Integrated Care for Individuals Dually Eligible for Medicare & Medicaid

The number of individuals dually eligible for Medicare and Medicaid has risen steadily in recent years to over 12 million people. Sixty-one percent of dually eligible individuals are age 65 and over; more than 40 percent have at least one mental health diagnosis; and just over half become eligible for Medicare-Medicaid because of disability. In comparison to Medicare-only enrollees, dually eligible patients have more complex and chronic health needs and are more likely to experience inequities in social determinants of health. Nearly half of dually eligible enrollees are people of color; furthermore, they are more likely to be female, have functional limitations, and report poorer health. Dually eligible people have also been disproportionately affected by COVID-19 and were three times as likely to be hospitalized for the virus than Medicare-only enrollees. Because dually eligible individuals are typically medically complex and in need of a wide range of services and supports, they are among the highest need and highest cost patients.

Medicare benefits for dually eligible people include primary care, preventive care, inpatient and outpatient acute care, post-acute skilled nursing care, and prescription drug coverage. Medicare is the primary payer while Medicaid may cover a range of services not covered by Medicare, including—depending on the state—LTSS, some behavioral health benefits, and transportation.

Integrated care models

Because Medicare and Medicaid are complex programs with distinct goals and coverage and payment rules, care for dually eligible people can be fragmented, poorly coordinated and difficult for patients to navigate. Suboptimal care coordination increases inefficiencies and administrative burdens and may compromise patient care and increase health spending.

Integrated care refers to delivery system and financing approaches that coordinate and integrate covered services and supports for dually eligible individuals. In theory, integrated plans and programs should have a high potential for reducing costs and improving care. In reality, achieving integration has been difficult due in part to the complex and diverse needs of dually eligible people and the siloed government health programs that were not designed to work in tandem.

The most prominent integrated care models being implemented across states include:

- Programs tested under the federal **Financial Alignment Initiative (FAI)**, overseen by the Centers for Medicare & Medicaid to better align financing and integrate primary, acute, behavioral health and LTSS;
- **Dual-Eligible Special Needs Plans (D-SNPs)**, which are Medicare Advantage health plans designed to provide targeted care and limit enrollment to special needs individuals; and
- **PACE**, a highly integrated model providing comprehensive, interdisciplinary care to certain frail people over age 55 who would otherwise require nursing home care.

Only 10 percent of dually eligible individuals are enrolled in integrated care models despite considerable work over the years. Although D-SNPs have enrolled over three million people, PACE and FAI have enrolled 55,000 and 395,000 enrollees, respectively. Most dually eligible individuals (70 percent) enroll in fee-for-service Medicare. Low enrollment in integrated care has been attributed to the lack of program availability in some states and high rates of disenrollment from certain programs. Resource constraints and competing priorities in states may also limit the availability of integrated care, with success often dependent on state capacity and resources.

Issues to consider

Integrated Care for individuals dually eligible for Medicare and Medicaid should align with AMA policy and meet the following criteria:

- Care should be grounded in the diversity of dually eligible enrollees and services should be tailored to individuals' needs and preferences.
- Coverage of medical, behavioral health, and LTSS should be aligned.
- Medicare and Medicaid eligibility and enrollment processes should be simplified, with enrollment assistance made available as needed.
- Enrollee choice of plan and physician must be honored, allowing existing patient-physician relationships to be maintained.
- Services should be easy to navigate and access, including in rural areas.
- Care coordination should be prioritized, with quality case management available as appropriate.
- Barriers to access, including inadequate networks of physicians and other providers and prior authorization, should be minimized.
- Administrative burdens on patients, physicians and other providers should be minimized.
- Educational materials should be easy to read and emphasize that the ability and power to opt in or out of integrated care resides solely with the patient.
- Physician participation in Medicare or Medicaid should not be mandated nor should eligible physicians be denied participation.

Where the AMA stands

- Various approaches to integrated deliver of care should be promoted under federal demonstration programs.
- Delivery and payment reform for dually eligible enrollees should involve practicing physicians and take into consideration the diverse patient population and local resources. Conflicting payment rules between Medicare and Medicaid should be eliminated.
- Mandatory enrollment of Medicare and/or Medicaid patients in managed care plans is strongly opposed.
- The Centers for Medicare & Medicaid Services should require states to develop forms and related processes to facilitate opting out of managed care programs by dually eligible individuals.
- Federal demonstrations testing integrated care for dually eligible individuals should not automatically enroll people without their approval and consent; should be rigorously evaluated; and should not be used as a policy lever to reduce provider payment rates.
- States with approved Financial Alignment Initiative demonstrations should provide education and counseling to enrollees on options for receiving Medicare/Medicaid benefits.
- Any savings from coordination of care in Financial Alignment Initiative demonstrations should come from better health outcomes and efficiencies gained by reducing duplicative and/or inappropriate care.
- States should pay deductibles and coinsurance amounts for Medicare/Medicaid dually eligible patients.
- Efforts by health plans to address social determinants of health in health insurance benefit designs are supported, and health plans should examine implicit bias and the role of racism in social determinants of health.
- Finally, health equity, defined as optimal health for all, is a goal supported by the AMA by advocating for health services, research and data collection; promoting equity in care; increasing health workforce diversity; influencing social determinants of health; and voicing and modeling commitment to health equity.

The AMA Council on Medical Service studies and evaluates the social and economic aspects of medical care and recommends policies on these issues to the AMA House of Delegates. For more information, see Council on Medical Service Report 5-NOV-21, Integrated Care for Individuals Dually Eligible for Medicare and Medicaid.