners with States and other stakeholders to advance high quality, coordinated care for these individuals who need it the most.