The Role of Medicare for the People Dually Eligible for Medicare and Medicaid

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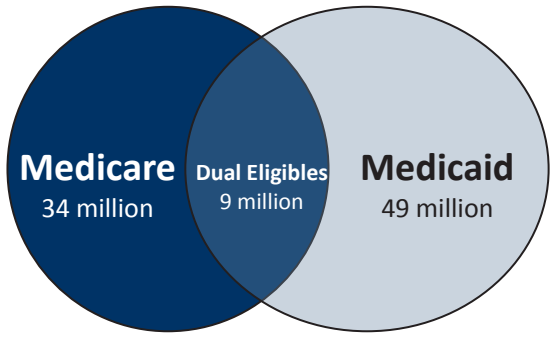
Introduction

The 2010 health reform law incorporates a number of provisions designed to improve the quality of medical care for high-need, high-cost populations, including the nine million low-income elderly and disabled people who are dually eligible for Medicare and Medicaid **(Exhibit 1)**. These "dual eligibles" are more likely than other Medicare beneficiaries to be frail, live with multiple chronic conditions and have functional and cognitive impairments. They also face the challenge of navigating two health care programs, Medicare and Medicaid, which do not always work well together because they have different benefits, billing systems, enrollment, eligibility, and appeals procedures, and often different provider networks.

EXHIBIT 1

Dual Eligibles Comprise 21 of the Medicare Population and 15 Percent of the Medicaid Population



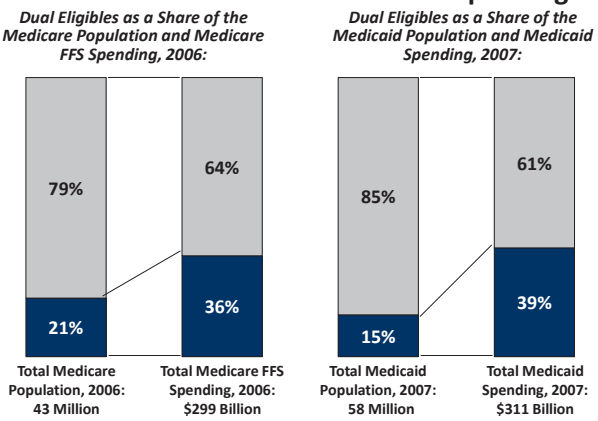
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2007, and Urban Institute estimates based on data from the 2007 MSIS and CMS Form-64.

The dual eligibles account for a disproportionate share of Medicare and Medicaid spending **(Exhibit 2)**. In 2007, dual eligibles comprised 21 percent of the Medicare population but 36 percent of Medicare spending, and 15 percent of the Medicaid population but 39 percent of Medicaid spending (2007).[1] As a result, the dual eligibles are increasingly the subject of the federal and state fiscal and policy discussions.

To help address the challenges facing the dual eligibles, and the associated cost pressures, the health reform law of 2010 established a new Federal Coordinated Health Care Office within the Centers for Medicare and Medicaid Services (CMS) to improve coordination between the two programs. It also established a new Center for Medicare and Medicaid Innovations to improve the health care for high-cost, high-need populations, which could have a significant impact on the care and costs of the dual eligible population. In addition, as part of emerging deficit reduction discussions, new proposals have emerged to limit spending on the dual eligibles, including proposals to require dual eligibles to enroll in Medicaid managed care programs.[2]

EXHIBIT 2

Dual Eligible Beneficiaries Account for Disproportionate Shares of Medicare and Medicaid Spending



NOTES: FFS is fee-for-service. Excludes Medicare Advantage enrollees' spending and Medicare prescription drug spending.
SOURCE: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2006, and Urban Institute estimates based on data from the 2007 MSIS and CMS Form-64.

This policy brief describes the roles played by Medicare and Medicaid in providing care for duals, presents characteristics of the dual eligible population, examines the Medicare and Mediciaid spending for the dual eligibles, reviews provisions in the 2010 health reform law that are relevant to the care and spending for the dual eligibles, and considers key issues for the future.

Background

Since 1965, Medicare has had the primary responsibility for providing basic medical services for all seniors, while Medicaid began providing coverage for low-income populations, including supplemental coverage for low-income people also covered by Medicare.[3] This supplemental coverage by Medicaid provides substantial help and serves an important role for the low-income beneficiaries because Medicare has high cost-sharing requirements and significant gaps in coverage. Medicare does not cover routine outpatient dental care or non-skilled long-term services and supports, and until 2006, did not cover outpatient prescription drugs. Medicaid, a need-based program funded jointly by the federal and state governments, provides help with Medicare's premiums and cost-sharing requirements, and helps pay for the services that are not covered by Medicare, thus limiting dual eligibles' out-of-pocket health care spending.[4] The majority of the dual eligibles receive full Medicaid benefits, while others qualify for more limited assistance with premiums and cost-sharing.[5]

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

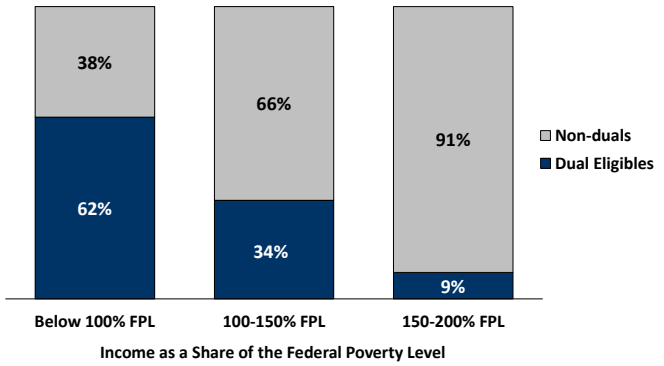
While all states provide some level of supplemental coverage for low income Medicare beneficiaries, the eligibility criteria and scope of benefits provided varies by state **(***See* ***Appendix*****)**. In general, Medicare beneficiaries are required to have income and assets below a defined level to qualify for Medicaid. Most dual eligibles qualify for full Medicaid benefits as well as coverage of Medicare premiums and cost-sharing; in most states (18 in 2009), this requires having an income less than 75 percent of the federal poverty level (FPL) and assets no greater than $2,000 for individuals and $3,000 for couples, although some states have higher, more generous income and asset limits.[6] 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 limits higher than those of the SSI program. In addition, for low-income beneficiaries with somewhat higher income or assets, Medicaid will cover their Medicare premiums, and in some instances cost-sharing, 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.

What Share of the Low Income Medicare Population Is Dually Eligible?

Medicaid provides supplemental coverage to nearly two-thirds (62%) of Medicare beneficiaries with incomes below 100 percent of the FPL, one-third (34%) of beneficiaries with incomes between 100 and 150 percent of the FPL, and 9 percent of Medicare beneficiaries with incomes between 150 and 200 percent of the FPL **(Exhibit 3).** Conversely, many low-income Medicare beneficiaries do not receive supplemental coverage from Medicaid – either because they do not meet the income and asset eligibility criteria or because they had difficulty navigating the application process. Most Medicare beneficiaries (63%) with incomes below 200 percent of the FPL *do not* receive any additional assistance from Medicaid. Among these low-income beneficiaries, 22 percent were without supplemental coverage and were thus fully responsible for paying Medicare's cost-sharing requirements on their own.

EXHIBIT 3

Many Low-Income Medicare Beneficiaries are Not Dual Eligibles, 2006



NOTE: FPL is federal poverty level.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2006.

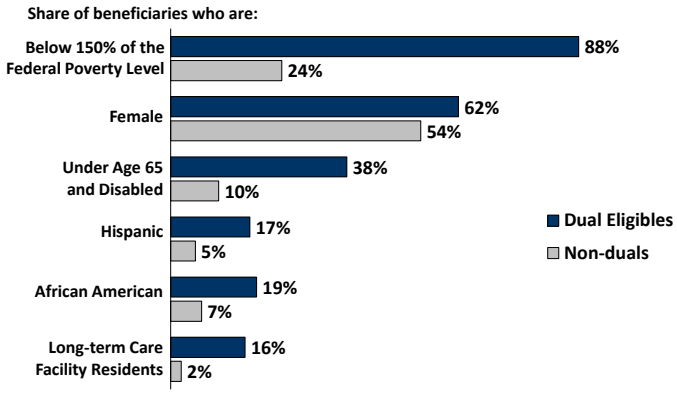
Nationwide, 21 percent of Medicare beneficiaries were dual eligibles in 2007. This ranges from less than 15 percent of beneficiaries in seven states to more than 25 percent in seven states and the District of Columbia **(Table A2).** Most dual eligibles were full duals (77%) in 2007, ranging from less than half of the dual eligibles in Delaware and Alabama to 98 percent of the dual eligibles in Alaska and California. Maine and Mississippi have the largest share of Medicare beneficiaries who are dually eligible (36% and 32%, respectively). This disparity in coverage among the states is likely due to a number of factors, including differences across states in demographics, enrollment procedures, and eligibility criteria. The states with the smallest shares of Medicare beneficiaries who are dually eligible are Colorado, Montana, Nevada, and Utah, in which 12 percent of beneficiaries are dual eligibles.

How Do Dual Eligibles Differ from Other Medicare Beneficiaries?

As would be expected, dual eligibles have disproportionately low incomes. Most dual eligibles (58%) have incomes below 100 percent of the FPL, almost one-third (30%) have incomes between 100 and 150 percent of the FPL, 6 percent have incomes between 150 and 200 percent of the FPL, and the remaining 6 percent have incomes above 200 percent of the FPL**.** Those with incomes above 150 percent of poverty are primarily individuals who are medically needy with substantial health care or long-term care costs.

EXHIBIT 4

Dual Eligibles are More Likely Than Other Medicare Beneficiaries to be Female, Disabled, Minorities, or Long-Term Care Facility Residents, 2006

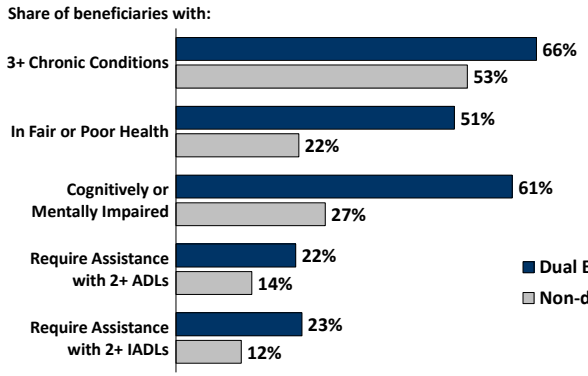


SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2006.

In addition to having lower incomes, dual eligibles differ from other beneficiaries in demographic composition, as well as health and long-term care needs. Women, African Americans, Hispanics, and the under-65 disabled beneficiaries on Medicare account for a relatively large share of the dual eligible population **(Exhibit 4).** Overall, 62 percent of dual eligibles are women, as compared to 54 percent of all other beneficiaries. African American and Hispanic beneficiaries together account for 36 percent of the dual eligible population but 12 percent of all other Medicare beneficiaries. More than one-third (38%) of the dual eligible population is under-65 and disabled, more than triple the rate among all other beneficiaries. The share of dual eligibles who are under 65 and disabled varies greatly across the states, from less than one-third (29%) in California to more than half (52%) in Utah. This is due to a number of factors, including variations in disability rates and Medicaid eligibility criteria that affect the composition of the dual eligible population across states.

EXHIBIT 5

Dual Eligibles Have More Medical Needs and Functional and Cognitive Limitations Than Other Medicare Beneficiaries, 2006



NOTE: ADLs are activities of daily living, and include self-care tasks. IADLs are instrumental activities of daily living and are tasks, such as shopping for groceries, that allow an individual to live independently in a community.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2006.

Dual eligibles tend to have greater medical needs, functional limitations and cognitive limitations than other beneficiaries **(Exhibit 5)**. More than half of all dual eligibles are in fair or poor health (51%), more than double the rate among non-duals (22%). A larger share of dual eligibles than other Medicare beneficiaries have three or more chronic conditions (66% of duals versus 53% of non-duals). Cognitive or mental impairments are also high among the dual eligible population: more than three out of

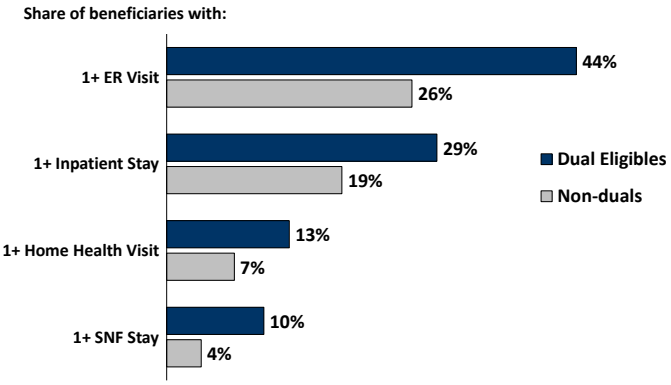
every five duals have a cognitive or mental impairment (61% versus 27%). A larger share of dual eligibles need help with at least two activities of daily living (ADLs), such as dressing or feeding, than non-dual eligibles (22% of duals versus 14% of non-duals), and help with at least two instrumental activities of daily living (IADLs), such as shopping for groceries or preparing meals, than non-dual eligibles (23% of duals versus 12% of non-duals). As a result of these limitations, a substantially larger share of dual eligibles lives in a long-term care setting, such as a nursing home (16% of duals versus 2% of non-duals).

What Medicare-Covered Medical Services Do the Dual Eligibles Use?

As a result of being in poorer health and having multiple chronic conditions, dual eligibles tend to use more Medicare-covered health services than other Medicare beneficiaries **(Exhibit 6).** For example, in 2006, duals were more likely than other Medicare beneficiaries to have one or more inpatient hospital stay (29% of duals versus 19% of non-duals), and are more than twice as likely to have multiple stays in an inpatient hospital (14% of duals versus 6% of non-duals). Dual eligibles are also more likely to visit the emergency room (44% of duals versus 26% of non-duals) and are more than twice as likely as other Medicare beneficiaries to have multiple emergency room visits (23% of duals versus 9% of non-duals). The dual eligibles also are more likely to stay in a skilled nursing facility (SNF) at least once (10% of duals versus 4% of non-duals), and more likely to use home health services (13% of duals versus 7% of non-duals) and outpatient services, such as physician visits (80% of duals versus 72% of non-duals). Even among beneficiaries who were admitted to a SNF or who used home health services, dual eligibles used these services more intensively. Among beneficiaries admitted to a SNF, dual eligibles had longer stays than others, on average (39 days among duals versus 32 days among non-duals), and among home health users, dual eligibles had substantially more Medicare-covered home health visits than others (48 days among duals versus 29 days among non-duals).

EXHIBIT 6

Dual Eligibles Use More Medical Services Than Other Medicare Beneficiaries, 2006



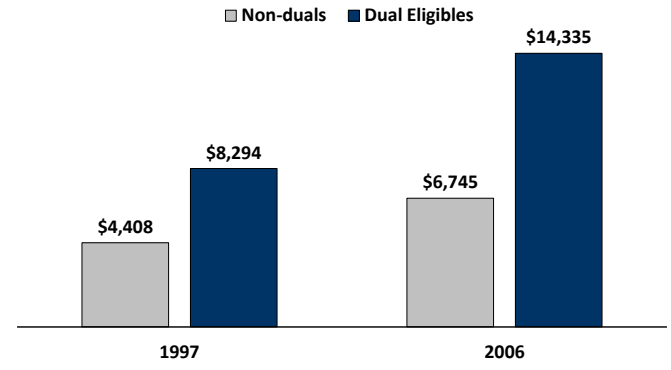
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2006.

How Much Does Medicare Spend on Health Care Services for the Dual Eligibles?

The high use of Medicare-covered acute care services by the dually eligible population adds up to relatively high Medicare spending. As noted earlier, dual eligibles account for 36 percent of Medicare spending and 39 percent of Medicaid spending.[7] Medicare spending for dual eligibles has increased from 31 percent of total Medicare spending in 1997 to 36 percent in 2006, primarily due to a faster growth rate in Medicare spending for dual eligibles than for other Medicare beneficiaries. On a per capita basis, Medicare spending for dual eligibles is $14,335 per person, on average, more than twice the average for other Medicare beneficiaries ($6,745 per person) in 2006 **(Exhibit 7)**. Some of the growth in per capita spending for dual eligibles between 1997

EXHIBIT 7

Medicare Spending for Dual Eligibles is Higher and Has Grown Faster Than for Other Medicare Beneficiaries, 1997 and 2006



NOTE: Excludes Medicare Advantage enrollees' spending. Excludes Medicare prescription drug spending.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2006.

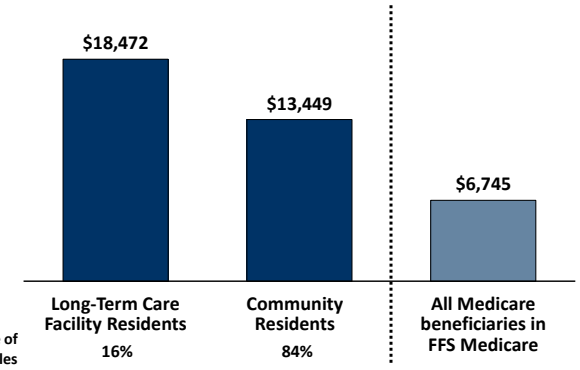
and 2006 can be attributed to the Medicare Part D program, which began covering the prescription drug costs for Medicare beneficiaries, including dual eligibles, in 2006 ($2,487 per dual eligible in 2006). The remainder of the growth in per capita Medicare spending between 1997 and 2006 ($3,554 per dual eligible) can be attributed to increases in spending for other health care services.

Although the total per capita Medicare spending is higher for duals than non-dual beneficiaries, the share of expenditures spent on various services is similar for the duals and non-dual beneficiaries. Inpatient hospital expenses comprised more than one-third (35%) of all Medicare spending for the dual eligibles, roughly the same share as for all other Medicare beneficiaries (38%). Medical provider services and supplies account for 21 percent of total spending for dual eligibles, a somewhat smaller share than for all other beneficiaries (32 percent). As might be expected, prescription drugs accounted for 20 percent of Medicare spending for dual eligibles but only 8 percent of Medicare spending for other Medicare beneficiaries.

Even though Medicaid is the primary payer of long-term care services, Medicare also incurs substantial costs for beneficiaries living in long-term care facilities --- 56% of the Medicare beneficiaries in long-term care facilities in 2006 were in the top quartile of Medicare spending (i.e., they were "high spenders").[8] Most (64%) Medicare beneficiaries who lived in a long-term care facility, such as a nursing home, were dual eligibles in 2006. Medicare spent, on average, more than $18,000 in 2006 for each dual eligible beneficiary living in a long-term care facility --- just on medical services, such as inpatient hospital visits **(Exhibit 8).**[9]

EXHIBIT 8

Medicare Spending is Higher for Dual Eligibles Living in Long-Term Care Facilities Than for Dual Eligibles Living in the Community, 2006



NOTE: FFS is fee-for-service, or traditional Medicare. Excludes Medicare Advantage enrollees' spending. Excludes Medicare prescription drug spending. Includes beneficiaries who were in long-term care facilities as of January 1, 2006, including those who died before the end of 2006.
SOURCE: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey Cost & Use File, 2006.

States, supported by federal resources, have tried to decrease their expenditures on nursing home care over the years by providing services that enable beneficiaries to continue living in the community. For example, the Money Follows the Person Rebalancing Demonstration program, is a recent initiative intended to allow beneficiaries living in institutions to transition back into the community through the use of home and community based services. Analyses suggest that the 29 state programs (plus the District of Columbia) have encountered many challenges but have been effective in helping almost 6,000 stay out of long-term care facilities.[10]

How Are Medicare and Medicaid Trying to Better Coordinate Care for the Dual Eligibles?

States can employ a range of approaches to coordinate health care services for dual eligibles. Although some states support care coordination in a Medicaid fee-for-service context, others support it through managed care programs. The idea of improving coordination between Medicare and Medicaid for the dual eligibles through managed care plans has evolved over time.

Some states have developed programs to improve the coordination of care for the dual eligibles, for example, though medical homes. North Carolina has employed an enhanced medical home model in its Medicaid program, including dual eligibles, since 1998. The program works with non-profit community networks to link beneficiaries to providers who serve as a medical home to better coordinate the beneficiaries' care. Studies funded by the program suggest that the program improved care and reduced Medicaid spending for asthma and diabetes patients, relative to projected costs.[11] Other states, such as Oklahoma, Vermont, and Illinois, have also developed medical home programs for their Medicaid beneficiaries, including dual eligibles.

The Program of All-Inclusive Care for the Elderly (PACE), which integrates Medicare and Medicaid services and receives capitated payments from both programs, began as a demonstration in the 1980s, and was authorized by the Balanced Budget Act (BBA) of 1997. Today, PACE serves an estimated 20,000 people nationwide, with only 74 PACE programs across 29 states.[12] The program serves a small share of the dual eligible population both because it is limited to people who need a nursing home-level of care and because of the challenges involved in providing appropriate care to this high-need, high-cost population.

In addition, several states have contracted with Medicare's Special Needs Plans (SNPs) as a means for improving the coordination of care for the dual eligibles.[13] SNPs were created in 2003 to improve the management of care for Medicare beneficiaries who are dually eligible, require an institutional level of care, or have certain chronic conditions. Like other Medicare Advantage plans, SNPs have contracts with Medicare and are run by private companies. The Medicare program pays the plans capitated amounts and requires the plans to have models of care and provide benefits not covered by traditional Medicare. Beginning in 2010, new SNPs for dual eligibles and existing SNPs that want to expand their service area are required to contract with states to provide at least some coordination with Medicaid benefits. Almost one million Medicare beneficiaries were enrolled in a SNP for the dual eligibles in 2010, up from 850,000 beneficiaries in 2008, despite a decline in the number of SNPs for dual eligibles.[14] The availability of SNPs for the dually eligible varies by county within states, and there are few SNPs in the Mountain and Midwest regions of the country.

What Provisions in the 2010 Health Reform Law Aim to Improve Care for the Dual Eligibles?

The 2010 health reform law includes several provisions aimed at improving care for dual eligibles. Foremost, the law creates the Federal Coordinated Health Care Office (CHCO), which is charged with improving the integration of benefits under Medicare and Medicaid for the dual eligibles. Specifically, the CHCO is responsible for monitoring the dual eligibles' expenditures, health outcomes, and access to benefits; educating the dual eligibles about the services available under Medicare and Medicaid; assisting states and providers with developing integrated programs for the dual eligibles; and making recommendations on how to improve care coordination and eliminate cost-shifting between the programs. The 2010 health reform law also created the Center for Medicare and Medicaid Innovation (CMMI). The overarching responsibility of the CMMI is to test and implement new models of care, including allowing states to test models for fully integrating the delivery and financing of health care for the dual eligibles; the CHCO and the CMMI will work together to test such models.

The law also expanded authority for the recently-established Medicaid and CHIP Payment and Access Commission (MACPAC)whose mandate is to study and make recommendations for improving the financing and care for beneficiaries covered under the Medicaid program and CHIP. Both MACPAC and the Medicare Payment Advisory Commission (MedPAC) will coordinate recommendations and efforts with respect to dual eligibles with the CHCO. Other provisions under the 2010 health reform law also aim to improve care for the dual eligibles, as well as other Medicaid beneficiaries. The law provides additional options and federal support for states to expand HCBS programs and extends the Money Follows the Person Rebalancing Demonstration program through 2016.

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 result, they use many health and long-term care services, which result in high per capita expenditures for both Medicare and Medicaid. Finding ways to better coordinate the benefits, providers, and management of 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.

Many questions remain for federal and state policymakers as they consider ways to better coordinate the care for the dual eligibles. For instance, what are the best models and strategies for improving coordination between the two programs? Should enrollment for dual eligibles in Medicare and Medicaid managed care programs be

mandatory or voluntary? On the one hand, voluntary enrollment allows the dual eligibles, like other Medicare beneficiaries, to maintain some control and autonomy over their choice of health care and to choose and maintain relationships with their health care providers. On the other hand, mandatory enrollment helps to boost enrollment, which may improve the efficiency, lower the per capita cost, and make it easier for the integrated care program to manage the care of the dual eligibles. In addition, there are questions regarding what safeguards are needed to ensure that necessary services are not inadvertently cut or that quality of care is not compromised. What consumer protections, including appeals processes and procedures, are needed, and which policies and procedures would be in the best interest of beneficiaries? What steps should be taken to limit the extent to which costs are shifted from one program to the other? Should states share in any Medicare savings achieved through integrated care programs? What steps should be taken to assure the financial integrity of plans that combine funds from both Medicare and Medicaid? Finally, little is known about the quality of care provided in the existing care coordination programs, and it is important to rigorously monitor and evaluate the programs before encouraging program expansion.

The challenges facing dual eligibles have become more evident over the years, as the fiscal pressures facing the Medicare and Medicaid programs to address the relatively high costs associated with caring for this population have continued to grow. Recent proposals for addressing the federal deficit and state budget shortfalls have included measures that would limit future spending on the dual eligibles, such as mandatory managed care enrollment.[15] 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 safeguard the dual eligibles' access to health care services and the quality of their care as these efforts get underway.

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[1] See Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," December 2010.
[2] See The National Commission on Fiscal Responsibility and Reform, "The Moment of Truth," December 1, 2010; and The Debt Reduction Task Force and Bipartisan Policy Center, "Restoring America's Future," November 17, 2010.
[3] For more information about the evolution of Medicaid benefits for Medicare beneficiaries, see Kaiser Commission on Medicaid and the Uninsured, "Medicaid: A Timeline of Key Developments," July 2005, available at [http://www.kff.org/medicaid/40years.cfm].
[4] See Neuman T, Cubanski J, and Damico A, "Revisiting 'Skin in the Game' Among Medicare Beneficiaries," Kaiser Family Foundation, February 2009.
[5] See Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," December 2010.
[6] 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.
[7] See Rousseau D, Clemans-Cope L, Lawton E, et al., "Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007," Kaiser Family Foundation, December 2010.
[8] See Perry M, Cummings J, Jacobson G, et al., "To Hospitalize or Not to Hospitalize? Medical Care for Long-Term Care Facility Residents," Kaiser Family Foundation, October 2010. See also Jacobson G, Neuman T, and Damico A, "Medicare Spending and Use of Medical Services for Beneficiaries in Nursing Homes and Other Long-Term Care Facilities: A Potential for Achieving Medicare Savings and Improving the Quality of Care," Kaiser Family Foundation, October 2010.
[9] See Perry M, Cummings J, Jacobson G, et al., "To Hospitalize or Not to Hospitalize? Medical Care for Long-Term Care Facility Residents," Kaiser Family Foundation, October 2010. See also Jacobson G, Neuman T, and Damico A, "Medicare Spending and Use of Medical Services for Beneficiaries in Nursing Homes and Other Long-Term Care Facilities: A Potential for Achieving Medicare Savings and Improving the Quality of Care," Kaiser Family Foundation, October 2010.
[10] See O'Malley Watts M, "Money Follows the Person: An Early Implementation Snapshot," Kaiser Commission on Medicaid and the Uninsured, June 2009. See also Denny-Brown N and Lipson DJ, "The National Evaluation of the Money Follows the Person (MFP) Demonstration Grant Program," Centers for Medicare and Medicaid Services, No. 3, November 2009, available at [http://www.cms.gov/CommunityServices/Downloads/MFPReportNo3Nov09.pdf]; last accessed January 2011. The 2010 health reform law extended the authorization and funding for MFP until September 30, 2016.
[11] See Kaiser Commission on Medicaid and the Uninsured, "Community Care of North Carolina: Putting Health Reform Ideas Into Practice in Medicaid," May 2009.
[12] See Centers for Medicare and Medicaid Services, "Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report - Monthly Summary Report," December 2010.
[13] For more information, see Medicare Payment Advisory Commission, *Report to Congress: Aligning Incentives in Medicare, Chapter 5*, June 2010.
[14] In theory, enrollment in a SNP is restricted to these special populations of Medicare beneficiaries; however, enrollment criteria has not been strict, and a proposed rule noted that more than one-quarter of enrollees in SNPs for the dually eligible are not eligible for Medicaid benefits and are not dually eligible. See Federal Register, 42 CFR Parts 422 and 423.
[15] See The National Commission on Fiscal Responsibility and Reform, "The Moment of Truth," December 1, 2010; and The Debt Reduction Task Force and Bipartisan Policy Center, "Restoring America's Future," November 17, 2010.

Appendix

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 A1)**. 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. In Florida, for example, Medicare beneficiaries were eligible for full Medicaid benefits in 2009 if their income was at or below 88 percent of the FPL and their assets were at or below $5,000 for individuals ($6,000 for couples).[3]

- **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.[4] 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.[5] The federal income limit for QMBs is 100 percent of the FPL, and the asset limit is $6,880 for individuals ($10,020 for couples) in 2011.

- **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 $6,880 for individuals ($10,020 for couples) in 2011.

- **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 $6,880 for individuals ($10,020 for couples) in 2011.

- **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 $12,640 for individuals ($25,260 for couples) in 2011.

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[1] See Kaiser Commission on Medicaid and the Uninsured, "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," December 2010.

[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 more information, see Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," February 2010.

[4] 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 Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," December 2010.

[5] Note that the QMB program will pay the 20% Medicare Part B coinsurance only if the provider is certified as a Medicaid provider.

TABLE A1

Common Medicaid Eligibility Pathways and Benefits for Medicare Beneficiaries, 2011

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**	**$6,880/$10,020**	**Medicare Part A and Part B premiums and cost sharing**
Specified Low-Income Medicare Beneficiary (SLMB), (mandatory)	**100%-120% of poverty**	**$6,880/$10,020**	**Medicare Part B premiums**
Qualified Individual (QI), (mandatory)	**120%-135% of poverty**	**$6,880/$10,020**	**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.

Table A2: Dual Eligibles by State, 2007

State	Total Medicare Beneficiaries	Number of Dual Eligibles	Share of Medicare Beneficiaries who are Dual Eligibles	Share of Dual Eligibles Ages 65+	Share of Dual Eligibles Younger Than Age 65 and Disabled	Full Duals as a Share of All Dual Eligibles
United States	**43,259,280**	**8,896,020**	**21%**	**62%**	**38%**	**77%**
Alabama	789,250	204,145	26%	60%	40%	49%
Alaska	56,803	13,020	23%	55%	45%	98%
Arizona	840,527	141,159	17%	59%	41%	79%
Arkansas	496,335	99,375	20%	57%	43%	69%
California	4,368,858	1,167,865	27%	71%	29%	98%
Colorado	558,222	68,788	12%	63%	37%	92%
Connecticut	537,064	100,257	19%	62%	38%	77%
Delaware	136,206	22,942	17%	57%	43%	47%
District of Columbia	74,085	21,852	29%	61%	39%	87%
Florida	3,132,634	560,967	18%	67%	33%	58%
Georgia	1,110,510	262,343	24%	61%	39%	57%
Hawaii	189,385	31,927	17%	70%	30%	92%
Idaho	206,570	30,317	15%	51%	49%	72%
Illinois	1,740,751	304,346	17%	58%	42%	88%
Indiana	940,825	149,447	16%	52%	48%	64%
Iowa	500,056	79,303	16%	53%	47%	84%
Kansas	411,660	62,097	15%	54%	46%	76%
Kentucky	710,977	176,477	25%	54%	46%	64%
Louisiana	639,499	182,015	28%	61%	39%	59%
Maine	246,571	88,660	36%	61%	39%	60%
Maryland	723,302	108,122	15%	60%	40%	69%
Massachusetts	996,741	250,744	25%	54%	46%	96%
Michigan	1,540,827	257,837	17%	52%	48%	88%
Minnesota	729,147	129,160	18%	57%	43%	91%
Mississippi	469,402	149,494	32%	60%	40%	52%
Missouri	946,284	169,391	18%	52%	48%	91%
Montana	155,753	18,051	12%	57%	43%	86%
Nebraska	267,588	41,301	15%	55%	45%	91%
Nevada	317,741	38,412	12%	61%	39%	56%
New Hampshire	204,313	27,773	14%	50%	50%	74%
New Jersey	1,257,125	200,442	16%	67%	33%	83%
New Mexico	284,910	53,342	19%	63%	37%	71%
New York	2,840,560	723,565	25%	69%	31%	90%
North Carolina	1,358,548	305,904	23%	59%	41%	81%
North Dakota	105,324	15,243	14%	61%	39%	76%
Ohio	1,805,235	290,634	16%	53%	47%	68%
Oklahoma	565,079	111,156	20%	58%	42%	84%
Oregon	566,960	87,672	15%	57%	43%	70%
Pennsylvania	2,183,604	380,676	17%	58%	42%	85%
Rhode Island	175,012	39,236	22%	60%	40%	87%
South Carolina	697,189	149,211	21%	57%	43%	88%
South Dakota	129,381	20,257	16%	61%	39%	68%
Tennessee	974,803	275,737	28%	52%	48%	76%
Texas	2,708,229	609,468	23%	68%	32%	62%
Utah	254,060	30,280	12%	48%	52%	90%
Vermont	101,593	31,217	31%	62%	38%	63%
Virginia	1,044,603	167,845	16%	59%	41%	70%
Washington	873,385	144,224	17%	55%	45%	76%
West Virginia	367,338	77,258	21%	52%	48%	63%
Wisconsin	854,343	215,227	25%	70%	30%	59%
Wyoming	74,113	9,839	13%	55%	45%	68%

Source: Urban Institute and KCMU estimates based on data from MSIS 2007.

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