Chapter 7
Medicare and Medicaid Coordination: Special Case of the Dual Eligible Beneficiary

Gregg Warshaw and Peter A. DeGolia

Background

The Affordable Care Act of 2010 (ACA) includes several provisions related to the cost and quality of the care received by dually eligible Medicare and Medicaid beneficiaries. The "dual eligibles" are low income older adults and younger persons with significant disabilities. More than nine million Medicare beneficiaries are also enrolled in the Medicaid program. Sixty percent are age 65 years and older and 40 % are under age 65 [1]. Among the participants in Medicare and Medicaid, the dual eligible population includes many recipients who have the lowest incomes and highest chronic disease burden. It is recognized that providing care for the dual eligible population is an expensive component of both the Medicaid and Medicare budgets. The "Duals" comprise only 15 % of total Medicaid enrollment yet represent 39 % of annual Medicaid expenditures. Similarly for Medicare, duals represent 21 % of Medicare enrollees but 36 % of Medicare expenditures [2]. In 2007, Medicare, Medicaid, supplemental insurance, and out-of- pocket expenses, on

G. Warshaw, M.D. (✉)
Geriatric Medicine Program and Department of Family and Community Medicine, College of Medicine, University of Cincinnati, 231 Albert Sabin Way, PO Box 670504, Cincinnati, OH 45267-0504, USA
e-mail: gregg.warshaw@uc.edu

P.A. DeGolia, M.D.
Department of Family Medicine, University Hospitals Case Medical Center, 11100 Euclid Ave, Cleveland, OH 44106, USA

J.S. Powers (ed.), *Healthcare Changes and the Affordable Care Act*,
DOI 10.1007/978-3-319-09510-3_7

average, amounted to $28,500 per dual-eligible beneficiary; nearly twice as much as for other Medicare beneficiaries [3]. Since the costs of Medicaid are shared between the federal government and the states; Congress and state legislatures are seeking more effective and less costly approaches to caring for the "Duals" population.

"Duals" Illness Burden and Diversity

One of the challenges for health planners seeking strategies to improve the care experience and outcomes for the dual eligibles is that the population is very diverse. Many of the older "duals" live in nursing homes and suffer from chronic illnesses, such, as, Alzheimer's disease. Among the older adults living in the community, functional impairment is common, although some older "duals" in the community are independent and healthy. The remainder of the beneficiaries are younger adults with mental or physical disabilities. Eligibility for Medicare for these younger adults comes through the social security disability system (generally eligible after 24 months on Social Security Disability benefits) or by eligibility for certain end-stage renal disease services (renal dialysis or transplant). In summary, 43 % of all Dual beneficiaries have at least one mental or cognitive impairment; while 60 % have multiple chronic conditions. Nineteen percent live in institutional settings, compared to only 3 % of non-dual eligible Medicare beneficiaries [4].

Care Coordination Challenges

Qualifying for both Medicare and Medicaid reduces the out-of-pocket cost burden for dual eligible beneficiaries. However, many dual-eligible patients and their caregivers experience difficulties navigating the health care system. The division of responsibility across the Medicare and Medicaid programs only intensifies these problems for dual eligibles. For example, many physicians who care for Medicare beneficiaries may not be familiar with the benefits and services available through Medicaid. Also, poorly aligned financial incentives may discourage health care providers and the Medicare and Medicaid programs from coordinating care, leading to costly and inefficient care.

In general, Medicare will reimburse acute care and physician visits, and Medicaid will be the primary payer for community based long-term services and supports. Because of the separate financing streams and conflicting incentives, Medicare and Medicaid cannot realize equal savings from their investment in improved care. For example, patients may be moved from a nursing home where Medicaid is the primary payer, to a hospital, where Medicare is the primary payer, to shift costs from one program to the other. Better long-term care coordination, for example, may result in reduced hospitalizations, but these saving may benefit

the Medicare program far more than the Medicaid program. These inefficiencies, relatively poor care coordination, and combined with the high costs of care are driving the need for change on how the care for the "duals" is organized [4, 5].

Models of Care Prior to the ACA

Legal statute mandates Medicare and Medicaid. These mandates are significantly different. The Social Security Act [6] mandates that Medicare cover services that are medically "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member". Consequently, this coverage tends to be focused toward acute care services. Medicaid, on the other hand, pays for "necessary medical services and …rehabilitation and other services to help …individuals attain or retain capability for independence or self-care" [7]. The Medicaid program's benefits are more focused on the care of chronic disease.

Medicare is the primary insurer for dual eligibles and covers services such as physician, hospital, hospice, skilled nursing facility, home health services and durable medical equipment. Since the passage of the Medicare Part D program in 2006, Medicare also covers prescription medications.

Medicaid is organized as 50 state programs each having their own rules and processes for determining eligibility for benefits, approved services, and payments. These programs include both managed care and fee-for-service models. Some states allow potential Medicaid beneficiaries with higher income and asset levels to qualify if they are "medically needy" and have high health care bills. Qualifying for Medicaid coverage is affected by a person's income and assets as well as individual state coverage and payment policies. Medicaid generally covers services not provided by Medicare. These services include long-term care services such as custodial nursing facility care, home and community-based services (e.g. personal care, social service assistance), dental, vision, and transportation. Approximately two-thirds of the Medicaid benefit package is offered at the option of the state [8], resulting in significant geographic variation in coverage. This variation can apply to dental, vision, and therapy services, as well as the amount of hospital coverage. As state budgetary problems mount, pressure to restrict or reduce Medicaid services result. For example, in 2004 seven states reduced dental and chiropractic services while five states restricted podiatric, psychological services, therapy services and mental health therapies [9].

Medicare has coverage gaps and that often requires cost sharing for covered benefits. Medicaid helps fill many gaps for dual eligible beneficiaries. State Medicaid programs are not required to pay the full cost-sharing amount that Medicare pays as long as their payment policies are written into their state plan [8]. Consequently, certain services may be reimbursed at a lower rate or not at all. When Medicare cost sharing and benefits change, such as limitations on home health services, the cost of one program is shifted to the other and impacts access to care and quality of care for dual eligible beneficiaries.

Medicare Advantage

Prior to the passage of the Affordable Care Act of 2010, the vast majority of dual eligible beneficiaries were enrolled in fee-for-service coverage. An alternative care model option for Medicare beneficiaries is managed care. This option has been available to Medicare beneficiaries since the 1970s. Originally developed as "Medicare+Choice" plans, Medicare beneficiaries were offered the option of enrolling in private health plans for their benefits. With passage of the Medicare Modernization Act of 2003, Congress replaced Medicare+Choice with Medicare Advantage which expanded the types of managed care models to choose from and increased payments to insurance companies to encourage participation [10].

Medicare Advantage plans are generally offered by health insurance companies or large provider organizations. These plans include health maintenance organizations, preferred provider organizations, private fee-for-service plans, or special needs plans. Medicare beneficiaries cannot be mandated to enroll in managed care plans as federal law provides for "freedom of choice". States can mandate Medicaid beneficiaries to enroll in Medicaid managed care plans but this does not apply to dual eligibles. These beneficiaries are considered to be Medicare beneficiaries first.

Over 14 million beneficiaries (28 % of the Medicare population) enrolled in a Medicare Advantage plan in 2013. Enrollment is concentrated in urban areas and varies widely across the states with 42 % of Medicare beneficiaries enrolled in Oregon, and only 3 % in Wyoming. Two-thirds of beneficiaries chose an HMO model plan [11].

Special Needs Plans (A Form of Medicare Advantage)

Special Needs Plans (SNPs) were authorized by Congress in 2003 to focus on specific subtypes of dual eligible beneficiaries with the intent to integrate the financing and delivery of care for the full range of health care needs. This averts some of the coordination–of-benefit problems faced in fee-for-service or non-integrated managed care programs. Integrated care delivery is intended to align financing with incentives to achieve better care coordination and quality of care.

These plans were developed on the assumption that improved quality of care would reduce potentially avoidable emergency department visits, hospitalizations, and nursing facility admissions while saving Medicare funds [12]. Enrollment in a SNP does not necessarily mean a dual eligible beneficiary will receive integrated care. These plans can manage just the Medicare benefits but have the potential to coordinate Medicare benefits with state-administered Medicaid benefits. There are D-SNP (dual eligible SNP), I-SNP (Institutional, usually nursing home based, SNP), and C-SNP (Chronic disease SNP) programs. D-SNPs account for 82 % of all SNP enrollees, although, nationwide, in 2013, only 12 % of dual-eligible beneficiaries were in D-SNPs [11].

One SNP model of care that integrates Medicare and Medicaid services is based on a voluntary integration approach. Minnesota Senior Health Options, a capitated model, started in 1997 and Massachusetts Senior Care Options begun in 2004 are examples of voluntary integrated programs where dual-eligible beneficiaries choose

to enroll in a SNP for their Medicare benefits and voluntarily enroll in the same health plan which has contracted with the state Medicaid agency to manage their Medicaid benefits. The state oversees a single contract with participating plans that provide Medicare and Medicaid services through a capitated system with payments combined at the plan level rather than the state level. This approach minimizes regulatory duplication and differences between Medicare and Medicaid while streamlining processes such as enrollment, grievances, and data reporting.

A second SNP model of care has dual eligibles required to enroll in a capitated Medicaid managed care program administered by a managed care organization while allowing the individual to choose whether or not to participate in a capitated Medicare program, a Managed Fee-for-Service Model (MFFS). This model has been implemented in Arizona and Texas [13].

These models were the prototypes for the ACA Financial Alignment Demonstrations, and the states are modifying their approach to dual eligibles based on these early experiences (see below).

State Demonstration Waiver Programs

Medicare granted waiver status for several states to implement State Demonstration Waiver programs to promote the alignment of finances and service with outcomes for dually eligible beneficiaries prior to the passage of the Affordable Care Act. The Minnesota Senior Health Options and Disability Health Options program and Massachusetts Senior Care Options began as waiver programs. The Wisconsin Partnership Program involves community-based organizations entering into a Medicaid managed care contract with the Wisconsin Department of Health and Family Services and a Medicare contract with CMS. The community agencies are responsible for all participant services and receive a monthly capitated payment. This program serves nursing facility certified physically disabled dual eligibles and seniors over 55 years of age [14].

The Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) stands out as a successful example of a seamlessly integrated program that brings together Medicare and Medicaid benefits into one delivery system. Dual eligible beneficiaries are the majority of enrollees in these programs. As of February, 2014, there are 100 PACE programs operating in 31 states [15]. PACE programs tend to be small and personal, serving nursing home-eligible individuals 55 years of age or older who live in the community served by the PACE organization. Individuals managed within these programs are primarily community-dwelling but also include participants who transition to custodial care in nursing facilities. Interdisciplinary team-based care directs this comprehensive medical and social delivery program which offers adult day health center services, transportation, in-home and referral services based on individual needs (see Box 7.1 for a PACE client case example).

Box 7.1 Case Example: The Program of All-Inclusive Care for the Elderly
G.O. is a 72 year old Woman with advanced Alzheimer's type dementia with behavioral problems. Historically she was combative and resistant to care; often refusing to take her prescribed medications. She qualified for Long Term Care Services and Support through a community-based agency which provided her 32 h per week of home health aide services and a social service case worker. She frequently was admitted to the local hospital following acute changes in mental status, often associated with urinary tract infections or dehydration. Her medical care was limited as it was difficult to transport her to her primary care physician's office and her behavior became unmanageable while at the office. Her primary care physician expressed frustration in trying to manage her care as he did not see her in the office and was often responding to crises and completing paper work to authorize specific services. He felt disconnected from her care. Her family was committed to caring for her at home, but G.O.'s care needs and frequent medical problems caused significant caregiver strain. This led to custodial care placement following an acute illness in which G.O. was hospitalized.

After a month in a long-term care facility, a family member discovered the local PACE program. Mrs. O's family decided to make a second attempt at keeping her at home. Upon enrollment in the PACE program, G.O. attended the PACE Center (an adult day health center) 5 days a week. She received special care and activities designed to meet her social and health care needs. While at the PACE Center she would be evaluated by medical, nursing, social work, and dietary staff. Modifications in her medication regimen were made. The PACE health professionals worked with G.O.'s family to address care needs at home and assist them in managing her medical regimen. Intermittent respite stays were organized to give the family necessary relief from day-to-day caregiving. Today, 2 years after enrolling in the PACE program, G.O. has not been hospitalized in over a year, continues to live at home with family, and attends the PACE program regularly.

Most PACE programs employ staff providers. However, some employ community physicians, often with PACE advance practice registered nurses assisting in the management of their panel of participants. In one PACE program in the Midwest, community-based primary care physicians are expected to participate once a month in a conference call to the interdisciplinary team (IDT) during regular IDT meetings to review all of the participants managed by the physician. Care plans are reviewed and developed after each 6-month comprehensive assessment. Physicians are paid for their involvement in these care coordination activities. Community providers must have unrestricted appointments for continuity of care and provide 24 h call coverage.

PACE programs are capitated and reimbursement rates are tied to a frailty adjuster based on limitation in Activities of Daily Living. PACE plans negotiate a Medicaid rate with their state Medicaid organization and must provide services through a contracted network of collaborating agencies. CMS has evaluated PACE programs and found that they have positive sustainable outcomes for reduced hospitalizations, improved health status and quality of life, and lower mortality rates compared to similar non-PACE cohorts [16].

Lessons from Previous Demonstration Projects

Lessons from previous demonstration projects targeted at improving the care of the "duals" population help to define some of the characteristics of successful, integrated, well-coordinated, less costly approach to care for this complex population [17–19].

- Many adults in the dual-beneficiary population have multiple chronic illnesses or significant mental health illness that requires intensive care coordination. This may include care managers attending clinical appointments, keeping track of upcoming appointments, making home visits, making telephone contact, etc.
- Care coordinators need to be able to work comfortably across the spectrum of acute and community- based long-term services and supports (CB-LTSS) services. Ideally, care coordination is provided by one individual who has a full grasp of the resources commonly utilized by the "duals" population. Ongoing education for the care managers is essential.
- Access to behavioral health care remains limited in many communities and is critical to well being, particularly for the younger "duals" with significant mental health illness.
- Functional limitations (e.g., inability to leave one's home without assistance), and limited transportation to medical services interferes with access to medical visits and lowers the quality of care.
- States with low Medicaid reimbursement rates are experiencing difficulty attracting managed care organizations to participate in capitated dual eligible demonstrations

ACA Provisions Directly Related to the Care of the Duals

The Centers for Medicare and Medicaid Services (CMS) administers the Medicare and Medicaid programs, which provide health care to almost one in every three Americans. CMS directly employs over 4,500 employees, sub-contracts with many others, and has an annual budget well over $800 billion. The Center for Medicare and the Center for Medicaid and CHIP (Children's Health Insurance Program) Services have traditionally been separate CMS entities with limited coordination of

effort. In response to the challenges facing the dual eligible population, the ACA established the Federal Coordinated Health Care Office (FCHCO or Duals Office). The goals of this small office are [20]:

- Providing dual eligible beneficiaries full access to the benefits to which such individuals are entitled to under the Medicare and Medicaid programs.
- Simplifying the processes for dual eligible beneficiaries to access the items and services they are entitled to under the Medicare and Medicaid programs.
- Improving the quality of health care and long-term services for dual eligible beneficiaries.
- Increasing dual eligible beneficiaries understanding of and satisfaction with coverage under the Medicare and Medicaid programs.
- Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.
- Improving care continuity and ensuring safe and effective care transitions for dual eligible beneficiaries.
- Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.
- Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

In addition to the Dual's Office, the ACA also established the Center for Medicare and Medicaid Innovation (CMMI). The ACA provides CMMI with significant budget authority to test and expand innovative models of care, including models involving dual eligibles. A number of other provisions in the ACA effect the care provided to dual eligible beneficiaries and these are summarized in Table 7.1.

Financial Alignment Demonstrations

In 2011, the Duals Office began the Medicare-Medicaid Financial Alignment Demonstration. The program allows state Medicaid offices to develop innovative approaches to improve the coordination of care for the dual eligible population, while adding efficiencies and incentives that will reduce the cost of care. Initially, 15 states were awarded $1 million planning awards (California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin). Subsequently, several states have submitted specific proposals to CMS that allows for an integration of Medicaid and Medicare dollars [22]. These financial alignment demonstrations can take two forms:

- **Capitated Model:** A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care.
- **Managed Fee-for-Service Model:** A State and CMS enter into an agreement by which the State would be eligible to benefit from savings resulting from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid.

Table 7.1 Affordable care act provisions relating to the care of dually eligible Medicare and Medicaid beneficiaries

New CMS offices/centers
Federal Coordinated Health Care Office to improve coordination of care for dual eligibles (FCHCO or Duals Office)
Center for Medicare and Medicaid Innovation to test new models of care (CMMI or Innovation Center)
Coordination of care
Independence at home Medicare demonstration project for beneficiaries with chronic illness
Medicaid option to provide health homes for beneficiaries with chronic conditions
Medicaid waivers involving dual eligibles
Preventive benefits (provisions not exclusive to dual eligibles)
New Medicare annual wellness benefit
Medicare and Medicaid preventive services
Medicare part D prescription drug plans
Improved calculation of Low-Income Subsidy (LIS) benchmark premium
Elimination of cost-sharing for certain full benefit dual eligible beneficiaries
Dispensing techniques for medicines prescribed for long-term care facility residents
Inspector General studies of Part D plan formularies
Medication therapy management programs (MTMP) for at-risk enrollees
Medicare advantage plans
Extends the authority for MA plans for special needs individuals (SNP)
Permanently authorized the senior housing facility demonstration
Hold harmless for Program for All-Inclusive Care for the Elderly (PACE)
Long-term care (provisions not exclusive to dual eligibles)
Medicaid community first choice option
Money follows the person demonstration extended
Temporary spousal impoverishment protection
Advisory bodies
Medicaid and CHIP Payment and Access Commission (MACPAC) to study the interaction of Medicaid and Medicare policies
Independent Payment Advisory Board (IPAB) to take into account the unique needs of dual eligibles

Adapted by the author based on: The Henry J. Kaiser Family Foundation's [21]

The State proposals are reviewed by CMS and then a Memorandum of Understanding (MUO) is signed between CMS and the State. At the start of 2014, eight States had completed signed MUO's with CMS, most pursuing the capitated model (California, Illinois, Massachusetts, Ohio, New York, South Carolina, Virginia, and Washington), Minnesota completed a modified administrative alignment MUO; 14 States had pending proposals; 3 States had withdrawn their proposals; and 24 States were not yet participating in the demonstration [23].

The financial alignment or integrated care demonstration projects will be 3 years long and will be evaluated on measures of quality and cost. Participants with full Medicaid and Medicare benefits can participate; although each State can choose to

include dual eligible adults over and/or under 65 years old, and will initially limit participation by geographic area. The plans in most States will be implemented by contracts with private managed care insurance companies.

For example, in Ohio, over 100,000 dual eligible beneficiaries are targeted for enrollment in 2014. The program in Ohio will be implemented in seven geographic districts; mostly focused on large urban areas. Ohio initiated a bidding process to allow insurance providers to apply to participate in the demonstration. An MUO requirement is that each region be served by at least two insurance companies. Managed care plans selected to participate in Ohio include: Aetna, Buckeye Community Health, Care Source, Molina Healthcare, and United Community Plan. A controversial aspect of many of the proposals is CMS acceptance of passive enrollment of beneficiaries. Participants would be able to opt out of the Medicare portion of the demonstration; but in most States be required to stay in Medicaid managed care. It is not yet clear what the effects on the demonstrations would be if many of participants decided to opt out of the Medicare portion.

The insurance companies in the capitated model will receive a prospective blended rate that includes payments from CMS for the Medicare portion of covered services and from the State for the Medicaid portion of covered services. CMS is requiring that the agreed upon capitated rate allow for upfront savings for both CMS and the State. CMS is also requiring a quality withhold from the plans' capitated rates; plans could earn back the withheld amount if they meet quality objectives. Although the withhold varies by MUO, it is in the range of 1 % in year 1, 2 % in year 2, and 3 % in year 3 of the demonstrations [24].

The demonstration clinical programs must include full primary care and acute care, mental health, pharmacy, and LTSS benefits. Care coordination is an important component of most of the proposals. This care coordination should include comprehensive care plans for each participant that take into account the patient and families' wishes. The demonstrations will be evaluated on quality measures, including consumer satisfaction, and cost savings. CMS has contracted with the Research Triangle Institute (RTI) to conduct the national evaluation of these demonstrations.

The financial alignment of the demonstrations has created considerable controversy among providers and consumers. For example, nursing home providers are concerned about their future rates and the demonstrations' likely emphasis on home and community-based care. Existing providers of LTSS, such as area agencies on aging, have actively pursued lobbying efforts to ensure that they are included as part of the care management plans of the new managed care plans. Consumer advocacy organizations acknowledge the need for better coordination of services for this vulnerable population, but have been closely monitoring the details of the developing new care systems. Consumer concerns include the proposals for passive enrollment, the size of the clinical networks and disruption of existing care teams, role of consumers in ongoing advisory committees, and restricted home and community based services and transportation (Table 7.2).

Table 7.2 Financial alignment demonstrations – integrating Medicare and Medicaid payment: top consumer concerns

Enrollment in demonstrations should be voluntary via an opt-in process
Delivery systems must have robust provider networks that include a sufficient number of experienced providers
Delivery systems should take steps to allow people to continue seeing long-standing providers
Long-term services and supports (LTSS) needs should be accessed through a comprehensive assessment
An interdisciplinary team should be used to coordinate beneficiaries' care
In addition to the full range of Medicare and Medicaid benefits, states should include additional needed benefits and services, such as, dental, vision, transportation, behavioral diversionary services, etc.
While the demonstration project is being implemented, beneficiaries and advocates should have defined roles at both the state oversight and delivery system levels
Enrollees in demonstrations should be guaranteed a robust set of protections including the freedom to choose their plan, providers, way in which care is delivered, and access to an easy-to-navigate appeals and grievances system
There must be a payment structure that provides sufficient resources to meet the medical and support needs of beneficiaries, especially those with the most complex needs
The state and CMS should rigorously evaluate demonstrations using meaningful and uniform quality measures that evaluate data on beneficiaries' experience, including their level of confidence in taking care of themselves, managing problems, and getting better healthcare and level of involvement in their community
The state and CMS should guarantee dual eligibles a choice of providers who speak their language and understand their culture as well as culturally sensitive written materials

Role of Geriatrics and Primary Care Providers in Implementing New Models of Care for the Dual Eligible Beneficiaries

While Fee-For-Service (FFS) Medicare remains the dominant form of health insurance coverage for dual eligibles, pressure to control costs and integrate services is rapidly changing the practice environment for many physicians. The purpose of the new CMS "Duals" office is to help Medicare and Medicaid to work more effectively together. This office is working to speed up the transformation of health services from fragmented, episodic, often duplicative and unnecessary care to comprehensive and integrated services for dual eligibles.

Geriatric Medicine and Primary Care Principles

Geriatric medicine and primary care principles and models of care, if applied to the care of the vulnerable dual eligible population, have the potential to increase quality of care and reduce the cost of services. The ACA initiatives directed at the dual

eligible population will more likely be successful if geriatrics and primary care providers participate in planning and direct care provision. Geriatrics providers have the opportunity to display leadership in their communities and institutions to ensure adequate resources to promote patient-centered healthcare outcomes. A few of these principles include:

An important geriatrics strategy is to provide just the *"right" amount of care* (not too much, not too little), in the *"right" location* (usually the least intensive; home is the first choice; the hospital the last choice). To provide the "right" amount of care, the care providers, the patient, and caregivers must develop a care plan that addresses the patient's goals of care. Providing care in the least intensive setting reduces the risk of iatrogenic problems.

Another principle is the importance of *interprofessional teams* in providing care. As the system for providing care to dual eligible beneficiaries is changing, the role of the primary care provider is changing as well. No longer is the physician viewed as the lone provider of health services. Although, the physician is, and will remain, a critical member within the health care team responsible for managing the care of dual eligibles; advance practice registered nurses and physician assistants are playing increasing roles in helping to provide more comprehensive and appropriate health services. The care needs of the dual eligible population are often complex and involves biopsychosocial challenges. Managing patients as a team leads to better continuity, enhanced care coordination, improved patient safety, better chronic illness care, enhanced medication adherence, fewer adverse drug reactions, preserved function, and decreased hospital readmissions [25, 26].

The *Patient-Centered Medical Home (PCMH)* model is not specifically designed for managing dual eligibles or integrating Medicare and Medicaid services. However, this model of high quality primary care is similar to the principles and practices employed by PACE programs which have proven the value of integrated, interprofessional-based care for dual eligible beneficiaries [27]. Health care providers will be valued for their ability to be active, constructive members of a health care team. Working as a member of an interprofessional team, health care providers will need to learn to be effective team players. In the interprofessional environment, such as in PCMH practices, interacting in person or electronically with other health care professionals will be necessary and common. In an interprofessional team setting, face-to-face meetings and discussions with other health professionals to discuss clinical problems and develop plans of care is routine. To be an effective team player, and to engage the assistance of other health professionals, health care providers will need to better understand the role of these other professionals. Knowing what a nurse, social worker, rehabilitation therapist or recreation therapist can and should be able to do, will facilitate primary care providers in their work as team members. It will also allow them to better utilize the resources available to them to the benefit of their patients.

For vulnerable patients living in the community, *enhanced primary care models* have shown promise for improving the care for the vulnerable, functionally impaired patient. For example, the Geriatrics Resources for Assessment and Care of Elders (GRACE) model creates an interprofessional team in the primary care physicians (PCP) office. The team, an advanced practice nurse and social worker, provide home-based geriatrics assessment for vulnerable patients and long-term care management.

The team is supervised by a geriatrician consultant. The care plan is implemented by the entire team under the direction of the PCP. The nurse and social worker coordinate care among all providers and sites of care, utilizing the electronic health record. This model has demonstrated better quality of care for geriatrics syndromes, improvements in health-related quality of life, decreased use of the emergency room, and decreased hospitalizations in high-risk patients [28].

Transitions of care from one setting to another can be dangerous for the vulnerable patient. Poor patient outcomes and frequent hospital readmissions are the result of poorly managed transitions. Evidenced based models to improve care transitions are now available [29, 30]. Key elements that are associated with successful transitional care include:

- Accurate and timely information transfer to the next set of providers.
- Patient and family education about the disease process, self-management recommendations, and expectations at the next level of care.
- Empowerment of patients to assert their preferences for the type, intensity, and location of services.

Emphasizing the quality of visits and procedures rather than volume will become increasingly valued. Under Medicare Fee-For-Service the more providers do, the more providers are paid. This can lead to a misalignment of incentives and poor outcomes. Duplicative or even unnecessary care and services may result. Services that could be provided without a visit may not be performed. Time spent addressing multiple, complex problems that are time consuming are discouraged and avoided. The alignment of financial and quality incentives will promote a more cost effective, evidence-based approach to medicine. With a change in payment structure, spending time to address and resolve complex medical problems, working collaboratively with other team members to avoid institutional care or improve adherence to lifestyle changes, or holding a goals of care discussions with patients and caregivers should be possible.

Electronic Health Records and information technologies will be used to manage disease, prescribe medications, and communicate with other health professionals.

Health providers will need to *know the expectations as well as the policies and practices of the health plans* for which they work. Provider performance will be tracked and measured based on specific processes and procedures. Following appropriate procedures for prescribing medications, using the electronic health record to document clinical care and medications, and adhering to recommended clinical practices are some of the tasks that providers may be expected to perform.

Summary

Geriatrics/gerontology care principles and models of care, if applied to the care of the vulnerable dual eligible population, have the potential to increase quality of care and reduce the cost of services. The ACA initiated demonstrations of the dual eligible population will more likely to be successful if geriatrics providers participate

in planning and direct care provision. Geriatrics providers' clinical leadership, when combined with consumer advocacy efforts, is essential to ensure that the financial incentives in the integrated care demonstrations are aligned to ensure optimal care for vulnerable older adults.

References

1. Data book: Beneficiaries dually eligible for Medicare and Medicaid. MedPAC|MACPAC. 2013. http://www.medpac.gov/documents/Dec13_Duals_DataBook.pdf. Accessed 3 June 2014.
2. Henry J Kaiser Family Foundation. Focus on health reform. 2011 (#8192). www.kff.org. Accessed 11 Jan 2013.
3. MEDPAC. Dual eligible beneficiaries. In: A data book: health care spending and the Medicare program. 2011. www.medpac.gov. Accessed 11 Jan 2001.
4. Branch E, Bella M. What is the focus of the integrated care initiatives aimed at Medicare-Medicaid Beneficiaries? J Am Soc Aging. 2013;37:6–12.
5. Davenport K, Hodin RM, Feder J. The "dual eligible" opportunity. Center for American Progress and Community Catalyst. www.americanprogress.org. Accessed 11 Jan 2013.
6. Social Security Act. http://www.ssa.gov/OP_Home/ssact/title18/1812.htm. Accessed 3 June 2014.
7. Frye JE, Center for Medicare Advocacy. Dually eligible for Medicare and Medicaid. Slide presentation at National Health Policy Forum. Washington, DC: Reserve Officers Club; 2003.
8. MEDPAC. Dual eligible beneficiaries: an overview, Chapter 3. In: Report to the congress: new approaches in medicare. Medicare Payment Advisory Commission 2004. pp. 71–92. http://www.medpac.gov/documents/june04_entire_report.pdf. Accessed 18 Jul 2014.
9. Kaiser Family Foundation. Medicaid update: expenditures and beneficiaries in 1994 – policy brief. 1996. http://kff.org/medicaid/issue-brief/medicaid-update-expenditures-and-beneficiaries-in-1994/. Accessed 3 June 2014.
10. Milligan CJ, Woodcock CH. Medicare advantage special needs plans for dual eligibles: a primer. Issue Brief Commonw Fund. 2008;31. 1108
11. Gold M, Jacobson G, Damico A, Neuman T. Issue brief: medicare advantage 2013 spotlight. Kaiser Family Foundation. 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8448.pdf. Accessed 3 Apr 2014.
12. Medicare Special Needs Plans: A Critical Need for Quality Standards of Care. 2008. http://www.communitycatalyst.org/doc-store/publications/medicare_special_needs_plans_a_report.pdf. Accessed 3 June 2014.
13. Milligan CJ, Woodcock CH. Coordinating care for dual eligibles: options for linking state medicaid programs with medicare advantage special needs plans. Issue Brief Commonw Fund. 2008;1109;32.
14. Medicare Advantage/Part D Contract and Enrollment Data; Special Needs Plans Comprehensive Report. Centers for Medicaid and Medicare Services. 2008. http://www.cms.hhs.gov/MCRAdvPartDEnrolData/. Accessed 4 Apr 2014.
15. PACE in the States. National PACE Association. http://www.npaonline.org/website/download.asp?id=1741&title=PACE_in_the_States. Accessed 4 Apr 2014.
16. Chatterji P, Burstein NR, Kidder D, White A. Evaluation of the Program of All-inclusive Care for the Elderly (PACE) demonstration: the impact of PACE on participant outcomes. Baltimore; Centers for Medicare & Medicaid Services, Department of Health and Human Services. 1998.
17. MEDPAC. Care needs for dual eligibles, Chapter 6. Report to the congress: new approaches in medicare. Medicare Payment Advisory Commission 2004. pp. 145–163. http://www.medpac.gov/documents/june04_entire_report.pdf. Accessed 18 Jul 2014.

18. Burwell B, Saucier P. Managed long-term services and supports programs are a cornerstone for fully integrated care. Generations. 2013;37:33–8.
19. Browdie R. Why is care coordination so difficult to implement? Generations. 2013;37:62–7.
20. Medicare-Medicaid Coordination Office. Centers for Medicare and Medicaid Services. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/. Accessed 23 Dec 2013.
21. Henry J. Kaiser Family Foundation's. Affordable care act provisions relating to the care of dually eligible Medicare and Medicaid beneficiaries. 2011. http://kff.org/health-reform/issue-brief/affordable-care-act-provisions-relating-to-the/
22. Medicaid Coverage of Medicare Beneficiaries (Dual Eligibles) At a Glance: Medicare Learning Network. Department of Health and Human Services, Centers for Medicare and Medicaid Services. ICN 006977. 2013. http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf. Accessed 6 Apr 2014.
23. Kaiser Family Foundation. State demonstration proposals to integrate care and align financing and/or administration for dual eligible beneficiaries. 2014. http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/. Accessed 4 Oct 2014.
24. Kaiser Family Foundation. Explaining the state integrated care and financial alignment demonstrations for dual eligible beneficiaries. 2012. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8368.pdf. Accessed 23 Dec 2013.
25. Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. JAMA. 2002;288:1775–9.
26. Cohen HJ, Feussner JR, Weinberger M, et al. A controlled trial of inpatient and outpatient geriatric evaluation and management. N Engl J Med. 2002;346:905–12.
27. Hirth V, Baskins J, Dever-Bumba M. Program of All-inclusive Care (PACE): past, present, and future. J Am Med Dir Assoc. 2009;10:155–60.
28. Counsell SR, Callahan CM, Clark DO, Tu W, Buttar AB, Stump TE, et al. Geriatric care management for low-income seniors: a randomized controlled trial. JAMA. 2007;298(22):2623–33.
29. Coleman EA, Parry C, Chalmers S, et al. The care transitions intervention. Arch Intern Med. 2006;166:1822–8.
30. Naylor MD, Aiken LH, Kurtzman ET, et al. The importance of transitional care in achieving health reform. Health Aff. 2011;30:746–54.