

# Complex Care & Dual Eligibility

A Primer from Arnold Ventures



## INTRODUCTION

**12.2 million American adults with disabilities and older adults receive coverage from both Medicare and Medicaid — a population often called “dual-eligible” in policy circles.**

Because Medicare and Medicaid are two large, complex systems that were not designed to work together, dual-eligible individuals all too often have to jump through hoops to get necessary care. This includes challenges with trying to find the right doctors, understanding enrollment processes, and getting their medical bills paid on time and correctly.

## MELISSA'S STORY

Melissa is among the 12.2 million dual-eligible individuals. A working mom of six, she first filed for Medicare coverage a decade ago after experiencing abrupt vision loss brought on by diabetes. Despite that she is entitled to more generous coverage than the average person on Medicare or Medicaid, her benefits come from two different sources, and the two do not coordinate well. Melissa likens her insurance struggles to a pair of shoelaces where one side cannot create a knot with the other.

When Melissa tries to access care, her health care providers do not often have all the correct information about her insurance status. Although she is covered by both Medicare and Medicaid, staff often tell her she does not have Medicaid (which covers out-of-pocket payments), and request that she pay for her prescriptions. “I just pay my co-pays. If they say I have them, then I have them. It takes too much time to try and battle insurances.”

For Melissa, managing her care can feel like a full-time job in a two-system plan with limited communication between them. She receives dozens of thick marketing pamphlets per week for health plan alternatives but rarely opens them. She worries that if she attempts to change plans, her choice may further complicate her care and take her away from her current doctors.



***“Who do I talk to? Where do I go? How do I find out some of the answers to my questions? How come I’m being told one thing, and then when I go to put a plan into action, I’m being told a completely different thing? Some of the downfalls to being dual-eligible are trying to get both insurances to see eye to eye.”***

While trying to navigate between the two government programs, patients like Melissa face a mountain of red tape, waste, and a lack of coordination. As a result, dual-eligible patients suffer from worse health outcomes, and our health care system gets more and more costly. The U.S. spends nearly **2X** more on care for dual-eligible individuals than other Medicare and Medicaid-eligible individuals.

## WHAT CONGRESS CAN DO

It is no surprise that the vast majority of voters (70%) favor major reforms for dually-eligible individuals. Policymakers must act to create less bureaucracy and better coordination so people are no longer forced to navigate between two separate programs. Simplifying the patient experience and improving coordination is key to getting more people the care they need to lead healthy, independent lives. Integrated Medicare-Medicaid models offer a promising way to make meaningful transformations to care delivery. The following outlines key policy goals that must be met to substantially transform the care and coverage landscape for the dual-eligible population.

## POLICY GOALS

### 1. INCREASE ACCESS TO MEANINGFULLY INTEGRATED COVERAGE

Every dual-eligible individual should have access to an integrated coverage option. Access is particularly critical for dual-eligible individuals who are eligible for the full range of Medicaid benefits in their state. Integrated coverage should more meaningfully align Medicare and Medicaid than it does today. It should ensure that the programs feel like one program to dual-eligible individuals (e.g., one insurance card, one set of marketing materials, one document that explains all their benefits, etc.). It should also allow dual-eligible beneficiaries to have all their services covered under one program. If an individual cannot get their physical, mental, and long-term health care needs met under one program, it does not represent integrated coverage.

### 2. SUPPORT INFORMED DECISION-MAKING AND SEAMLESS ENROLLMENT INTO INTEGRATED COVERAGE

Dual-eligible individuals should have access to assistance in understanding their coverage options. This means making clearer descriptions available online and ensuring access to a neutral third party (i.e., someone who does not represent a managed care plan) to discuss their options. When adequate enrollment supports are provided, the default coverage option for people who are dual-eligible should be the integrated coverage option, and they should have an opportunity to disenroll into non-integrated coverage options if that is what they want. Additionally, people should be permitted to remain enrolled in an integrated coverage option for a period of 12 months without having to be reassessed for eligibility in the program.

### 3. ENSURE THE DELIVERY OF SERVICES UNDER INTEGRATED COVERAGE CREATES ACCOUNTABILITY AND MEETS PEOPLE'S NEEDS

At-risk delivery models, like managed care organizations, have historically been effective partners in delivering integrated coverage. These entities should be held accountable for the outcomes people care about. They should also be given the flexibility to provide services that improve outcomes — including services that address social needs. People of color and individuals who experience severe mental health issues are disproportionately represented in the dual-eligible population — managed care plans must address these disparities. Another goal of the program should be to keep as many people living in the community as possible, consistent with their wishes. Incentives to encourage this outcome should be built into plan payment measures.