Stop Settling:

Are You Getting Partial Dual Premiums for Full Dual Risk?

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Content

Our Mission

To improve lives and positively impact social determinants of health barriers by providing our healthcare partners with the information they need, and people with the advocacy they deserve.

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The History of the CMS Payment Model

President Lyndon B. Johnson chose the Harry S. Truman Library as the site for the signing of the Medicare Act in order to honor former President Harry S. Truman, who he dubbed: The Father of The Medicare Concept.*

The Centers for Medicare and Medicaid Services (CMS) has had a rich and intricate history. Since Lyndon B. Johnson signed the Medicare and Medicaid Act, also known as the Social Security Amendments, on July 30, 1965, Medicaid and Medicare have touched millions of lives and provided medical coverage for much of America's older and underprivileged populations.

* Photo Source: Lyndon B. Johnson, Library and Museum. Web Site: https://www.lbjlibrary.org/object/photo/signing-medicare-bill-7 Origin date: 07/30/1965, location: Harry S. Truman Library, Independence, Missouri, credit: LBJ Library photo by unknown, rights: public domain, serial number: 34897-16

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Although most of us are aware of Medicare and Medicaid programs, a significant amount of Medicare beneficiaries are still not aware of all the benefits potentially available to them. Medicare recipients, who are low-income and meet other criteria, may qualify to receive full or partial Medicaid benefits. These individuals are referred to as "dually eligible beneficiaries", "dual eligibles", or "duals".

Because low-income seniors typically have severe chronic health conditions and social health barriers, CMS pays a Medicaid Add On (MAO) to the capitated monthly premium that Medicare Advantage (MA) plans receive each month based on a member's risk score.

The MAO is a component of the member's risk adjusted monthly capitated premium from CMS. In 2017, the CMS payment model went through extensive changes. For dual enrolled members, the HCC risk adjustment model created subsegments based on age and Medicaid status.

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Under the new methodology, beneficiaries are divided into six groups:

1. ***Full benefit dual aged***
2. ***Full benefit dual disabled***
3. ***Partial benefit dual aged***
4. ***Partial benefit dual disabled***
5. ***Non-dual aged***
6. ***Non-dual disabled***

The model change increased the MAO for most individuals with full dual benefits and decreased the MAO for most partial dual eligible and non-dual eligible individuals.

Before this change, the revenue model did not adjust for partial or full dual members.

Even if a full dual member received extra benefits from their State Medicaid plans or had higher severity of illness or more conditions, the plan received the same MAO ($125 pmpm on average). Because the payment model wasn't impacted, many vendors followed the least challenging path to dual enrollment, which in most states, is a Medicare Savings Program application.

Since 2017, CMS has noted that full duals are often higher utilizers of services; therefore, "the model distinguishes these six groups. On average, the current MAO is $27 pmpm for partial duals" and $275 pmpm for full duals – creating an incentive to understand all pathways to Medicaid.

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Dual Eligibility

The term "dual eligible beneficiaries" refers to those individuals qualifying for both Medicare and their state's Medicaid program. "Partial duals" are members that qualify for Medicare Savings Programs (MSP) such as QI-1, SLMB, and QMB. The federal minimum income limit for the MSP is 135% Federal Poverty Level (FPL); however, seven states have elected to use higher income limits. "Full duals" are members that qualify for Medicare and full Medicaid benefits available through the Medicaid state plan.

According to Centers for Medicare and Medicaid Services, 12.3 million people were considered dual enrolled in 2020.

However, an additional 50% of individuals who meet eligibility standards continue to go unidentified every year[1].

61.5M
Americans are enrolled in Medicare

12.3M
Are dual enrolled in 2020

3.8M
Are new enrollees

34%
Live at or below **150%** of the Federal Poverty Level

7.6M
Are potentially eligible but not enrolled in Medicaid or Medicare Savings Programs

Duals make up 14%
of Medicaid enrollment yet spend **33%** of Medicaid Expenditures

Duals total 20%
of Medicare enrollment and **spend 34%**
of Medicare dollars

71%
Duals receives full Medicaid benefits and are often in poorer health and require more care

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Because these members typically have greater health concerns and more costly medical needs, it is crucial that health plans can identify their dual members and help them receive the benefits they need.

While identification of dual eligible beneficiaries helps to ensure the Medicare Advantage plan is paid accurately for the risk of their members, the member also receives much needed financial assistance including state payment of their Medicare Part B premiums and may also qualify for coverage of deductibles/ copays and additional benefits such as transportation, dental or vision.

In 2022, the Part B premium is $170.10 for most members.

For low-income individuals, refunding that Part B premium into their Social Security check substantially increases their monthly income and standard of living. Helping members overcome financial insecurity has also been shown to lower the medical costs for these members[2].

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The Benefit in Converting a Partial Dual Member to a Full Dual

Because it did not impact revenue whether their members were signed up for partial or full Medicaid, many of the early Medicare and Medicaid vendors had taken the less challenging route to dual eligibility.

This less challenging route for vendors typically involved filling out applications for Medicare Savings Programs, which in some states only have the member screened for partial dual enrollment.

Since 2017, the focus has shifted to encourage MA plans to get the most benefits for their members and to help ensure they were paid accurately for the risk of these members.

Members eligible for full dual enrollment are more likely to use medical services, utilize more costly services, and have more serious health conditions and social determinant of health barriers than those who are partial or not dual eligible.

This means that plans who have "settled for partial" benefits for their members not only miss out on additional capitation, but are, on average, spending more on these members[3].

Dual members often spend more than a third (34%) of their annual income on healthcare costs, which at 100% of FPL leaves very little to pay for necessities such as food, utilities and housing[4].

Some of the most significant ways plans can assist Medicare Advantage

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members is by providing financial assistance and connecting members with Medicaid benefits. This, in turn, helps to improve quality of life and overall health outcomes.

How Can We Get Members There?

Re-evaluation: Members classified as partial duals should be re-evaluated for potential eligibility for full Medicaid. These members may possibly meet the eligibility requirements for full dual benefits because their circumstances have changed (i.e. change in marital status, loss of job income, reduction in countable assets, etc.). Other variable factors include changes in state Medicaid eligibility criteria such as elimination of asset limits, increased income standards, or changes in age requirements for the working disabled. Re-evaluation should be conducted at regular intervals to confirm that members have not had a change in finances or assets that would now qualify them for more benefits in their state given the current program limits. Many members see a significant reduction in savings due to unforeseen circumstances and healthcare costs, which could lead to the conversion of a

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partial dual to a full dual. We also need to ensure that members are receiving the most benefits they can at any given time.

Expertise: It is important that your eligibility systems are aware of your state's Medicaid eligibility criteria and that advocates are educating members on available programs and their qualifications. Because Medicaid programs can be complicated, it is often challenging for those who do not regularly work with these entities to navigate their systems. This typically makes members very reliant on their advocates to give them the information they need. Because eligibility criteria vary from state-to-state, it is important that advocates are also evaluating all pathways to Medicaid, which might require members applying for Supplemental Security Income (SSI) through the Social Security Administration first.

Address member stigma: Despite the efforts made to identify and educate members, there is still stigma associated with Medicaid services.

Many newly eligible members may have preconceived impressions and attitudes towards Medicaid, and they may be hesitant to explore their options.

Before a member signs up as a dual member, they should speak with their healthcare advocate to address any concerns and clarify possible misconceptions.

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Medicaid Pathways

There are several pathways that should be explored that may qualify a member for full Medicaid benefits.

These pathways include: SSI, Modified Adjusted Gross Income (MAGI), non-MAGI Medicaid, Medically Needy, and Working Disabled.

Each of these pathways have specific rules and qualifications for enrollment, which is why it is important to have well-trained and knowledgeable advocates that can assist members every step of the way.

• **SSI:** Screening for SSI eligibility takes place in all 50 states and Washington D.C. Thirty-five states have completed the 1634 agreement with the Social Security Administration, which determines an individual's eligibility for that specific state's Medicaid program based on whether or not he/she qualifies for SSI[5]. Individuals who receive SSI are eligible for Medicaid automatically without having to fill out any additional paperwork or apply for Medicaid separately. In non-1634 such as 209(b) and "SSI criteria" states, members have to apply for Medicaid even if they are enrolled in SSI.

• **MAGI:** MAGI-based methodology is used to determine whether an individual qualifies for Medicaid by considering taxable income and tax filing relationships. Unlike other pathways to Medicaid, it does not allow for income disregards that vary by state or eligibility group, and does not allow for an asset limit.

For example, an adult age 65 or older who is the primary caregiver to a minor, might qualify for this particular pathway to Medicaid.

• **Non-MAGI Medicaid (Categorically Needy):** States have the option to provide full Medicaid benefits to aged, blind, or disabled (ABD) members who do not qualify for SSI, because their income and/or assets exceed SSI standards. The asset and income limits vary from state to state and by family size.

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• **Medically Needy:** Some states have medically needy programs for individuals with significant out-of-pocket medical expenses and income that exceeds the categorically needy income limit has countable assets within the program limit. An individual qualifies for a state's medically needy Medicaid program if they "spend down" their monthly income on healthcare expenses to below a state's medically needy income standard. Once an individual meets this "spend down" threshold, he/she becomes eligible for Medicaid, which then pays the difference in medical costs for the amount exceeding that threshold[6].

• **Working Disabled:** The working disabled program allows an individual to qualify for Medicaid at a higher Federal Poverty Level (typically around 250%) if they are working and considered totally or permanently disabled according to the SSI definition of disabled[7]. This program allows disabled individuals to continue to work and earn a modest income, while still receiving the Medicaid benefits he/she needs.

Dual Advocacy at BeneLynk

Founded by a team with decades of experience working at the intersection of Medicare and Medicaid, BeneLynk's dual eligibility advocacy services lead the market and iteratively incorporate new and improved methods to help members get all the benefits to which they are entitled. Our technology and Medicaid expertise helps to ensure that members are screened for various pathways to Medicaid.

Our live, friendly, onshore advocates enhance the member experience, which helps increase dual enrollment and member retention.

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Our government relations team has decades of experience working with state Medicaid programs and ensures our advocates are informed about current and changing legislation. This allows us to optimize services and assist members every step of the way.

BeneLynk also utilizes an advanced eligibility engine that uses predictive models to identify possible dual eligible members. Because members too often lack the information and help that they need, it is estimated that as much as 37% of dual eligible members remain unenrolled[8].

We're experts at identifying dual members, even if they have not previously been considered dual eligible by traditional pathways. The combination of our skilled advocates and technology-enabled system allows us to help our clients and their members avoid settling for less benefits than they deserve.

Citations

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About BeneLynk

BeneLynk is a national provider of social determinant of health (SDoH) solutions for Medicare Advantage and Managed Medicaid health plans. We serve plans and their members by creating a human-to-human connection and providing the assistance a member needs to get the benefits they deserve.

By employing one dynamic conversation that flows organically to meet social determinant of health challenges, we build stronger human connections that are supported by innovative technology.

All of our services are customized to the specific geography where we provide services and provide the members with the specific information they need to keep their benefits in place.

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