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Medicare Policy

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Medicare's Role for Dual Eligible Beneficiaries

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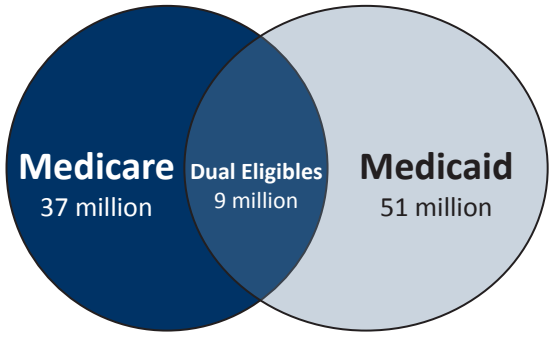
Introduction

Nine million low-income elderly and disabled people are covered under both the Medicare and Medicaid programs **(Exhibit 1)**. These beneficiaries (often called "dual eligibles") are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions, and have functional and cognitive impairments. Medicare is their primary source of health insurance coverage, as it is for the nearly 50 million elderly and under-65 disabled beneficiaries in 2012. Medicaid supplements Medicare, paying for services not covered by Medicare, such as dental care and long-term care services and supports, and by helping to cover Medicare's premiums and cost-sharing requirements. Together, these two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket medical and long-term care costs.

EXHIBIT 1

Dually eligible beneficiaries comprise 20% of the Medicare population and 15% of the Medicaid population



SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2008, and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY2008 MSIS and CMS Form-64.

Policymakers at the federal and state level are increasingly interested in developing initiatives for dual eligibles both to improve the coordination of their care, and to reduce spending for both Medicare and Medicaid. To help inform ongoing policy discussions, this policy brief describes the roles played by Medicare and Medicaid in providing care for duals, illustrates how dual eligibles differ from others on Medicare, and examines the variations in medical needs and Medicare spending among dual eligibles.

Key findings include:

- In 2008, dual eligibles comprised 20 percent of the Medicare population but 31 percent of Medicare spending, and 15 percent of the Medicaid population but 39 percent of Medicaid spending.
- A larger share of dual eligibles than others on Medicare were in fair/poor health (49% versus 22%), had cognitive/mental impairments (58% versus 25%), functional impairments (44% versus 26%) and lived in facilities (13% versus 1%); a larger share of dual eligibles than others died in 2008 (7% versus 3%).
- Dual eligibles had higher hospitalization rates than others on Medicare (26% versus 18%), and were more likely to have two or more hospitalizations (11% versus 6%).
- Average Medicare spending for dual eligibles was 1.8 times higher for dual eligibles than others on Medicare ($14,169 versus $7,933), and 8% incurred $40,000 or more in Medicare expenditures in 2008; total Medicare spending for dual eligibles in 2008 was $132 billion.
- Medicare spending for under-65, disabled dual eligibles is substantially lower than spending for dual eligibles age 65 or older ($13,661 per capita versus $16,445 per capita, on average).
- Not all dual eligibles are high spenders and most (74%) were not admitted to a hospital in 2008; 16% of dual eligibles had Medicare spending below $2,500 in 2008.

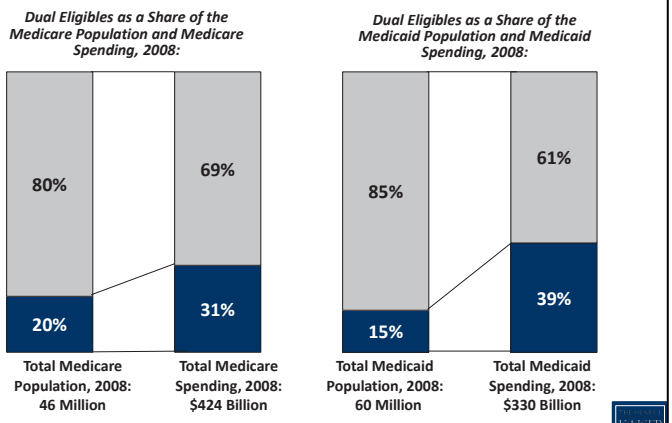
A more in-depth discussion of these and other findings follows, with a description of data sources and estimation methods used in this brief in the Appendix.

Medicare and Medicaid Play Important but Different Roles for People who are Dually Eligible

Dual eligibles, like all other Medicare beneficiaries, are eligible for Medicare if they are age 65 or older or are under age 65 with a permanent disability receiving SSDI, or have end-stage renal disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS).[1] While dual eligibles account for 20 percent of all Medicare beneficiaries nationwide, they are a larger share of the Medicare population in some states than others, ranging from 36 percent of the Medicare population in Maine to 12 percent of the Medicare population in Colorado, Montana, Nevada and Utah **(Table 1)**. Medicare is the primary source of health insurance for dual eligibles, and covers most medical services, including inpatient and outpatient care, physician services, diagnostic and preventive care and, since 2006, outpatient prescription drugs under Part D plans. Medicare does not cover routine outpatient dental care or non-skilled long-term services and supports, such as in home care or extended home and personal care in the community.

EXHIBIT 2

Dual eligible beneficiaries account for a disproportionate share of Medicare and Medicaid spending

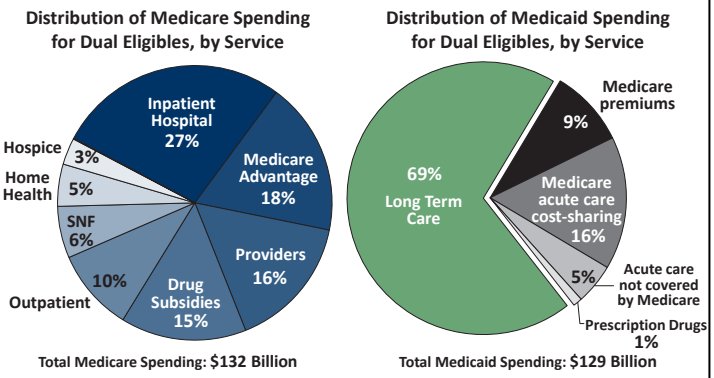


SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2008, and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY2008 MSIS and CMS Form-64.

Medicaid, a need-based program funded jointly by the federal and state governments, plays a key role in filling these gaps for low-income Medicare beneficiaries. Medicaid provides help with Medicare's premiums and cost-sharing requirements, and helps pay for the services that are not covered by Medicare. The majority of the dual eligibles (77%) receive full Medicaid benefits, ranging from more than 98 percent of dual eligibles in California and Alaska to less than 50 percent in Alabama and Delaware **(Table 1)**. The remaining 23 percent of dual eligibles (sometimes called "partial dual eligibles") qualify for more limited assistance with premiums and cost-sharing under Medicare Savings Programs **(Table 2)**, according to the Kaiser Commission on Medicaid and the Uninsured.[2]

EXHIBIT 3

Hospitalizations and long-term care are the largest components of Medicare and Medicaid spending for dual eligibles



NOTES: Home health and dental services comprise less than 1% of Medicaid spending. Payments to facilities comprise less than 1% of Medicare spending. Medicare premiums paid by Medicaid also includes cost-sharing for Qualified Medicare Beneficiaries only. Medicare Advantage payments are for Part A and B services only. Prescription drug subsidy payments include both the federal direct subsidy and the low income subsidy (LIS) payments.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2008, and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY2008 MSIS and CMS Form-64.

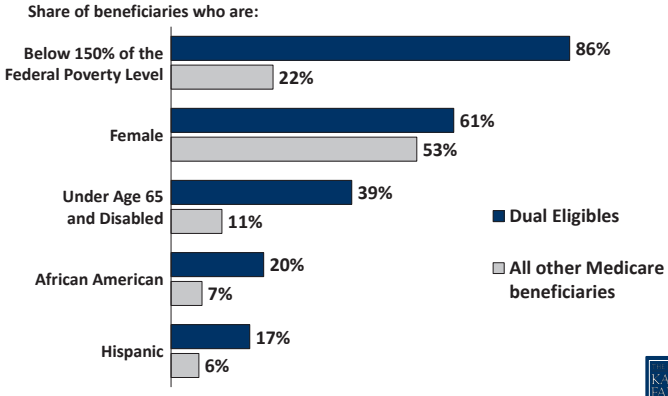
Dual eligibles are disproportionately counted among Medicare and Medicaid's high spenders **(Exhibit 2)**. In 2008, dual eligibles comprised 20 percent of the Medicare population but 31 percent of Medicare spending, and 15 percent of the Medicaid population but 39 percent of Medicaid spending.[3] In 2008, Medicare spent $132 billion on medical services for people who are dual eligibles **(Exhibit 3)**. More than one-quarter (27%) of Medicare spending for dual eligibles was for inpatient hospital services, 18 percent for Part A and Part B services provided to dual eligibles through Medicare Advantage plans, 16 percent for physicians and other medical providers, and 15 percent for direct and low-income subsidy (LIS) payments for Part D prescription drug premiums and cost-sharing. Medicaid spent $129 billion on care for the dual eligibles in 2008, the majority of which (69%) was for long-term care services and supports.

Dual Eligibles are Poorer and Have More Medical Needs Than Other Medicare Beneficiaries

People who are dual eligibles differ from others on Medicare in their demographic composition, health care needs, service utilization, and Medicare spending. Due to eligibility criteria, dual eligibles have lower incomes, and 86 percent have incomes below 150 percent of the federal poverty level **(Exhibit 4).** Those with higher incomes are primarily individuals who "spend down" their assets and become eligible for Medicaid due to medical and long-term care expenses. Nearly four in 10 dual eligibles (39%) is under-65 and disabled – more than triple the rate among all other beneficiaries (11%). The share of dual eligibles who are under-65, disabled varies greatly across the states, from less than one-third (29%) in California to more than half (53%) in Utah **(Table 1)**.

EXHIBIT 4

A larger share of dual eligibles than other beneficiaries is low-income, female, under age-65 disabled and minorities

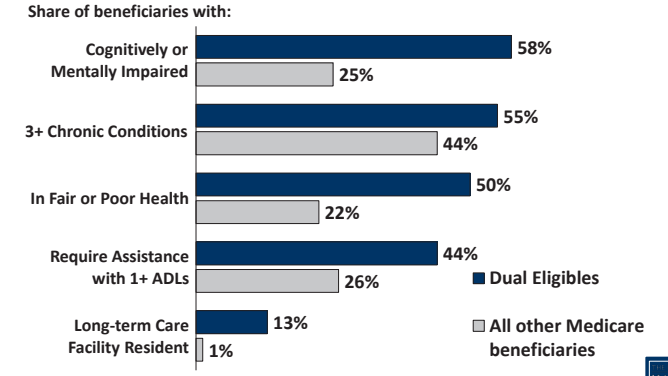


SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2008.

Dual eligibles tend to have more chronic conditions, cognitive limitations and functional limitations than other Medicare beneficiaries **(Exhibit 5)**. Half of all dual eligibles rate their health status as fair or poor, more than double the rate among non-dual eligibles. More than half (55%) of dual eligibles have three or more chronic conditions (versus 44% of non-dual eligibles), and more than half (58%) of all dual eligibles have a cognitive or mental impairment (versus 25% of non-dual eligibles). A larger share of dual eligibles need help with activities of daily living (ADLs), such as dressing or feeding, than non-dual eligibles (44% of dual eligibles versus 26% of non-dual eligibles).

EXHIBIT 5

A larger share of dual eligibles than other Medicare beneficiaries has multiple chronic conditions, and functional or cognitive impairments



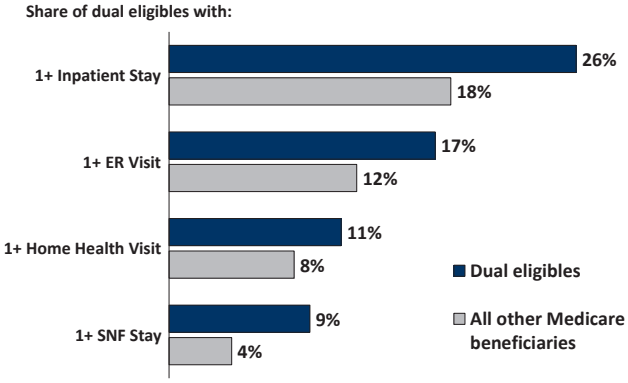
NOTE: ADLs are activities of daily living, and include self-care tasks.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2008.

With relatively high rates of cognitive and physical limitations, it is not surprising that a substantially larger share of dual eligibles than other Medicare beneficiaries live in a facility, such as a nursing home or mental health facility (13% of dual eligibles versus 1% of non-dual eligibles). In fact, almost three-quarters (73%) of all Medicare beneficiaries living in a long-term care facility are dual eligibles. As a consequence of their poorer health status, dual eligibles are more than twice as likely as other beneficiaries to die during the year (7% of dual eligibles versus 3% of other beneficiaries).

As a result of having greater medical needs, dual eligibles also use more Medicare services, particularly acute care services, than other Medicare beneficiaries **(Exhibit 6)**. Among dual eligibles in fee-for-service Medicare, more than one-quarter (26%) had at least one hospitalization in 2008 (versus 18% of other beneficiaries) and 11 percent had two or more hospitalizations (versus 6% of other beneficiaries). Dual eligibles were also more likely to use the emergency room; 17 percent of dual eligibles had at least one emergency room visit (versus 12% of others). Dual eligibles also used more post-acute care than other Medicare beneficiaries. Nine percent of dual eligibles had at least one stay in a skilled nursing facility (SNF) compared to 4 percent of others, and among those with a a SNF stay, dual eligibles spent more days in the SNF than other Medicare beneficiaries (on average, 44 days for dual eligibles versus 29 days for other beneficiaries). Similarly, home health rates were higher for dual eligibles than for other beneficiaries, and among users, dually eligible beneficiaries had nearly twice as many visits in 2008 than others (on average, 237 visits for dual eligibles versus 118 visits among other Medicare beneficiaries).

EXHIBIT 6

Hospital, ER, home health and skilled nursing facility rates are higher for dual eligibles than for other beneficiaries

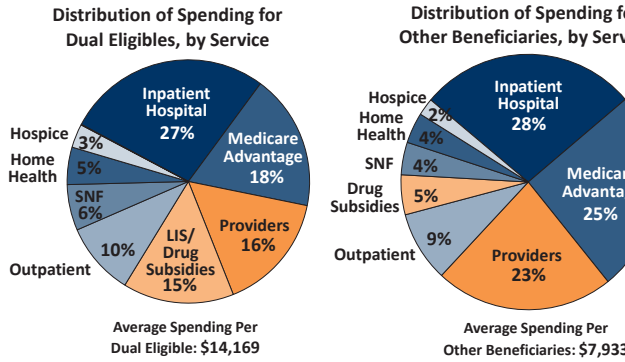


NOTE: Excludes Medicare Advantage enrollees.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2008.

In 2008, Medicare spending for dual eligibles averaged $14,169 per person – 1.8 times higher than spending for other Medicare beneficiaries, which averaged $7,933 **(Exhibit 7)**. Inpatient hospital comprised the largest component of Medicare spending for both dual eligibles and other beneficiaries, accounting for roughly one quarter of average per beneficiary spending., followed by payments to Medicare Advantage plans for Part A and Part B services. Payments to medical providers comprised a smaller share of spending for dual eligibles than for other beneficiaries (16% versus 23%). Of note, federal subsidy payments (general subsidies and low-income subsidies) for prescription drug premiums comprised a much larger share of spending for dual eligibles than for other beneficiaries (15% versus 5%), as would be expected since dual eligibles receive low income subsidy (payments for premiums and cost-sharing in addition to direct subsidy payments.

EXHIBIT 7

The distribution of Medicare spending by type of service is similar for dual eligibles and other beneficiaries



NOTE: Prescription drug subsidy payments include both the federal direct subsidy and the low income subsidy (LIS) payments. Payments to facilities comprise less than 1% of Medicare spending. Medicare Advantage payments are for Part A and B services only.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2008.

Dual Eligibles: A Population with Diverse Needs, Patterns of Service Utilization and Costs

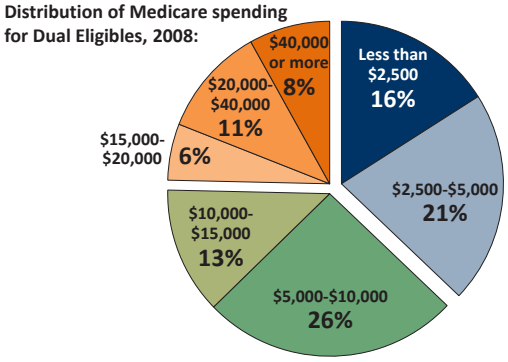
The dual eligible population is far from homogeneous. People who are dual eligibles have a wide range of conditions, circumstances, and health care needs. Some, often described as "high need" or "high cost", have extensive need for acute, post-acute and long-term care services and supports. Other dual eligibles, while low income and qualify for Medicaid in addition to Medicare, use relatively few services and and have lower than average Medicare costs. Almost three-quarters (74%) of all dual eligibles never had an inpatient hospitalization

and the vast majority (83%) never had an emergency room visit in 2008 – some of the most expensive health care services on a per capita basis. While a large share of dual eligibles are in fair or poor health, as previously noted, almost one in five (19%) dual eligibles rated their health as excellent or very good. Below, we examine variations within the dual eligible population in terms of health needs, service utilization, and Medicare spending.

More than one-third of dual eligibles incurred up to $5,000 in Medicare spending in 2008. While average Medicare spending for dual eligibles was $14,169 in 2008, Medicare spending was less than $7,036 for half of the dual eligibles **(Exhibit 8)**. For 16 percent of dual eligibles, Medicare spending was less than $2,500 in 2008 and for another 21 percent, Medicare spending was between $2,500 and $5,000. Conversely, Medicare spending for one-quarter (25%) of dual eligibles exceeded $15,000, and Medicare spending for 8 percent of dual eligibles exceeded $40,000 in 2008.

EXHIBIT 8

Medicare spending was more than $40,000 for 8% and less than $2,500 for 16% of the dual eligible population

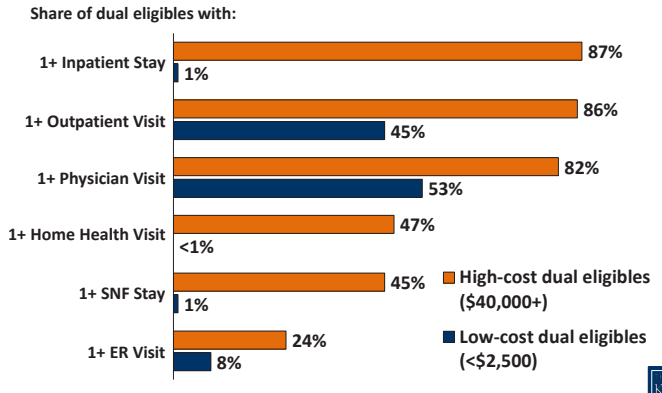


SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2008.

Not surprisingly, dual eligibles with Medicare spending below $2,500 ("low cost") were slightly younger and healthier than dual eligibles with Medicare spending above $40,000 ("high cost") in 2008 (on average, age 66 years old versus 72 years old for high-cost dual eligibles). A much smaller share of low-cost than high-cost dual eligibles lived in a long-term care facility (10% versus 31%) reflecting the relatively high rates of hospital and skilled nursing facility care among Medicare beneficiaries living in nursing homes. As migh be expected, a smaller share of the low-cost dual eligibles rated their health status as fair or poor health than the high-cost group (38% versus 72%) and a smaller share reported having three or more chronic conditions (43% versus 73%). The low-cost dual eligibles were far less likely than the high-cost dual eligibles to have end-stage renal disease (less than 1% versus 11% of high-cost dual eligibles), diabetes (21% low-cost versus 50% high–cost), or a heart valve problem or other heart condition (29% low-cost versus 60% high–cost).

EXHIBIT 9

Use of acute and post-acute services is much higher for high-cost than low-cost dual eligibles



NOTE: Excludes Medicare Advantage enrollees.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2008.

Service Use. By definition, people with relatively low Medicare spending use fewer services than those with high Medicare spending, and the differences are especially notable for inpatient stays, emergency room visits, and post-acute home health and SNF care **(Exhibit 9)**. Among dual eligibles in fee-for-service Medicare, low-cost dual eligibles were far less likely than high cost duals to have a hospital admission (1 percent versus 87 percent, an emergency room visit (8% low-cost dual eligibles versus 24% high-cost dual eligibles). Very few low-cost dual eligibles had a SNF stay or home health visit whereas almost half of all high-cost dual eligibles had one or more SNF stays or home health visits (45% and 47% of high-cost dual eligibles, respectively).

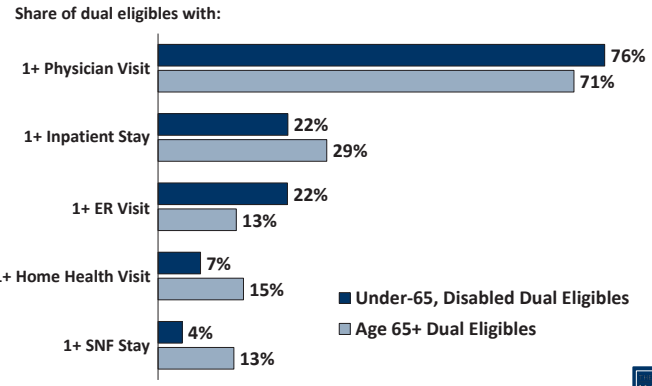
Disabled (under age 65) dual eligibles have different needs and lower per capita Medicare costs than dual eligibles ages 65 and older. Of the 9 million dual eligibles, 3.6 million (39%) were under age 65 and disabled in 2008. The under-65 disabled dual eligibles as a group differ from those who are 65 and older in their demographic composition, health status, use of health services, and Medicare spending.

The under-65, disabled dual eligibles are less likely than dual eligibles age 65 or older to have 3 or more chronic conditions (43% versus 63%), and a slightly smaller share of under-65, disabled dual eligibles require assistance with one or more ADLs (40% versus 46%). A smaller share of disabled dual eligibles live in a mental facility or nursing facility than dual eligibles ages 65 or older (9% versus 21%). However, a larger share of the under-65, disabled dual eligibles have cognitive or mental impairments than dual eligibles ages 65 or older (73% versus 48%).

Service Use. A smaller share of under-65, disabled dual eligibles compared to older dual eligibles had an inpatient stay (22% versus 29%), used hospice services (1% versus 7%), home health services (7% versus 15%), or used skilled nursing facility services (4% versus 13%) in 2008 **(Exhibit 10)**. In fact, the only services used by a larger share of the under-65, disabled dual eligibles than the 65 or older dual eligibles are physician visits and emergency room visits. Notably, nearly twice as many disabled dual eligibles had one or more emergency room visits compared to older dual eligibles (22% versus 13%) in 2008.

EXHIBIT 10

Use of inpatient hospital and post-acute care services is lower for under-65, disabled dual eligibles than those ages 65+



NOTE: Excludes Medicare Advantage enrollees.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2008.

Medicare Spending. Medicare spending for under-65, disabled dual eligibles is substantially lower than spending for dual eligibles age 65 or older ($11,423 per capita versus $15,924 per capita, on average). This appears to be due to lower rates of hospitalization among the under-65, disabled dual eligibles.

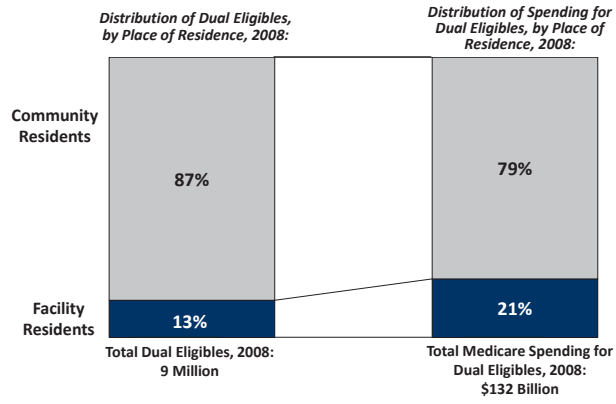
Nearly one in seven dual eligibles live in a long-term care facility – a group that accounts for a large share of Medicare spending among dual eligibles. In 2008, approximately 1 million dual eligibles (13%) lived in a facility, such as a nursing home or mental health facility. The majority of dual eligibles residing in facilities (92%) had cognitive or mental impairments (versus 52% of those living in the community). Nearly two-thirds of dual eligibles in facilities (64%) were in fair or poor health (versus 48% of dual eligibles living in the community). As would be expected, the vast majority of dual eligibles living in facilities (88%) required assistance with one or more ADLs, but a substantial share of dual eligibles living in the community (43%) also required such assistance and may receive home and community based services. As a consequence of their poorer health status, dual eligibles living in long-term care facilities have higher mortality rates than those living in the community (24% versus 4%).

Service Use. Among dual eligibles who were enrolled in fee-for-service Medicare, 42 percent of the dual eligibles living in facilities were admitted to the hospital at least once in 2008 – almost double the rate among dual eligibles living in the community (23%). A much larger share of dual eligibles residing in facilities than in the community were admitted to a SNF at least once in 2008 (37% versus 4%, respectively). Dual eligibles in long-term care facilities were also more likely to use outpatient services (80% versus 72%) and hospice services (13% versus 3%), but less likely to have a separately-billed physician visit (45% versus 78%), a home health visit (8% versus 12%), or an emergency room visit (3% versus 20%).

Medicare Spending. In 2008, Medicare spending for dual eligibles in facilities averaged $22,366 compared to $12,915 for dual eligibles living in the community.[4] Dual eligibles living in facilities accounted for 13 percent of the total dual eligible population, but 21 percent of Medicare spending for dual eligibles in 2008 **(Exhibit 11)**. For dual eligibles living in facilities, inpatient services comprised the largest component of Medicare spending (33%), followed by SNF (20%), medical provider services (14%), hospice services (8%), outpatient services (7%), and home health (2%); federal subsidies for prescription drug premiums and cost-sharing comprised 9 percent and payments to Medicare Advantage plans comprised 6 percent of spending for dual eligibles living in facilities.

EXHIBIT 11

Dual eligibles living in long-term care facilities account for a disproportionate share of Medicare spending



SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2008.

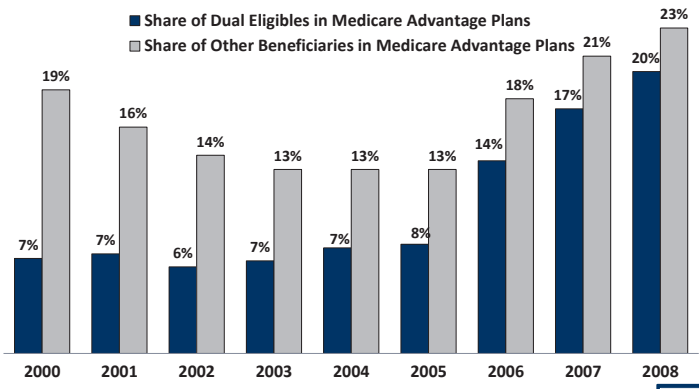
The Role of Medicare Managed Care Plans for Dual Eligibles

Today, all Medicare beneficiaries have the option of receiving their Medicare benefits under the fee-for-service program or through a Medicare Advantage plan. Medicare Advantage plans, such as HMOs and Preferred Provider Organizations (PPOs), receive capitated payments from the federal government to provide Medicare benefits to enrollees.

In 2008, the most recent year of data for enrollment of dual eligibles in Medicare Advantage plans, 80 percent of dual eligibles were covered under the fee-for-service program and 20 percent were enrolled in a Medicare Advantage plan.[5] While the majority of dual eligibles are in fee-for-service, the share in Medicare Advantage plans has increased considerably since 2005 **(Exhibit 12)**. The growth was at least partly due to the introduction of Special Needs Plans (SNPs) for dual eligibles and other beneficiaries with multiple chronic conditions or living in an institution. SNPs receive capitated payments from Medicare to provide Medicare-covered benefits. In 2012, about 1.2 million Medicare beneficiaries were enrolled in SNPs for dual eligibles.[6] It has been estimated that less than 100,000 dual eligibles are in "fully integrated" managed care plans that receive capitated payments from both Medicare and Medicaid, such as the Program of All-Inclusive Care for the Elderly (PACE).[7]

EXHIBIT 12

Enrollment in Medicare Advantage plans has been increasing among dual eligibles



NOTES: Data exclude dual eligibles living in Puerto Rico and other territories.
SOURCE: Kaiser Family Foundation analysis of the CMS MCBS Cost and Use File, 2000-2008

Since Medicare Advantage plans are not required to report claims data for their enrollees, information is not available on the use of health services, and the spending for those services, by dual eligibles enrolled in Medicare Advantage plans. In the aggregate, federal capitated payments to Medicare Advantage plans for dual eligible enrollees were approximately $24 billion in 2008.

Policy Issues for the Future

Most dual eligibles have multiple chronic conditions, and many are in poor health with physical disabilities or mental disorders. As a group, beneficiaries who are dually eligibles for Medicare and Medicaid are more likely than others to use many health and long-term care services, which results in high per capita expenditures for both programs. While the two programs help to shield very low-income Medicare beneficiaries from potentially unaffordable out-of-pocket costs, dual eligibles also face the challenge of navigating two separate health care programs, which often have different eligibility criteria, enrollment processes, benefits, billing systems, appeals procedures, and provider networks. Finding ways to better coordinate the two programs may not only reduce the growth in expenditures for the federal and state governments, but also improve the quality of care for this high-need population.

This analysis confirms the heterogeneity among the 9 million Medicare beneficiaries with Medicaid. While 8 percent of dual eligibles incurred relatively high Medicare expenditures ($40,000 or more), 16 percent incurred less than $2,500 in Medicare expenditures in 2008. Some dual eligibles had two or more hospitalizations in 2008, while 74 percent were never hospitalized that year. Some have substantial need for both acute and long-term care services and supports, while others require more of the former or the latter, but may not need both, in any given year. Efforts to improve the care for this population may be more effective if targeted in a fashion that recognizes the unique needs of different subgroups of dual eligibles.

The Centers for Medicare and Medicaid Services (CMS) has implemented several demonstrations designed to improve the coordination of care for dual eligibles and reduce spending under Medicare and Medicaid. These demonstrations include issuing contracts to 15 states to design a program to integrate Medicare and Medicaid services for the dual eligibles in the state, and testing two models – a capitated model and a managed fee-forservice model – for financing both Medicare and Medicaid services for dual eligibles.[8] CMS has also undertaken an initiative to prevent unnecessary hospitalizations of nursing home residents, most of whom are dual eligibles, by providing enhanced on-site services and supports.[9]

As CMS undertakes these intiatives, many questions remain for federal and state policymakers. Will new approaches improve or adversely affect the quality of care for people dually eligibles for Medicare and Medicaid? What restrictions and regulations will be established? Will enrollment for dual eligibles be voluntary or will beneficiaries be auto-enrolled into plans? What steps will be taken to prevent disruptions between patients and their providers? Will programs achieve savings for Medicare and Medicaid? And how will these demonstrations be evaluated?

The challenges facing dual eligibles have become more evident over the years, as have the fiscal pressures facing the Medicare and Medicaid programs in caring for this population. Finding effective and efficient means for coordinating the care of the dually eligible could help to assure the fiscal sustainability of the Medicare and Medicaid programs in the years to come. At the same time, given the significant needs and vulnerabilities of this population, it remains important to ensure adequate protections are in place to assure that the dual eligibles retain access to health care services and providers, and receive high quality care.

For more indepth discussion of Medicaid's Role for Dual Eligible Beneficiaries, see Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Role for Dual Eligible Beneficiaries," April 2012

References

[1] Specifically, people are eligible for Medicare if they are 1) age 65 or older; 2) under age 65 and receive Social Security Disability Insurance (SSDI); or 3) under age 65 and have end-stage renal disease (ESRD). People with ESRD must have worked long enough to qualify for Medicare Part A (or be the spouse or dependent child of someone who qualifies for Part A) and be on regular dialysis or require a transplant in order to be eligible for Medicare before the age of 65.
[2] See Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Role for Dual Eligible Beneficiaries," April 2012.
[3] See Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Role for Dual Eligible Beneficiaries," April 2012.
[4] Many studies have shown that dual eligibles in long-term care facilities incur higher Medicare expenses than other dual eligibles. For example, see Kaiser Family Foundation, "Medicare Spending and Use of Medical Services for Beneficiaries in Nursing Home and Other Long-Term Care Facilities: A Potential for Achieving Medicare Savings and Improving Quality of Care," October 2010.
[5] CMS data on the total number Medicare beneficiaries enrolled in Medicare Advantage, and the number of beneficiaries in Dual-SNPs is available for 2012.
[6] Kaiser Family Foundation analysis of CMS Medicare Advantage Enrollment files, 2012.
[7] Bella M. Opportunities to Integrate Care for Dual Eligibles. July 23, 2010 presentation, Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261139.
[8] See Kaiser Family Foundation, "Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A Look at the 15 State Design Contracts Funded by CMS," August 2011.
[9] Centers for Medicare and Medicaid Services press release, "New Opportunity for Better Care for Nursing Facility Residents through Enhanced Coordination Efforts," March 12, 2011.

Appendix

Data Sources and Estimation Methods

Most data used in this analysis come from the Center for Medicare and Medicaid Services (CMS) Medicare Current Beneficiary Survey (MCBS) Cost and Use file for 2008. The MCBS includes a representative sample of the Medicare population on a rotating panel interviewed three times each calendar year. Sample persons are interviewed three times a year for a maximum of four years to form a continuous profile of each individual's personal health care experience. Medicare beneficiaries are selected for the MCBS from the list of beneficiaries enrolled in Medicare as of January 1 of the prior year (e.g., January 1, 2007 for the 2008 survey), and the sample is supplemented with the use of services and expenditures for the "newly enrolled" beneficiaries who otherwise would be excluded from the MCBS.

In this analysis, beneficiaries were identified as dual eligibles if they either self-identified as dually eligible in one of the three times in the year they were asked or were identified as a dual eligible in the administrative claims data at any point during the year. Beneficiaries were identified as enrolled in Medicare Advantage from administrative data showing enrollment in either a Medicare risk HMO or an MA-PD plan during the calendar year. Dual eligibles residing in the territories were excluded from the analysis of the share of dual eligibles who were enrolled in Medicare Advantage, so to remain consistent with other similar analyses. Facility residents were defined as beneficiaries living in a long-term care facility at any point during the calendar year; community residents were defined as any beneficiaries who never lived in a facility during the year. A long-term care facility is defined in the MCBS as having three or more beds and providing long-term care services throughout the facility or in a separately identifiable unit. Types of facilities currently participating in the MCBS include nursing homes, retirement homes, domiciliary or personal care facilities, distinct long-term units in a hospital complex, mental health facilities and centers, assisted and foster care homes, and institutions for the mentally retarded and developmentally disabled. Skilled nursing facilities (SNFs) are not included in the definition of a long-term care facility and dual eligibles who stayed in a SNF during the year but did not stay in a long-term care facility are defined as community residents in this analysis.

Medicare spending was defined as the sum of all Inpatient, Outpatient, Home Health, Hospice, Medical Provider, SNF, and Medicare-reimbursable long-term care charges, plus any capitated payments to private Medicare Advantage and Part D plans. Medicare-reimbursable long-term care charges for beneficiaries in long-term care facilities are defined by the MCBS as charges for Medicare covered services that are not captured by other Medicare spending categories. Service utilization was analyzed for Medicare beneficiaries enrolled in fee-for-service Medicare, and excludes beneficiaries enrolled in Medicare Advantage. All reported values are statistically significant at the 95 percent confidence level.

Table 1: Dual Eligibles by State, 2008

State	Total Medicare Beneficiaries	Number of Dual Eligibles	Share of Medicare Beneficiaries who are Dual Eligibles	Full Duals as a Share of All Dual Eligibles	Under-65, Disabled Duals as a Share of All Dual Eligibles
United States	44,831,390	9,142,228	20%	77%	39%
Alabama	804,351	208,250	26%	48%	43%
Alaska	59,435	13,006	22%	98%	40%
Arizona	852,880	147,966	17%	77%	43%
Arkansas	505,634	118,405	23%	58%	39%
California	4,470,439	1,201,009	27%	98%	35%
Colorado	574,263	69,872	12%	92%	34%
Connecticut	546,623	103,162	19%	76%	57%
Delaware	139,709	23,796	17%	47%	46%
District of Columbia	74,805	22,192	30%	85%	25%
Florida	3,180,256	601,276	19%	58%	40%
Georgia	1,145,727	264,172	23%	55%	40%
Hawaii	193,333	32,688	17%	91%	39%
Idaho	212,381	30,889	15%	70%	41%
Illinois	1,769,546	313,365	18%	88%	44%
Indiana	958,270	155,826	16%	65%	48%
Iowa	504,944	81,382	16%	84%	52%
Kansas	416,167	63,077	15%	74%	44%
Kentucky	724,356	178,381	25%	62%	38%
Louisiana	653,018	180,354	28%	59%	35%
Maine	252,025	91,976	36%	58%	56%
Maryland	740,811	109,905	15%	68%	34%
Massachusetts	1,015,086	254,979	25%	97%	23%
Michigan	1,571,709	263,859	17%	89%	41%
Minnesota	746,505	132,224	18%	91%	49%
Mississippi	476,564	150,850	32%	54%	39%
Missouri	961,308	171,506	18%	91%	45%
Montana	159,650	18,446	12%	86%	40%
Nebraska	270,435	41,643	15%	90%	54%
Nevada	327,629	40,009	12%	54%	40%
New Hampshire	203,608	28,783	14%	71%	60%
New Jersey	1,279,020	203,908	16%	84%	41%
New Mexico	292,363	55,971	19%	71%	36%
New York	2,877,270	737,161	26%	89%	35%
North Carolina	1,392,450	310,496	22%	81%	44%
North Dakota	106,005	15,353	14%	74%	57%
Ohio	1,830,807	303,761	17%	68%	38%
Oklahoma	575,298	113,553	20%	84%	45%
Oregon	580,425	90,355	16%	69%	46%
Pennsylvania	2,210,989	391,855	18%	85%	32%
Rhode Island	177,279	39,388	22%	86%	39%
South Carolina	714,008	150,973	21%	87%	46%
South Dakota	131,368	20,520	16%	67%	48%
Tennessee	995,254	284,368	29%	76%	45%
Texas	2,778,533	626,375	23%	61%	36%
Utah	262,064	30,952	12%	91%	44%
Vermont	104,460	31,828	30%	63%	56%
Virginia	1,071,681	171,256	16%	69%	45%
Washington	896,838	149,782	17%	76%	37%
West Virginia	371,770	79,682	21%	62%	35%
Wisconsin	871,111	211,378	24%	61%	46%
Wyoming	75,790	10,065	13%	68%	46%

Source: Kaiser Family Foundation analysis of the CMS State/County Market Penetration Files, 2008, and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY2008 MSIS.

How Do Beneficiaries Qualify for Medicaid and What Medicaid Benefits Do They Receive?

Full Medicaid Benefits. Most dual eligibles qualify for full Medicaid benefits, as well as coverage of Medicare premiums and, in some instances, cost-sharing.[1] Medicare beneficiaries can receive full Medicaid benefits through several pathways **(Table 2)**. All states are required to provide full Medicaid benefits to individuals who meet the income and asset limits for the Supplemental Security Income (SSI) Program: incomes less than 75 percent of the federal poverty level (FPL) for individuals (83 percent for couples) and assets at or below $2,000 for individuals ($3,000 for couples). The 209(b) states are permitted to set Medicaid income or asset limits for the elderly and disabled *below* the limits for the SSI program, but the states must afford individuals at the SSI level the opportunity to qualify by incurring medical expenses that reduce their income to the state level.[2] States are also permitted to disregard a portion of beneficiaries' income before their income is measured against the eligibility level; most states allow $20 per month of income to be disregarded.

Other Pathways to Eligibility for Full Medicaid Benefits. Medicaid programs also have the option of providing full Medicaid benefits, and assisting with Medicare premiums and cost-sharing, for beneficiaries with slightly higher income, certain nursing home residents, and beneficiaries eligible for home and community based services (HCBS). For these categories, states are permitted, but not required, to make their income and resource counting rules more generous (but not less generous) than those of the SSI program.

- **Poverty Related:** Most states (28 states plus the District of Columbia in 2009) provide full Medicaid benefits to Medicare beneficiaries with slightly higher incomes.

- **Medically Needy:** Most states (33 states plus the District of Columbia in 2009) have a medically needy or equivalent program that allows individuals with higher income or assets to qualify for Medicaid benefits if they have high medical expenditures. Eligibility is computed in these programs by deducting an individual's medical costs from the individual's income, and thus beneficiaries "spend down" their income to the "medically needy income level", which is usually considerably lower than the SSI level.[3] The eligibility limits for the medically needy programs vary considerably across states, and are permitted to vary within states.

- **Special Income Rules for Nursing Home Residents:** Some Medicaid programs apply special standards to nursing home residents, since few Medicare beneficiaries can afford the high cost of nursing home care. In 2009, 40 states had higher Medicaid income limits for nursing home residents, 38 of which set the limit at 300 percent of the limit for the SSI program. In states without a special income rule for nursing home residents, such individuals can qualify for Medicaid as medically needy.

- **HCBS Waivers:** Medicaid programs may apply for HCBS waivers, also known as 1915(c) and 1915(d) waivers, to design programs that provide care in the community for individuals who would otherwise be treated in hospitals, nursing homes, or institutions for the mentally disabled. States are given latitude in designing the eligibility criteria for the programs, but all such HCBS programs are available only to individuals who would only qualify for Medicaid if they were in an institutional setting, such as a nursing home. Forty-nine states and the District of Columbia offer services through HCBS waivers, or a similar program.

- **State Plan Amendment Home and Community Based Services:** Since 2005, states have had the option, under section 1915(i), of providing community based services to people who, but for the program services, would need an institutional level of care and have incomes no greater than 300 percent of the limit for the SSI program.

Medicare Savings Programs. Medicaid programs are required to cover the Medicare premiums, and in some instances cost-sharing, for Medicare beneficiaries with slightly higher incomes or assets through the Medicare Savings Programs (MSPs). Individuals covered under some of the MSPs are not eligible for other Medicaid benefits, such as nursing home care or dental services. Although minimum federal income and assets limits are specified, as is true for other Medicaid categories of eligibility, states are permitted to make the eligibility criteria more generous; for example, Connecticut does not have an asset test for its MSPs. The federal asset limits allow for an additional $1,500 per person for burial expenses. The asset limits for QMB, SLMB and QI are indexed and thus change annually; the limits for QDWI are not indexed, and instead they remain constant from year to year.

- **Qualified Medicare Beneficiaries (QMBs):** These beneficiaries are eligible for assistance with both Medicare premiums and cost-sharing, while other MSP beneficiaries receive assistance only with Medicare premiums. The federal income limit for QMBs is 100 percent of the FPL, and the asset limit is $6,940 for individuals ($10,410 for couples) in 2012.

- **Specified Low-Income Medicare Beneficiaries (SLMBs):** These beneficiaries are eligible for assistance with Medicare Part B premiums, and must have incomes between 100 and 120 percent of the FPL and assets at or below $6,940 for individuals ($10,410 for couples) in 2012.

- **Qualified Individuals (QIs):** The QI program is a limited expansion of the program for SLMBs, with an entitlement block-grant to the states for the program. Enrollment in the QI program is limited by the federal appropriations, and applications are approved on a first-come-first-served basis. QIs are eligible for assistance with Medicare Part B premiums, and must have incomes between 120 and 135 percent of the FPL and assets at or below $6,940 for individuals ($10,410 for couples) in 2012.

- **Qualified Disabled and Working Individuals (QDWIs):** Beneficiaries may be eligible for assistance with their Medicare Part A premiums through the QDWI program if they are younger than 65 years old, have a disabling impairment, and are no longer entitled to free Medicare Part A because they successfully returned to work. To receive this Medicaid assistance, their income must be at or below 200 percent of the FPL and assets must be at or below $4,000 for individuals ($6,000 for couples).

Additionally, QMBs, SLMBs, and QIs are automatically eligible for some assistance with their prescription drug costs through the Low-Income Subsidy (LIS) program, which provides assistance with Medicare Part D premiums and cost-sharing. LIS is also available for individuals with incomes at or below 150 percent of the FPL and assets no greater than $11,570 for individuals ($23,120 for couples) in 2012.

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[1] Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Role for Dual Eligible Beneficiaries," April 2012.

[2] In 209(b) states, Medicaid eligibility criteria for elderly and disabled can be more restrictive than the SSI limits, as long as they are no more restrictive than the rules in place in 1972. The 209(b) states are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia. For more information, see Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," February 2010.

[3] For 209(b) states, individuals must be permitted to spend down to the state's income standard for mandatory eligibility whether or not the state has a program for the medically needy. For details and more information, see Kaiser Commission on Medicaid and the Uninsured, "Dual Eligible Beneficiaries: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2008," April 2012.

TABLE 2

Common Medicaid Eligibility Pathways and Benefits for Medicare Beneficiaries, 2012

Pathway to Eligibility	Income Eligibility Level[1] (individual/couple)	Asset Limit[2] (individual/couple)	Covered Costs and Benefits[3]
SSI Related (mandatory)	**<75% of poverty (SSI income eligibility)**	**$2,000/$3,000 (varies by state)**	**Medicaid benefits, Medicare Part A and Part B premiums and cost sharing**
Poverty Level (optional)	**≤100% of poverty**		
Medically Needy[4] (optional)	**Must spend income down to a specified level to qualify, varies by state**		
Special Income Rule for Nursing Home Residents (optional)	**Institutionalized individuals with income <300% of the SSI level**		
HCBS Waiver (optional)	**Must be eligible for institutional care**		
Medicare Savings Programs			
Qualified Medicare Beneficiary (QMB) (mandatory)	**<100% of poverty**	**$6,940/$10,410**	**Medicare Part A and Part B premiums and cost sharing**
Specified Low-Income Medicare Beneficiary (SLMB), (mandatory)	**100%-120% of poverty**	**$6,940/$10,410**	**Medicare Part B premiums**
Qualified Individual (QI), (mandatory)	**120%-135% of poverty**	**$6,940/$10,410**	**Medicare Part B premiums**
Qualified Disabled and Working Individual (QDWI), (mandatory)	**<200% of poverty**	**$4,000/$6,000**	**Medicare Part A premiums**

NOTES: SSI is Supplemental Security Income. HCBS is home and community based services. [1]Applicants in most states are allowed at least a $20 per month disregard from any income before their income is measured against the poverty levels, with the exception of New Hampshire which allows a $13 per month disregard. [2]States have flexibility to modify income and asset limits; some have no asset limits. QMB, SLMB, QI, and QDWI are allowed an additional $1,500 per person for burial expenses. [3]Cost sharing is covered up to the amount Medicaid pays, at states' discretion. [4]Medicaid benefits may be more limited than for SSI.

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