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There Is Little Experience And Limited Data To Support Policy Making On Integrated Care For Dual Eligibles

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ABSTRACT Coordinating care for the nine million elderly or disabled and low-income people who are dually eligible for Medicare and Medicaid is a pressing policy issue. To support the debate over this issue, we synthesized public data on how services are provided to dual eligibles receiving covered benefits in both programs. Our analysis confirmed that most dual-eligible beneficiaries receive benefits separately for each program through fee-for-service arrangements. Their enrollment in Medicare and Medicaid managed care is growing but still low, with highly uneven experiences across states. Few states or health plans have experience with coordinating care for dual eligibles within an integrated plan. These findings reinforce the need for caution in considering policies that would rapidly give states the responsibility for coordinating dual eligibles' care and coverage. We also found data gaps that warrant prompt attention in order to provide national-level oversight and improve the evidence base for debating and tracking policy changes.

There are nine million people in the United States who have low incomes and either are elderly or have disabilities and as a result qualify for benefits under both Medicare and Medicaid. These dual-eligible individuals are diverse. Their extensive needs include a mix of medical and social services that typically are expensive and not well coordinated.[1]

As a result, dual eligibles are counted disproportionately among Medicare and Medicaid's high spenders. In 2008, dual eligibles accounted for 20 percent of the Medicare population but 31 percent of Medicare spending, and 15 percent of the Medicaid population but 39 percent of Medicaid spending.[2,3]

Although the federal Medicare and federal-state Medicaid programs provide a wide range of benefits to support the care for these individuals, the programs generally operate independently of one another. Each is structured around specific types of services, and each includes its own administrative and service limitations and does not necessarily address the composite needs for integrated coverage for people served by both programs.[4]

To improve care for dual eligibles, the Affordable Care Act of 2010 authorized a new Medicare-Medicaid Coordination Office within the Centers for Medicare and Medicaid Services (CMS). This office is charged with developing and implementing new models of care and financing so that dual eligibles receive coordinated care that meets their health care needs.[5] Any new models will invariably be shaped by current practice, so it is important to understand how care is now provided to dual-eligible individuals.

This paper uses publicly available data to examine how Medicare and Medicaid benefits are now provided to dual eligibles. As we show, most dual eligibles receive Medicare and Medicaid benefits through traditional programs based on fee-for-service payment.

A small but growing share is enrolled in Medi-

care or Medicaid managed care plans. Very few dual eligibles nationwide are in fully integrated plans, in which their care is coordinated across both Medicare and Medicaid. However, many companies provide both Medicare and Medicaid managed care benefits to them in non-integrated ways.

We found many limitations in the data available on current arrangements for these individuals. These data gaps should be addressed as policy makers discuss options for integrating care provided under Medicare and Medicaid benefits.

Background

MEDICARE AND MEDICAID COVERAGE There are two main categories of dual eligibles: people with disabilities under age sixty-five, and elderly Medicare beneficiaries; all dual eligibles have low incomes and limited assets, allowing them to be eligible for Medicaid benefits. Medicare is the primary source of health insurance for dual eligibles. It covers most acute care services, including inpatient and outpatient care; physician services; diagnostic and preventive care; and, since 2006, outpatient prescription drugs under Part D (see online Appendix Exhibit A-1).[6]

Medicare has considerable gaps in coverage and frequently requires cost sharing for covered benefits. Medicaid plays a key role in filling these gaps for dual eligibles. For example, Medicaid provides help with Medicare's premiums and cost-sharing requirements, such as doctor visit copayments, and it covers services that Medicare does not cover, such as long-term care, dental services, and transportation.

Most dual eligibles (77 percent) qualify for full Medicaid benefits, making them "full dual eligibles," while others, referred to as "partial dual eligibles," qualify for more limited assistance with Medicare premiums and cost sharing under the Medicare Savings Programs.[7]

AVAILABLE CARE ARRANGEMENTS FOR DUAL ELIGIBLES Dual eligibles may encounter a wide array of options for receiving their Medicare- and Medicaid-covered benefits, from traditional fee-for-service to private managed care and Special Needs Plans (see online Appendix Exhibit A-2).[6] Not all options are available in all states, and some are limited to people with very specific needs.

Within Medicare, enrollment in a managed care plan is voluntary. Since the 1970s, dual eligibles and other Medicare beneficiaries have had the options of enrolling in a Medicare Advantage (managed care) plan available in their area or remaining in the traditional fee-for-service program to receive Medicare-covered benefits.[8] Although Medicare Advantage plans typically restrict dual eligibles' provider networks, such plans may help them manage their Medicare benefits better or may provide additional services not covered by the traditional Medicare program.

Special Needs Plans (SNPs) are special types of Medicare Advantage plans created under the Medicare Modernization Act of 2003. They are usually referred to by various acronyms. Dual Eligible SNPs, or D-SNPs, are plans offered to dual-eligible individuals. Beneficiaries requiring or eligible for institutionalization may enroll in Institutional SNPs, or I-SNPs. Beneficiaries with severely disabling or chronic conditions may enroll in Chronic Condition SNPs, or C-SNPs.

The most common type of Special Needs Plan is that for dual eligibles. Such plans provide the option of tailoring supplemental benefits to dual eligibles' particular needs.[9] However, dual eligibles who qualify may also choose to enroll in another type of Special Needs Plan or a Medicare Advantage plan open to all Medicare beneficiaries.

In contrast to Medicare, under Medicaid, some states may require that dual eligibles enroll in managed care plans, subject to federal approval, or they may make such plans available to dual eligibles voluntarily. Dual eligibles may be enrolled in a comprehensive risk plan that covers all Medicaid benefits, including long-term care and Medicare cost sharing. More commonly, they are in plans that cover only Medicaid acute care benefits.

Some states provide some benefits through limited-benefit plans that focus on specific services. Known as "carve-outs," these generally cover such services as behavioral health, long-term care, dental care, or transportation. Dual-eligible individuals may be enrolled in multiple Medicaid carve-outs as well as a comprehensive risk plan to receive the care they need. In most cases, these arrangements operate independently from each other. They are not structured to integrate or coordinate Medicare and Medicaid benefits for their covered populations.

A notable exception is the Program of All-Inclusive Care for the Elderly, universally referred to by its acronym, PACE. PACE is a Medicare option in which state Medicaid programs can participate. It is a fully integrated program that provides all services covered by Medicare and a given state's Medicaid program. Dual eligibles may enroll in a PACE plan if one is offered in their area and if they are age fifty-five or older; have been certified by the state as needing nursing home-level care; and, at the time of enrollment, can live safely in the community. Because PACE provides fully integrated services to dual

eligibles, PACE enrollees are not enrolled in other plans.

In addition to PACE, states have pursued other options for coordination, such as creating "virtual" coordination through contracts with organizations serving both Medicare and Medicaid beneficiaries or seeking federal waivers to test alternative arrangements. There are some examples of states that have used D-SNPs and other Special Needs Plans to coordinate Medicare and Medicaid benefits for their dual-eligible populations, and a few Special Needs Plans receive capitated payments from both Medicare and state Medicaid programs.

However, full integration of Medicare and Medicaid benefits for dual eligibles is still rare. Policy makers estimate that in 2010, fewer than 2 percent of dual eligibles were in integrated Special Needs Plans that provided both Medicare and Medicaid benefits.[10]

Study Data And Methods

We drew on publicly available data to examine enrollment of dual eligibles in both Medicare and Medicaid managed care plans throughout the United States, excluding Puerto Rico and other territories. The Medicare Current Beneficiary Survey Cost and Use files for 2000 through 2008 provided historical data on the total number of dual eligibles enrolled in any Medicare Advantage plan, including D-SNPs. These data files link and reconcile individual survey responses with administrative claims data for each survey respondent.[11]

To analyze these data, we defined *dual eligibles* using a combination of self-reported and administrative claims data, producing an estimate for the number of individuals that closely matches estimates from other sources. We estimated Medicare Advantage enrollment using administrative claims data. Partial-year enrollment could result in some overstatement of estimates.

To provide a more current picture, we analyzed publicly available data on plan enrollment for mid-2010, the most recent year for which Medicaid data were available. Current enrollment of dual eligibles in all types of Medicare Advantage plans was not available through any public data source, but current enrollment in D-SNPs was available through the SNP Comprehensive Report from CMS. We analyzed this report by state for July 2010.

Medicaid managed care enrollment data came from annual Medicaid Managed Care Enrollment Reports published by CMS. These provided point-in-time (June 30), state-by-state estimates of the number of dual eligibles as well as dual eligibles' enrollment in managed care by plan.

We restricted our core analysis to comprehensive managed care plans, including commercial and Medicaid-only managed care organizations, as well as California's county-based Health Insuring Organizations. We also summarized enrollment in limited benefit plans, such as managed behavioral health and long-term care plans. Although the CMS reports provided detailed data on plan names, these data did not allow analysis of whether an individual was enrolled simultaneously in multiple Medicaid managed plans.

We merged data for 2010 from both programs to identify the overlap in firms enrolling dual eligibles within the same state across comprehensive Medicaid managed care, Medicare Advantage, and D-SNP programs. All subsidiaries were aggregated by the parent organization. National numbers represent unduplicated counts of firms across all states.

Study Results

MANAGED CARE ENROLLMENT GROWTH Compared to traditional Medicare benefits, Medicare Advantage offers Medicare beneficiaries some extra benefits, such as additional covered services and reduced copays. In contrast, Medicare beneficiaries who are also dually eligible for Medicaid have limited financial incentives to enroll in Medicare Advantage plans, because they receive Medicaid assistance with the costs associated with fee-for-service Medicare that are often covered in Medicare Advantage. Partial dual eligibles, particularly those receiving premium assistance only, have more incentive than full duals to consider enrollment in Medicare Advantage plans.

Our analysis of data from the Medicare Current Beneficiary Survey showed that about 8 percent of dual eligibles received care through Medicare Advantage plans from 2000 to 2003; this proportion rose to 10 percent between 2004 and 2005.[8] These findings are consistent with the general growth in Medicare Advantage enrollment as payment rates increased and other program changes occurred (Exhibit 1). Designed to stabilize and expand the scope of Medicare Advantage, such changes included minimum payments (floors) for urban counties and higher floors in rural counties starting in 2001, and more generous annual update factors for all plans starting in 2004.[12]

Dual eligibles enrolled in Medicare Advantage are a combination of partial and full dual eligibles seeking specific delivery options (such as Kaiser Permanente), in a demonstration plan (such as a social health maintenance organization), unaware that they might receive the same extra benefits through their state's Medicaid

program, or otherwise wanting a Medicare Advantage plan to help manage their care. Our Medicare data unfortunately did not differentiate between full and partial dual eligibles.

The percentage of dual eligibles who enrolled in Medicare Advantage began to grow in 2006, coinciding with the overall rise in enrollment in private Medicare plans by other Medicare beneficiaries, as well as the introduction of Special Needs Plans and private fee-for-service plans authorized under 2003 Medicare reforms.[13] Twenty percent were enrolled in a Medicare Advantage plan by 2008. This figure includes partial dual eligibles and may have included partial-year enrollment or not fully accounted for changes in Medicaid eligibility status during the calendar year. This estimate appears consistent with other data.[14]

The CMS Special Needs Plan Comprehensive Reports for 2008 showed that about 7 percent of all dual eligibles were enrolled in D-SNPs, implying that the remainder (13 percent) were in other Medicare Advantage plans (data not shown).

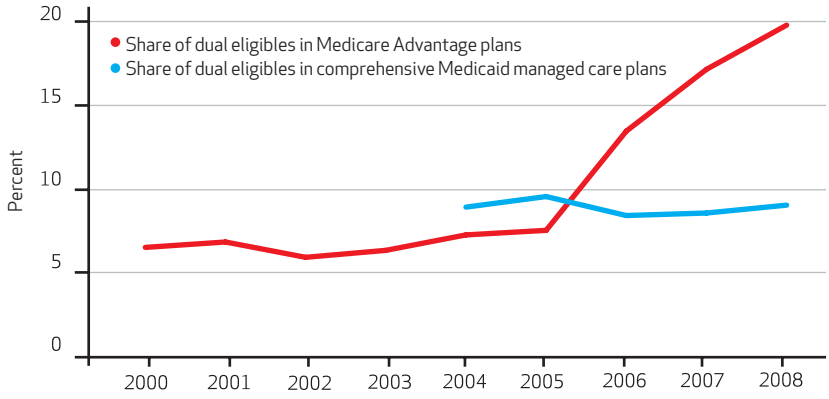
In contrast, dual eligibles' enrollment in comprehensive Medicaid managed care remained at just 9 percent during 2004–08 (Exhibit 1), while total Medicaid enrollment in comprehensive managed care plans grew from 41 percent to 46 percent during the same period (data not shown).[15,16] Some dual eligibles (9 percent) also were enrolled in limited-benefit managed behavioral health care plans over the 2004–08 period, and a very small share (fewer than 1 percent) were enrolled in long-term care–only plans.[17] This enrollment is not represented in Exhibit 1 because these data do not provide unduplicated counts of enrollment in plans.

CURRENT ENROLLMENT AND VARIATION ACROSS STATES In 2010, the most recent year for which data are available nationally for Medicaid, 12 percent of dual eligibles were enrolled in a D-SNP, 9.3 percent in a comprehensive Medicaid managed care plan, and 0.2 percent in a PACE program (Exhibit 2). With the exception of the PACE program, these data do not indicate whether these Medicare and Medicaid enrollees were the same or different dual eligibles. More recent data, from after 2008, showing the number of dual eligibles enrolled in other types of Medicare Advantage plans are not available.

These national enrollment figures mask substantial variation across states. Nearly all states had some dual eligibles who were enrolled in D-SNPs. In four states, more than a quarter of the dual-eligible population was enrolled in such a plan (Arizona, 44 percent; Minnesota, 32 percent; Hawaii and Utah, 28 percent each). In Pennsylvania, Florida, Oregon, and Alabama, 20–25 percent of dual eligibles were enrolled in such a plan. In contrast, in thirteen states, fewer than 1 percent of dual eligibles were in D-SNPs; these were mostly rural states where Medicare Advantage enrollment also was uncommon.

EXHIBIT 1

Share Of Dual Eligibles In Medicare Advantage And Medicaid Managed Care Plans, 2000–08



SOURCE Authors' analysis of data from three Centers for Medicare and Medicaid Services data files: the Medicare Current Beneficiary Survey Cost and Use file, 2000–08; the Medicaid Managed Care Enrollment Reports, 2004–08; and the Medicaid Statistical Information System, 2004–08. **NOTES** Data exclude dual eligibles living in Puerto Rico and other territories. Medicaid managed care data include dual eligibles in commercial and Medicaid managed care organizations (comprehensive risk), Health Insuring Organizations, and Program of All-Inclusive Care for the Elderly (PACE) plans. Information on dual enrollment in comprehensive Medicaid managed care plans was not available at the time of publication for years prior to 2004.

PACE programs operate in thirty states, but they served only a very small fraction of the dual-eligible population in each state. Only in Colorado were more than 1 percent of dual eligibles in a PACE program.

On the Medicaid side, most states had no or very limited comprehensive Medicaid managed care enrollment among dual eligibles. The exceptions were Hawaii, Arizona, Tennessee, New Mexico, and Vermont, which enrolled at least half of their dual-eligible populations in such plans. Eleven states reported dual-eligible enrollment in a specialty managed behavioral health plan (data not shown).[18] Only Florida, New York, and Wisconsin specified enrollment in a long-term care plan, and these plans covered just a small share of dual eligibles in those states.[19]

When we looked at states with high levels of enrollment in both Medicare private plans and Medicaid managed care plans, we found that only four states with high D-SNP penetration rates also had relatively high enrollment of dual eligibles in comprehensive Medicaid managed care plans: Arizona, Hawaii, Minnesota, and Oregon. Of these, Arizona and Minnesota had well-established integrated programs that relied on Special Needs Plans.

Arizona's program passively enrolled dual eli-

EXHIBIT 2

Enrollment Of Dual-Eligible Individuals In Managed Care, By State, 2010

State	Total number of dual eligibles[a]	Percent enrolled in Medicare D-SNPs	Percent enrolled in PACE	Percent enrolled in comprehensive Medicaid managed care[b]
All states	8,887,087	12.0	0.2	9.3
AL	187,130	20.1	—[c]	—[c]
AK	13,064	—[c]	—[c]	—[c]
AZ	147,772	44.3	—[c]	68.2
AR	110,894	8.5	0.0	—[c]
CA	1,135,406	18.6	0.2	20.1
CO	78,556	15.5	1.9	4.1
CT	106,443	5.2	—[c]	—[c]
DE	23,185	0.9	—[c]	—[c]
DC	16,447	7.6	—[c]	—[c]
FL	577,163	21.8	0.1	3.9
GA	236,983	12.9	—[c]	—[c]
HI	29,723	27.8	0.0	88.9
ID	22,993	6.9	—[c]	—[c]
IL	649,200	1.2	—[c]	—[c]
IN	131,771	1.7	—[c]	—[c]
IA	74,980	0.3	0.1	—[c]
KS	68,931	0.9	0.4	—[c]
KY	165,940	6.2	—[c]	18.7
LA	176,078	6.2	0.1	—[c]
ME	84,539	3.1	—[c]	—[c]
MD	102,557	8.9	0.1	—[c]
MA	242,000	6.7	1.0	5.8
MI	239,262	2.8	0.2	—[c]
MN	121,394	31.6	—[c]	41.3
MS	152,414	3.6	—[c]	—[c]
MO	168,084	7.6	0.1	—[c]
MT	19,970	—[c]	0.2	—[c]
NE	33,223	0.9	—[c]	—[c]
NV	39,796	2.0	—[c]	—[c]
NH	26,405	—[c]	—[c]	—[c]
NJ	189,503	3.2	0.0	12.1
NM	62,442	5.8	0.6	50.7
NY	676,143	14.5	0.4	0.9
NC	286,798	9.1	0.0	—[c]
ND	14,081	—[c]	0.2	—[c]
OH	284,818	4.6	0.2	—[c]
OK	101,359	1.6	0.1	—[c]
OR	88,039	21.1	0.9	36.5
PA	390,971	22.3	0.5	0.7
RI	35,752	5.8	0.5	—[c]
SC	131,649	16.0	0.3	—[c]
SD	18,429	—[c]	—[c]	—[c]
TN	233,094	15.3	0.1	57.4
TX	578,134	15.2	0.2	15.4
UT	22,947	27.9	—[c]	12.4
VT	30,347	—[c]	0.3	49.8
VA	161,847	0.7	0.3	—
WA	149,182	6.2	0.2	0.6
WV	70,172	—[c]	—[c]	—[c]
WI	169,543	6.7	0.4	6.1
WY	9,534	—[c]	—[c]	—[c]

SOURCES Data on dual eligibles' enrollment, Program of All-Inclusive Care for the Elderly (PACE) enrollment, and Medicaid managed care enrollment are from Centers for Medicare and Medicaid Services. 2010 Medicaid managed care enrollment report [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2010 [cited 2012 May 3]. Available from: https://www.cms.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrlRep.asp. Data on SNP enrollment are from Centers for Medicare and Medicaid Services, SNP Comprehensive Report, July 2010. **NOTE** D-SNPs are Special Needs Plans for dual eligibles. [a]Unduplicated number of Medicaid dual eligibles receiving full or partial Medicaid benefits. [b]Includes enrollment in Health Insuring Organizations, commercial managed care organizations, or Medicaid-only managed care organizations. [c]No enrollment.

gibles in SNPs in 2006, although enrollees had the option of disenrolling from the state-selected plan.[20] In Hawaii, the state Medicaid program requires dual eligibles to enroll in Medicaid managed care and has contracts with Special Needs Plans to coordinate care.[21] Minnesota and Oregon were among those states developing plans to integrate Medicare and Medicaid benefits for dual eligibles through a demonstration program with the CMS Medicare-Medicaid Coordination Office.[22]

The other two states with many dual eligibles enrolled in D-SNPs, Florida and Pennsylvania, had fewer than 1 percent or no dual eligibles enrolled in comprehensive Medicaid managed care. Both states used managed care carve-outs to deliver some services to dual eligibles—long-term care in Florida and behavioral health care in Pennsylvania.

Some states with relatively low or no enrollment of dual eligibles in D-SNPs, such as New Mexico, Tennessee, and Vermont, reported relatively high participation in comprehensive Medicaid managed care because they required most dual eligibles to enroll in such plans. Because Medicare has primary responsibility for acute care benefits, presumably these Medicaid plans focus on coordinating the benefits for which Medicaid is the primary payer. All three of these states have indicated interest in building on their Medicaid managed care programs to integrate Medicare benefits, and Tennessee and Vermont have been awarded CMS design contracts to move forward with these efforts.[21–23]

INTEGRATION OF PLANS SERVING DUAL ELIGIBLES In 2013, D-SNPs will be required to have a contract with a state Medicaid program. Some states are going further to propose state-run integrated risk-based arrangements that cover both Medicare and Medicaid benefits. Thus, it is important to know whether the same insurers have experience in serving both programs in the same state, because some policy makers see experience as ideal. California, for example, requires companies to have experience with both programs in the state to be eligible providers under the state's demonstration program for dual eligibles.[24]

Nationwide, 53 percent of the companies offering D-SNPs also had a comprehensive Medicaid managed care plan for dual eligibles in the same state (Exhibit 3). A high percentage of companies with comprehensive Medicaid managed care plans that enrolled dual eligibles also participated in Medicare Advantage (69 percent) or offered D-SNPs (61 percent) in the same state. Companies that offered Medicare Advantage plans but not D-SNPs were less likely than those offering D-SNPs to participate in Medicaid. Only 26 percent of all Medicare Advantage–participating companies sponsored Medicaid managed care in at least one state.[25]

These statistics differed across states, with some states having much more overlap in companies across the two programs than other states had. The statistics also did not capture plans' experience with other populations, such as non-dual-eligible aged or disabled Medicaid beneficiaries with needs similar to those of dual eligibles.

Policy Implications

Policy makers are actively discussing models of care for dual eligibles in which Medicare and Medicaid benefits are coordinated and financially integrated.[26] Our analysis shows that current experience with integrated plans is limited. Data gaps are large. It is evident that most dual eligibles are in unmanaged fee-for-service arrangements. In this context, any coordination probably occurs outside of the fee-for-service payment structure.

Opportunities for coordination are, at least in theory, enhanced by risk-based payments to managed care plans. On the Medicare side, Medicare Advantage provides some experience with coordinating acute care benefits; the growth of D-SNPs adds the opportunity to coordinate such coverage with Medicaid benefits, particularly in states where the same companies operate in both programs. However, although state Medicaid programs have considerable experience with managed care for other Medicaid beneficiaries, few have similar experience with dual eligibles. When they do, their responsibility may be limited to selected benefits.

The PACE program, in concept, provides an integrated model, but it is very specialized and does not reach many people. Furthermore, arrangements that provide a basis for potential coordination are unevenly distributed across the states.

Some states have proposed providing capitated payments to managed care plans to integrate Medicare and Medicaid benefits for dual eligibles, while other states would directly manage both sets of benefits for them.[27] Our findings reveal the limited experience of most states with coordinating care for their dual-eligible populations and reinforce the need for caution in considering policies that would rapidly move responsibility for coordinating dual eligibles' coverage to states. Any such shift in policy must be sensitive to the states' different experience levels and capacities, as well as the scope of their dual-eligible population. It also should take into account the diversity across dual-eligible

EXHIBIT 3

Number Of Companies Providing Medicaid Comprehensive Managed Care Benefits To Dual-Eligible Individuals, Medicare Advantage (MA) Plans, And Dual Eligible Special Needs Plans (D-SNPs), By State, 2010

State	No. of companies with MA plans	No. of companies with D-SNPs	No. of companies with duals in comprehensive Medicaid managed care plans	% of companies with MA plans and duals in Medicaid managed care plans	% of companies with D-SNPs and duals in Medicaid managed care plans	% of companies with Medicaid managed care plans and MA plans
National	307	133	116	26	53	69
AL	76	5	0	0	0	—[a]
AK	72	0	0	0	—[a]	—[a]
AZ	83	10	13	10	70	62
AR	77	4	0	0	0	—[a]
CA	99	21	20	13	57	65
CO	77	4	1	1	25	100
CT	78	2	0	0	0	—[a]
DE	72	2	2	1	50	50
DC	72	0	0	0	—[a]	—[a]
FL	97	17	17	11	59	65
GA	79	4	0	0	0	—[a]
HI	75	2	5	5	100	80
ID	78	2	0	0	0	—[a]
IL	77	3	0	0	0	—[a]
IN	77	2	0	0	0	—[a]
IA	73	1	0	0	0	—[a]
KS	72	1	0	0	0	—[a]
KY	76	1	1	1	100	100
LA	76	5	0	0	0	—[a]
ME	72	1	0	0	0	—[a]
MD	75	2	0	0	0	—[a]
MA	80	4	5	5	100	80
MI	83	4	0	0	0	—[a]
MN	83	9	8	10	89	100
MS	74	2	0	0	0	—[a]
MO	77	5	0	0	0	—[a]
MT	73	0	0	0	—[a]	—[a]
NE	73	1	0	0	0	—[a]
NV	79	0	0	0	—[a]	—[a]
NH	72	0	0	0	—[a]	—[a]
NJ	78	5	4	5	60	100
NM	79	3	2	3	67	100
NY	100	18	9	8	44	89
NC	76	2	0	0	0	—[a]
ND	74	0	0	0	—[a]	—[a]
OH	86	6	0	0	0	—[a]
OK	77	2	0	0	0	—[a]
OR	82	7	13	10	86	69
PA	82	7	8	6	43	63
RI	74	0	0	0	—[a]	—[a]
SC	80	2	0	0	0	—[a]
SD	74	0	0	0	—[a]	—[a]
TN	78	6	3	3	33	67
TX	88	13	4	5	31	100
UT	77	2	1	1	50	100
VT	72	0	1	0	—[a]	0
VA	76	1	0	0	0	—[a]
WA	87	4	1	1	25	100
WV	75	0	0	0	—[a]	—[a]
WI	84	8	17	11	75	53
WY	74	0	0	0	—[a]	—[a]

SOURCE Analysis of Centers for Medicare and Medicaid Services (CMS) dual eligible enrollment in Medicaid managed care plans as of July 1, 2010; and CMS Medicare Advantage Enrollment File, July 2010. **NOTES** "Comprehensive Medicaid managed care" includes Medicaid-only managed care organizations, commercial managed care organizations, and Health Insuring Organizations. National estimates are unduplicated counts of companies across states. [a]Not applicable; no such company exists in the state.

individuals.

Research shows both limited overlap in high spenders across the two programs[28] and possible ways in which state policy may result in cost shifting between the two programs.[29] Presumably, the argument for integration is greater in states or for subgroups in which Medicaid now pays a disproportionately high share of combined costs for dual eligibles.

This analysis also clearly shows the limitations in available data for framing what is likely to be a highly controversial debate over strategies for coordinating care for dual eligibles and the respective roles of the federal and state governments. Areas for data improvement are discussed below.

BASIS FOR DETERMINING DUAL ELIGIBILITY Medicare and Medicaid data would be more informative to policy makers and useful to researchers if they distinguished between full and partial dual eligibles in all reporting. Such information would indicate the scope of coverage that a dual eligible is receiving from each program. Ideally, among partial dual eligibles, those eligible for cost-sharing support versus only premium assistance would be identified separately.

DUAL ELIGIBLE ENROLLMENT DATA IN MEDICARE ADVANTAGE Medicare now provides extensive data on Medicare contracts and plans by state and county. However, available reports only indicate dual eligibles' enrollment in D-SNPs. Data should identify dual eligibles in other kinds of Medicare Advantage plans—enrollment that our data suggest is substantial.

MORE TIMELY NATIONAL DATA ON MEDICAID PLAN ENROLLMENT BY STATE The most recent source of data on Medicaid managed care enrollment for states is publicly reported only annually, for June, and lags more than a year behind that for Medicare. Although this may be understandable, given the need to centrally capture data collected in each state, these are expensive programs that consume considerable resources. They thus warrant the critical investments in data management that will be necessary to support policy deliberations.

CONSISTENT CATEGORIZATION OF MEDICAID PLAN TYPE The CMS Medicaid Enrollment Reports include useful data on dual eligibles' enrollment by plan for each state. Unfortunately, these data do not show know how many are enrolled in multiple plans. Furthermore, we encountered inconsistencies and omissions that limit the analytical power and quality of these data.

For example, some states indicate, through either state reports[30] or Medicaid administrative data,[31] that dual eligibles are enrolled in managed care, but this enrollment does not appear in annual CMS reports. Person-level data such as those available through the Medicaid Statistical Information System could address some of the shortcomings of the enrollment reports. However, these data are available only after sizable time lag, which limits their usefulness. Consistent data reporting would enable researchers to more easily track program changes within states and compare state programs.

Beyond the enrollment numbers, more insight on how Medicare and Medicaid operate is critical. Existing CMS reports on Medicaid managed care enrollment could provide a better road map to increased understanding of care for dual eligibles in each state if they showed how various programs relate to Medicare and to one another.

Conclusion

Researchers and policy makers need better and more comprehensive information about the current availability of and enrollment in programs and plans that serve dual-eligible individuals. Any efforts to integrate care for dual eligibles are more likely to succeed if available data and experiences are shared. Incorporating federal- and state-level data on enrollment patterns and care use for these high-need individuals should be factored into the policy debate on how to better integrate care for them and make that care more person-centered and effective. ■

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NOTES

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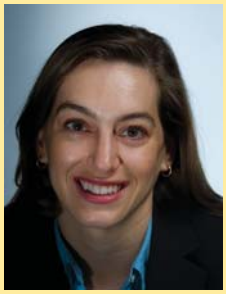
In this month's *Health Affairs*, Marsha Gold, Gretchen Jacobson, and Rachel Garfield write about their analysis of public data on how services are provided under Medicare and Medicaid to those dually eligible individuals who are enrolled in both programs. Their analysis confirmed that most dual-eligible beneficiaries receive benefits separately for each program through fee-for-service arrangements. It also confirmed that enrollment in Medicare and Medicaid managed care arrangements for this population is growing but still low. They found gaps in data that they urge be filled in order to accumulate the evidence needed for policy changes, such as moving dual-eligible beneficiaries into managed care.

Gold is a senior fellow at Mathematica Policy Research, an independent, nonpartisan public policy research firm headquartered in Princeton, New Jersey, with offices in Washington, D.C., and elsewhere. Her research focuses on health care delivery and financing, particularly in managed care and public programs such as Medicare and Medicaid. Gold is one of the foremost national experts on Medicare Advantage and its predecessors, and she has published extensively on the program since the 1990s.

Gold holds a doctoral degree in health services administration from Harvard University, and she earned a master's degree in urban studies and planning from Massachusetts Institute of Technology and a master's degree in public health from the University of California, Berkeley.



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