

# Guide to Equity for Medicare–Medicaid Enrollees (Dual Enrollees)

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## ABOUT THIS GUIDE

This guide equips advocates and other changemakers with key information on how Medicare and Medicaid serve people who qualify for both programs, including an overview of [the barriers and inequities](#) and suggestions for policy changes that can [advance equity for dual enrollees](#).

This guide is part of a larger project on inequities and policy levers in the US health care system. For the complete guide, visit [urbn.is/4054rNQ](http://urbn.is/4054rNQ).

The other topics covered [include the following](#):

- behavioral health care system
- Children’s Health Insurance Program
- health care for the uninsured
- Indian Health Service
- Marketplace insurance
- Medicaid
- Medicare
- pharmacy services
- Veterans Affairs

## OVERVIEW

Individuals dually enrolled in Medicare and Medicaid (sometimes called Medicare–Medicaid enrollees, dually eligible individuals, dual enrollees, or duals) are a large and diverse population of over 12 million adults in the US. Almost two-thirds of dual enrollees are seniors age 65 and older who also qualify for Medicaid benefits because they have low incomes and few assets. The remaining duals are adults under age 65 with disabilities. While all dual enrollees receive standard Medicare benefits, the range of Medicaid benefits varies. Most duals (73 percent) are “full-benefit” enrollees, meaning they are eligible for the full range of Medicaid benefits not covered by Medicare, such as long-term care services and supports. Many full-benefit dual enrollees also qualify for assistance with paying Medicare premiums or cost sharing through the Medicare Savings Programs. Duals who are “partial-benefit” enrollees (about 27 percent of all dual enrollees) do not qualify for full Medicaid benefits but can receive assistance with Medicare premiums—and often cost sharing—through the Medicare Savings Programs.

## For More Information

- **Medicare-Medicaid enrollees overview:** Maria T. Peña, Maiss Mohamed, Alice Burns, Jeannie Fuglesten Biniek, Nancy Ochieng, and Priya Chidambaram, “[A Profile of Medicare-Medicaid Enrollees \(Dual Eligibles\)](#),” KFF, January 31, 2023.

## POPULATION

In 2020, there were 12.5 million dual enrollees nationwide, with the following key characteristics:

- On average, about 20 percent of all Medicare beneficiaries are also enrolled in Medicaid, but this share can vary by state, ranging from 10 percent in Utah to 38 percent in DC.
- Nearly four in ten dual enrollees (37 percent) are under age 65.
- Six out of ten dual enrollees are women, likely driven by the fact that women in the US are more likely to experience poverty than men, especially women of color and older women.

- More than half of dual enrollees (51 percent) are from racial and ethnic minority groups: 22 percent Black, 20 percent Hispanic/Latino, and 9 percent identified as other racial and ethnic minorities.
- Almost nine in ten dual enrollees live in deep poverty, with 87 percent reporting annual incomes of less than \$20,000 in 2020.

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### For More Information

- **Dual-eligible beneficiaries:** [“Beneficiaries Dually Eligible for Medicare and Medicaid,”](#) MACPAC, February 2023.
- **Spending trends and enrollment among enrollees:** Maria T. Peña, Maiss Mohamed, Alice Burns, Juliette Cubanski, Nolan Sroczynski, and Priya Chidambaram, [“Enrollment and Spending Patterns Among Medicare-Medicaid Enrollees \(Dual Eligibles\),”](#) KFF, January 31, 2023.
- **Women enrollees and the likelihood of poverty:** Monique Morrissey, [“Women over 65 Are More Likely to Be Poor than Men, Regardless of Race, Educational Background, and Marital Status.”](#) Washington, DC: Economic Policy Institute, March 8, 2016; and Amanda Fins, [“National Snapshot: Poverty among Women & Families, 2020,”](#) Washington, DC: National Women’s Law Center, December 2020.

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## PROVIDERS AND SERVICE DELIVERY

Dual enrollees tend to have poorer health and use more health care services than Medicare-only beneficiaries. Besides primary care, dual enrollees access a variety of health care services, including the following:

- prescription medications
- specialist services such as cardiology, mental health and substance use services, and physical therapy
- home health services that include providing assistance with activities of daily living (such as bathing or getting dressed) to dual enrollees living at home
- long-term care institutional services, such as care provided in a nursing home
- hospital and emergency department services

Informal caregivers (e.g., family members, friends) are an important source of support for dual enrollees, but compared with Medicare-only beneficiaries, dual enrollees are more likely to live alone and rely on help from children, grandchildren, or other relatives.

State Medicaid programs coordinate health care services for dual enrollees through different types of programs, and many states offer multiple options for duals, including the following:

- 28 states use Medicaid managed care
- 30 states operate Programs of All-Inclusive Care for the Elderly
- 11 states offer integrated care models through the Financial Alignment Initiative
- 46 states operate Dual Eligible Special Needs Plans, which are Medicare Advantage programs that specialize in caring for dual enrollees

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## For More Information

- **Coordinating health care services for dual enrollees:** Maria T. Peña, Maiss Mohamed, and Alice Burns, “[Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals](#).” KFF, April 27, 2023.
  - **Care for the elderly:** “[Program of All-Inclusive Care for the Elderly](#),” Medicaid.gov, accessed November 14, 2023.
  - **Financial alignment:** “[Financial Alignment Initiative for Medicare-Medicaid Enrollees](#),” CMS.gov, accessed November 14, 2023.
  - **Specialized care for dual enrollees:** “[What Is a Dual Eligible Special Needs Plan \(D-SNP\)?](#)” NCOA.org, accessed November 14, 2023.
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## FINANCING

Medicare is financed by the federal government, while the federal government and states jointly fund Medicaid. The respective programs cover the following services:

- Medicare is the primary payer for most primary, preventative, acute, and post-acute care services and prescription drugs used by dual enrollees.
- Medicaid supplements Medicare by aiding with Medicare premiums and cost sharing for partial duals and by covering services that Medicare does not cover (like long-term services and supports) for full-benefit duals.

## BARRIERS TO ACCESSING HEALTH SERVICES AND ACHIEVING BETTER HEALTH

Dual enrollees face multiple barriers that affect their access to health care and health outcomes, including the following:

### *Provider-level barriers*

- Dual enrollees often have complex physical, behavioral, and long-term care needs and high unmet social needs related to poverty, which make it challenging for health care providers to meet all their needs and manage care effectively.
- In some states, access to primary care can be limited because reimbursement for care provided to dual enrollees is capped at the lower Medicaid rates rather than the higher Medicare rates, which can deter providers from serving duals.
- Some older adults and people with disabilities experience provider discrimination and mistreatment, which may discourage them from seeking care.

### *System-level barriers*

- Different coverage and benefit policies across two separate programs create a complex and inefficient care system that is difficult for patients to navigate. For example, applying and enrolling in Medicaid programs may be burdensome (e.g., documenting eligibility, reapplying regularly). Medicare beneficiaries may not be aware that Medicare does not cover long-term care services and that they might need to “spend down” their assets to be eligible for Medicaid-covered nursing home services.
- In addition, different coverage and payment policies between Medicare and Medicaid allow for cost-shifting between programs because there are no financial incentives to collaborate, which can contribute to the underuse or overuse of some services, inefficiencies, and high health care costs. Further, there is a lack of accountability around which program is responsible for care and outcomes of dual enrollees.

- Lack of coordination of services and benefits between the two programs can result in fragmented and poorly managed care and negatively affect the health outcomes of dual enrollees.
- Integrated care programs that aim to better coordinate between Medicare and Medicaid have long been promoted as a solution to improving care and outcomes among dual enrollees, but evaluation of these initiatives have mixed results. Only about 10 percent of duals were enrolled in integrated plans in 2019.

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### For More Information

- **Access to primary care physicians:** Vicki Fung, Stephen McCarthy, Mary Price, Peter Hull, Benjamin Lê Cook, John Hsu, and Joseph P. Newhouse, 2021, “[Payment Discrepancies and Access to Primary Care Physicians for Dual-Eligible Medicare-Medicaid Beneficiaries](#),” *Medical Care* 59 (6): 487–94.
  - **Provider discrimination and mistreatment among older adults:** Judith Graham, “[‘They Treat Me Like I’m Old and Stupid’: Seniors Decry Health Providers’ Age Bias](#),” KFF, October 20, 2021; and Stephanie E. Rogers, Angela D. Thrasher, Yinghui Miao, W. John Boscardin, and Alexander K. Smith, 2015, “[Discrimination in Healthcare Settings is Associated with Disability in Older Adults: Health and Retirement Study, 2008–2012](#),” *Journal of General Internal Medicine* 30: 1413–1420.
  - **Long-term services and support:** Priya Chidambaram, and Alice Burns, “[10 Things About Long-Term Services and Supports \(LTSS\)](#),” KFF, September 15, 2022.
  - **Financial Integration and Incentives:** Stephanie Anthony, Anthony Fiori, and Ashley Traube. “[Opportunities to Promote Financial Integration for Dual-Eligible Individuals](#),” Los Angeles: Manatt Health, January 2023.
  - **Enrollment within integrated plans:** [Medicare–Medicaid Coordination Office FY 2019 Report to Congress](#), Baltimore: CMS, 2019.
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### How Dual Enrollees Experience Care

*Edwin had worked his entire life and has been on Medicare since 65 years old, but at the age of 69, found it difficult to maintain a job because of his deteriorating health. Because of his small income, he now qualifies for Medicaid but does not fully understand what that means. He has several serious conditions, including prostate cancer, and takes many prescription medications. At times he has difficulty paying the copayments for his prescriptions, even after Medicare pays for most of the cost. He is especially worried about paying for medications that he needs, but his Medicare plan no longer covers. Often, Edwin seeks help from a local legal services organization to understand his health care benefits or paperwork.*

*—Story from [Faces of Dually Eligible Beneficiaries: Profiles of People with Medicare and Medicaid Coverage](#), page 7, San Francisco: KFF, July 2013.*

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## DISPARITIES

Research has consistently demonstrated disparities between dual enrollees and Medicare-only beneficiaries in access to, quality of care, and health outcomes. The following are examples:

- Compared with Medicare-only beneficiaries, dual enrollees are more likely to be in fair or poor health, have chronic physical and mental health conditions and functional limitations, and live in institutional settings.
- Dual enrollees account for high levels of health care spending, likely because of the high need for complex care and services and inefficiencies in having two different systems responsible for delivering these services—dual enrollees represent 19 percent of Medicare beneficiaries and 14 percent of Medicaid beneficiaries, but account for 34 percent of Medicare spending and 30 percent of Medicaid spending.
- Compared with Medicare-only beneficiaries, dual enrollees experience large disparities in access to and quality of care and health outcomes. Dual enrollees are more likely to be people of color than Medicare-only beneficiaries, suggesting racial and ethnic disparities among Medicare beneficiaries overall.
- There is little research on racial and ethnic disparities among dual enrollees, but the few available studies find inequities in access to benefits, spending, and outcomes.

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### For More Information

- **Health disparities:** Jia-Shu Chen, Kiara M. Corcoran Ruiz, Krissia M. Rivera Perla, Yao Liu, Chibueze A. Nwaiwu, and Carla C. Moreira, 2022, “[Health Disparities Attributed to Medicare-Medicaid Dual-Eligible Status in Patients with Peripheral Arterial Disease](#),” *Journal of Vascular Surgery* 75 (4): 1386–1394.e3; and S.C. Martino, MN. Elliott, J.W. Dembosky, K. Hambarsoomian, D.J. Klein, J. Gildner, and A.M. Haviland, 2021, [Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility or Eligibility for a Low-Income Subsidy](#), Baltimore, MD: CMS Office of Minority Health.
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## OVERSIGHT AND ACCOUNTABILITY

The federal government is responsible for the administration and oversight of the Medicare program. States are responsible for the administration of Medicaid programs, with oversight from the federal government.

### Federal

- **The Centers for Medicare and Medicaid Services (CMS):** CMS oversees and guides Medicare and Medicaid programs under the US Department of Health and Human Services. CMS analyzes program data to monitor access and quality of care for Medicare beneficiaries, including dual enrollees.
- **Medicare–Medicaid Coordination Office (MMCO):** The Affordable Care Act created MMCO within CMS to increase coordination between Medicare and Medicaid.

### Other

- **National and state/local advocacy and support groups:** Many organizations serve as program watchdogs and advocates for issues affecting dual enrollees, including AARP, Area Agencies on Aging, and the Arc (advocating for people with intellectual and developmental disabilities).

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## For More Information

- Oversight and accountability mechanisms within individual programs: Kimá Joy Taylor, Sofia Hinojosa, Eva H. Allen, and Taylor Nelson, “[Guide to Equity in Medicaid](#),” Washington, DC: Urban Institute.
  - **Overview of the Medicare-Medicaid Coordination Office:** “[About the Medicare-Medicaid Coordination Office](#),” CMS.gov, accessed November 14, 2023.
  - **Stratified Reporting:** “[Stratified Reporting](#),” CMS.gov, accessed November 14, 2023.
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## POLICIES AND ACTIONS THAT COULD LESSEN BARRIERS AND DISPARITIES

Improving integration and coordination between Medicare and Medicaid programs has long been promoted to improve access, quality, and outcomes of dual enrollees. Key policy and practice considerations to ensure equitable access to benefits and health care services for all dual enrollees include the following:

### *Improving dual enrollees' engagement and experience by:*

- simplifying and standardizing enrollment and benefit design across the two programs in ways that allow patient choice and access to culturally and linguistically effective health and care coordination services; and
- meaningfully engaging diverse members of the dual eligibility community in policy and program design when developing new federal and state/local dual-eligible initiatives, including in defining measures of beneficiary access to and experiences with care.

### *Promoting financial alignment and efficiency between the two programs by:*

- removing statutory barriers to integrating financing mechanisms and payments between Medicare and Medicaid;
- requiring that providers serving dual enrollees are reimbursed at Medicare rates (not Medicaid rates which are generally much lower) for services provided; and
- accounting for savings to Medicare that occur from Medicaid-funded services (e.g., home and community-based services may reduce expensive emergency department and hospital services) and reinvesting those savings back into Medicaid programs.

### *Addressing health disparities experienced by dual enrollees by:*

- integrating Medicare and Medicaid data and using these data to study and report on disparities across race, ethnicity, and other demographic and socioeconomic characteristics and hold programs, plans, and providers accountable for eliminating the identified disparities;
- improving our understanding of the impacts integrated models have on disparities and replicating and expanding promising models, including those that offer culturally effective services; and
- adopting and enrolling in promising models, such as by requiring that all states implement integrated programs for dual enrollees.

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## For More Information

- **Opportunities to promote financial integration among states:** Anthony J. Fiori, Stephanie Anthony, and Lori Houston-Floyd, “[Opportunities for States to Promote Financial Integration for Dual-Eligible Individuals](#),” *Health Affairs Forefront*, May 26, 2023.
  - **How integration is preserved for the dually eligible:** Allison Rizer and Nils Franco, “[Preserving Integration for Dual Eligible Individuals after the End of the Medicare-Medicaid Plan Model](#),” *Health Affairs Forefront*, March 13, 2023.
  - **Medicare and Medicaid data to improve care quality:** Brittany Brown-Podgorski and Eric Roberts, 2022, “[Integrating Medicare and Medicaid Data to Improve Care Quality and Advance Health Equity among Dual-Eligible Beneficiaries](#),” *Health Affairs*.
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## GLOSSARY

**Accountability** is an assurance that an individual or organization is evaluated on its performance or behavior related to something for which it is responsible.

The **federal poverty level** is a measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits, including savings on Marketplace health insurance and Medicaid/Children's Health Insurance Program coverage.

**Health disparities** are preventable differences in disease, health status, or opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups and communities.

**Health equity** is the state in which everyone has a fair and just opportunity to attain their highest level of health.

**Quality measures** are tools that help assess or quantify health care processes, outcomes, patient experiences, and organizational structures and/or systems associated with providing high-quality health care.

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