

Legal Basics: Dual Eligibles

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Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since the organization's founding in 1972, we have focused our efforts on populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency. Justice in Aging authored this issue brief under a contract with the National Center on Law and Elder Rights.

Key Lessons

1. **Dual eligibles are a high need and high cost population.** They are more likely to be women and seniors of color, and they are in poorer health than the general Medicare-only population.
2. **Dual eligibles enjoy certain benefits as a result of their dual status, but the delivery of their healthcare also presents challenges.** Dual eligibles qualify for benefits like the Medicare Part D Low-Income Subsidy (LIS), but coordination of benefits across both programs can be challenging.
3. **Dual eligibles are at risk of being improperly billed for covered services.** Payment rules and low Medicaid reimbursement rates result in a higher risk of dual eligibles being improperly billed for covered services. Advocates should be aggressive in fighting these bills.
4. **As a result of efforts to better coordinate care for this population, dual eligibles enjoy a number of different enrollment options for their Medicare and Medicaid benefits.** Advocates should work closely with a dual eligible to find the best option in light of their individual needs and circumstances and be skeptical of plans that do not coordinate across the spectrum of benefits.

Introduction

Across the country, approximately twelve million individuals are dually eligible for both Medicare and Medicaid. They are referred to as dual eligibles or sometimes Medi-Medis. This population is comprised of older adults and younger individuals with disabilities who have low income and assets. As a result of poverty and lack of access, dual eligibles are one of the populations with the highest number of chronic conditions, corresponding to higher costs. They also face a number of unique barriers in navigating and coordinating two separate healthcare programs. This chapter summary begins with highlights of characteristics and demographic information of the dual eligible population, reviews basics of Medicare and Medicaid, discusses common barriers to accessing care, and concludes with an update on different Medicare enrollment options for dual eligibles.

Demographics of the dual eligible population

There are over 12 million¹ dual eligibles across the country, and they are more likely to be women (61

1 Centers for Medicare & Medicaid Services, People Dually Eligible for Medicare and Medicaid, March 2019, [cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf).

percent women to 53 percent men) and seniors of color (42 percent seniors of color to 15 percent white seniors) compared to Medicare-only beneficiaries. With respect to their health, over half (57 percent) have 1 or more ADL limitations compared to only 28 percent of the Medicare-only population; fewer tend to report themselves in excellent or very good health (23 percent) compared to half (51 percent) in Medicare-only. Although dual eligibles are only 20 percent of the Original Medicare population, they account for 34 percent of aggregate Original Medicare spending.²

Medicare and Medicaid Overview

Medicare is a federal health insurance program whose aim is to insure individuals who are 65 and older or individuals with disabilities. Medicare has four main benefit parts: Part A, B, C, and D.³ Part A is essentially in-patient or hospital coverage. Part B is outpatient coverage and physician services, and Part D is Medicare's prescription drug benefit. Medicare is delivered in either a fee-for-service system, otherwise known as Original Medicare, or through Part C managed care plans, known as Medicare Advantage (MA). In Part C managed care plans, enrollees receive their Part A and Part B benefits using the plan's network of providers. The Part D benefit must be delivered through either a Part D plan or a MA plan that includes Part D. Increasingly, there are a number of enrollment options tailored for dual eligibles in Medicare Advantage.

Medicaid is a state-administered health insurance program that offers coverage to a state's low-income individuals. States administer and fund the program subject to federal requirements, but within those requirements, states have significant discretion in operating the program.⁴ Like Medicare, Medicaid is offered through fee-for-service or Medicaid plans. States are increasingly requiring older adults and others to enroll in a Medicaid plan, especially to receive long-term services and supports (LTSS). Although the particulars of each state may vary, Medicaid tends to offer a broader array of services other than Medicare, and in particular, may fund services that older adults disproportionately rely on, including LTSS – like long-term care and in-home care services – auditory services, specialty behavioral health, transportation, oral health, and more.

There are some ways in which Medicare and Medicaid work together to offer some special protections for dual eligible individuals. For example, dual eligibles are automatically enrolled into the Low-Income Subsidy (LIS) program, which helps pay for Medicare Part D cost-sharing.⁵ Enrolling into LIS results in nominal co-payments for covered Part D prescription drugs. Many dual eligibles also qualify for Medicare Savings Programs, which help pay for Medicare cost-sharing.⁶ Separately, state Medicaid agencies participate in Medicare buy-in programs that help pay for Medicare premiums for dual eligibles, reducing their out-of-pocket costs. While these are instances of dual eligibles benefitting from their enrollment in both programs, advocates often experience challenges assisting dual eligibles coordinating two separate health care programs.

Common Barriers to Accessing Care

Medicare providers willing to accept Medicaid

Federal law requires any provider who works with the Medicare program to accept dual eligible patients. However, dual eligibles often report that Medicare providers are not willing to see them. This is because

2 MedPAC, MacPAC Duals Data Book, January 2017, [macpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf](https://www.medpac.gov/wp-content/uploads/2017/01/Jan17_MedPAC_MACPAC_DualsDataBook.pdf); Commonwealth Fund, Medicare Spending Growth for Dual-Eligible Beneficiaries Has Trended Down Since 2011, Aug. 7, 2018, [commonwealthfund.org/publications/journal-article/2018/aug/medicare-fee-for-service-spending-dual-eligibles](https://www.commonwealthfund.org/publications/journal-article/2018/aug/medicare-fee-for-service-spending-dual-eligibles).

3 Statutes governing the Medicare program are found at 42 U.S.C. §§1395-1395ccc.

4 Statutes governing the Medicaid program are found at 42 U.S.C. §§1396-1396v.

5 For more information on Medicare Part D, refer to the NCLER chapter summary at [ncler.acl.gov/pdf/Legal-Basics-Medicare-Part-D.pdf](https://www.ncler.acl.gov/pdf/Legal-Basics-Medicare-Part-D.pdf).

6 For more information on Medicare Savings Programs, refer to the NCLER chapter summary at [ncler.acl.gov/pdf/Understanding%20DME%20Issue%20Brief.pdf](https://www.ncler.acl.gov/pdf/Understanding%20DME%20Issue%20Brief.pdf).

Medicare generally pays only 80 percent of the Medicare rate for a covered service, and for dual eligibles, the remaining 20 percent cost-sharing is the responsibility of the state Medicaid agency. However, the “lesser-of” policy allows states to pay only in circumstances when the Medicaid rate for the service is equal to or greater than Medicare’s, which is rarely the case.⁷ As a result, many providers do not collect the 20 percent cost-sharing. Some Medicare providers, knowing that they will be reimbursed less for treating dual eligibles compared to other Medicare beneficiaries, refuse to treat them upon learning of their Medicaid coverage, or tell them that they are responsible for the 20 percent cost-sharing, a problem discussed later known as “improper billing.”

PRACTICE TIP

Although original Medicare providers can refuse to treat a dual eligible based on their Medicaid status, advocates working with dual eligibles should investigate whether a provider’s refusal violates state laws, which may prohibit medical providers from stopping treatment mid-course. Furthermore, refusing to see a Medicare beneficiary because of their source of payment – including Medicaid – is forbidden in the Medicare Advantage context.⁸

Coordination of Benefits

One of the most common issues facing dual eligibles in accessing healthcare is the coordination of benefits between Medicare and Medicaid. Generally, Medicaid only pays a provider after all other insurance programs have reimbursed, meaning, Medicaid is the payer of last resort.⁹ If advocates are seeking to find a particular service for a dual eligible individual, they should first look to see whether Medicare offers any coverage, and if so, **Medicare rules will govern** that particular service. This is still the case *even if* Medicaid offers coverage for the same service, as Medicaid is the payer of last resort. In another coordination challenge, Medicare and Medicaid may offer some coverage, but Medicaid’s coverage is superior in scope. This frequently happens with Durable Medical Equipment (DME).¹⁰ Medicare typically does not review claims until after the DME has been delivered, and since Medicaid is the payer of last report, dual eligibles needing DME can find themselves stuck between the two program’s rules.

CASE EXAMPLE: PAMELA NEEDS A THERAPIST

Pamela is a mother who recently suffered a tragic loss. When her son passed away, she started feeling severely depressed, and sought out therapy. Pamela is a dual eligible with Original Medicare. Her state required her to enroll in a Medicaid plan to receive her Medicaid benefit. Medicare offers therapy and other basic behavioral health coverage under Part B, and her Medicaid plan offers that coverage and specialty mental health services. Her caregiver has helped her by calling both 1-800-Medicare and her Medicaid plan, both of whom said they will cover her office visit for therapy. She is confused and has come to your office to try and determine how she should access her benefit.

For her basic therapy visits, Pamela should seek a therapist who will accept Original Medicare. Whether that provider also accepts Pamela’s Medicaid plan is immaterial as Medicaid is the payer of last resort and Medicare is primary. The provider first bills Medicare and then Medicaid would pay second if any amount is owed. If Pamela’s depression gets worse and she needs specialty mental health services, she may need to find a provider contracted with her Medicaid plan.

⁷ For a discussion on the “lesser-of” policy, see Centers for Medicare & Medicaid Services, Access to Care Issues Among Qualified Medicare Beneficiaries (QMB), July 2015, [cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf).

⁸ Medicare Managed Care Manual, Ch. 4, Sec. 10.5.2.

⁹ 42 U.S.C. § 1396a(a)(25).

¹⁰ For more information on Durable Medical Equipment, refer to the NCLER chapter summary at [ncler.acl.gov/pdf/Understanding%20DME%20Issue%20Brief.pdf](https://www.ncler.acl.gov/pdf/Understanding%20DME%20Issue%20Brief.pdf).

When Medicare offers little or no coverage of a particular service, and the Medicare provider does not know if the service is offered under Medicaid, the dual eligible individual may face a different coordination of benefits issue. Medicaid may require a provider's referral or certification of need before authorizing the service, but Medicare providers are not always familiar with benefits offered under Medicaid, especially LTSS or other ancillary services, or a Medicaid plan's authorization processes.

PRACTICE TIP

Advocates must be vigilant in working with a dual eligible's Medicare providers to ensure referrals and authorizations for Medicaid services are completed, timely, and proper.

Improper Billing

Sometimes dual eligibles are improperly charged for covered services. **Dual eligibles who qualify for the Qualified Medicare Beneficiary (QMB) program, a MSP that helps pay Medicare cost-sharing for those at or below 100 percent of the Federal Poverty Level, are protected from paying for premiums, deductibles, and co-payments for Medicare covered services.**¹¹ However, Medicare providers sometimes attempt to recoup this cost-sharing from QMB dual eligibles, a problem referred to as improper billing. For dual eligibles who may see multiple providers on a frequent basis, this cost-sharing can start to add up quickly.

CASE EXAMPLE: PAMELA WORRIES ABOUT BILLING

Your advocacy with Pamela is effective. She has an upcoming appointment scheduled with her Original Medicare therapist. When she gets to the front desk, Pamela shows both her Original Medicare card and her member identification card for her Medicaid plan. The receptionist informs Pamela that their office is not contracted with her Medicaid plan. The receptionist says Pamela is responsible for any costs Medicare does not cover. Pamela is now worried that she will have to pay for office visit and is not sure if she wants to continue with seeing the therapist.

The therapist does not need to be contracted with the Medicaid plan in order to treat Pamela or to receive payment for any cost sharing amounts. Assuming Pamela is QMB eligible, **any attempt to collect the cost-sharing would violate the QMB billing prohibition**, even if the provider does not receive anything in addition to the Medicare reimbursement. The bills, and any attempt from collection agencies to collect on those amounts, may further violate a state's consumer protection laws.

Developments with Different Enrollment Options Including Integrated Care Programs

About a dozen states are participating in demonstrations offering health plans that combine Medicare and Medicaid services for dual eligibles. These Medicare-Medicaid plans (MMPs) are responsible for the delivery of both Medicare and Medicaid benefits and are also required to coordinate care for dual eligible members. If advocates are working in states offering MMPs, they should consider whether the plan is an appropriate option for their dual eligible clients.

In addition to MMPs, dual eligibles are also able to enroll Dual Special Needs Plans (D-SNPs), which are Medicare Advantage plans that restrict enrollment to dual eligibles. The Centers for Medicare and Medicaid Services (CMS) recently finalized rules implementing regulations governing minimum integration standards for D-SNPs pursuant to the Bipartisan Budget Act of 2018. These rules seek to improve the experience of dual eligibles enrolled in D-SNPs by setting forth minimum responsibilities for D-SNPs to coordinate Medicaid benefits, requirements for integrating Medicare and Medicaid appeals, and more.

¹¹ 42. U.S.C. § 1396a(n)(3)(B).

PRACTICE TIP

Advocates should also be on the lookout for D-SNP “look-alike” plans. Sometimes called “mirror” plans, they are MA plans that plan sponsors have designed specifically to attract dual eligibles. Though plan sponsors sought and received approval from CMS for these plans as ordinary Medicare Advantage plans, the numbers show that they have been marketed almost exclusively to dual eligibles. These plans have not been approved as D-SNPs subject to D-SNP regulations, including requirements for Models of Care. Plan sponsors have not entered into the state contracts required for D-SNPs. They are serving dual eligible populations with none of the safeguards and none of the stakeholder input involved in regulation and oversight of D-SNPs and other integrated delivery models. As a result, dual eligibles enrolled in “look-alike” plans may find that the plans are not working to actively coordinate their Medicare and Medicaid benefits.

Conclusion

Dual eligibles are an important, high-needs population that faces unique challenges navigating two complicated health care programs. They may encounter problems finding Medicare doctors to treat them, issues coordinating benefits between Medicare and Medicaid, and even be charged for covered services. Policymakers have long given dual eligibles considerable attention, and recent policy changes allow greater enrollment options for dual eligibles to receive care. Advocates should be intimately familiar with these changes and the typical issues dual eligibles encounter.

Additional Resources

- Denny Chan, dchan@justiceinaging.org
- Amber Christ, achrist@justiceinaging.org
- 42 U.S.C. §§1395-1395ccc
- 42 U.S.C. §§1396-1396v
- 42. U.S.C. § 1396a(n)(3)(B)
- Justice in Aging: [Improper Billing Toolkit](#)
- NCLER Chapter Summary: [Understanding Durable Medical Equipment](#)
- NCLER Chapter Summary: [Medicare Savings Programs](#)
- NCLER Chapter Summary: [Legal Basics: Medicare Part D](#)
- [Kaiser Family Foundation Resources on Dual Eligibles](#)
- [Resources from the Medicare-Medicaid Coordination Office \(MMCO\) at CMS](#)

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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