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Medicaid's Role for Dual Eligible Beneficiaries

BY KATHERINE YOUNG, RACHEL GARFIELD, MARYBETH MUSUMECI, LISA CLEMANS-COPE, AND EMILY LAWTON

Medicaid fills in the gaps in Medicare's benefit package for many low-income Medicare beneficiaries. These "dual eligible" beneficiaries are individuals who are entitled to Medicare and are also eligible for some level of assistance from their state Medicaid program. Such assistance ranges from help paying for Medicare's premiums and cost-sharing to coverage of benefits not offered under Medicare, such as long-term care and at state option, hearing, vision, and dental services. Because dual eligible beneficiaries have significant medical needs and a much higher per capita cost on average than other beneficiaries, they are of great interest to both Medicare and Medicaid policymakers and to the state and federal governments that finance and manage the programs.

This brief provides an update on Medicaid enrollment and spending attributable to dual eligible beneficiaries through fiscal year 2010. The data comes from the FY 2010 Medicaid Statistical Information System (MSIS) maintained by the Centers for Medicare and Medicaid Services (CMS), having adjusted spending to align to Form CMS 64 levels, as well as having incorporated premium and some coinsurance and deductible data from the Form CMS 64. Further details on the methodology are provided in the appendix. This brief provides state-level estimates of Medicaid enrollment and expenditures for dual eligible beneficiaries, together with a breakdown of dual eligible Medicaid expenditures by service category, age group, and Medicaid eligibility group (elderly or under age 65 with disabilities). Key findings are:

- Over **9.6 million** older Americans and younger persons with disabilities were covered under both the Medicare and Medicaid programs in FY 2010. Although these "dual eligible" beneficiaries accounted for only **14 percent of Medicaid enrollment in 2010, 36 percent of all Medicaid expenditures** for medical services were made on their behalf. Dual eligible beneficiaries also accounted for 33 percent of Medicare spending in 2009.[1]
- Dual eligible beneficiaries as a share of total Medicaid enrollees **ranged from a low of 9 percent in Utah to a high of 26 percent in Maine**, due to demographic differences and policy preferences across the states. Similarly, spending on dual eligible beneficiaries as a percentage of total Medicaid spending ranged from a **low of 20 percent in Arizona to a high of 55 percent in North Dakota.**

» **Sixty-five percent of Medicaid spending on behalf of dual eligible beneficiaries was for long-term care services, which are generally not covered by Medicare or private insurance.** A quarter of spending was for acute care services. This includes both acute care services covered by Medicare (e.g. hospital, physician, and lab/x-ray services) and those not covered by Medicare (e.g., dental, vision, and hearing services).[2] Nine percent of Medicaid spending went toward Medicare premiums for Medicare services in 2010. The remaining 1 percent of Medicaid dual eligible spending was for prescription drugs, a percentage that has fallen significantly since coverage for nearly all prescribed drugs for dual eligible beneficiaries was shifted from Medicaid to Medicare Part D in 2006.

» Like health spending more generally, **spending on dual eligible beneficiaries is skewed toward those with the greatest health and long-term care needs**. **Although only 13 percent of dual eligible beneficiaries were in an institutional long-term care setting in 2010, these enrollees accounted for half of all spending on dual eligible beneficiaries.** The nearly 960,000 dual eligible beneficiaries who were in the top ten percent of spending in 2010 accounted for more than 60 percent of all dual eligible beneficiary spending.

» Fifty-nine percent of dual eligible enrollees were 65 or older and accounted for 60 percent of Medicaid spending on dual eligible beneficiaries. Individuals with disabilities under the age of 65 constitute at least half of all dual eligible enrollees in ten states. Over the nation as a whole, aged dual eligible beneficiaries spend less than $100 more per capita per year than individuals with disabilities under the age of 65. However, there is considerable variation on this spending differential at the state level.

An Overview of FY 2010 Dual Eligible Beneficiary Enrollment and Spending

Who are the Dual Eligible Beneficiaries?

Dual eligible beneficiaries are individuals who are entitled to Medicare and eligible for some level of assistance from their state Medicaid program. Medicare acts as a primary payer for these people, providing coverage for a variety of services. However, there are gaps in the range of services that Medicare insures, which Medicaid may then cover. Additionally, Medicaid assists in the dual eligible beneficiaries' cost-sharing responsibilities. Categories of Medicare participants who are eligible to receive assistance under Medicaid are listed in Table 1. Some dual eligible beneficiaries, referred to as "full dual eligible beneficiaries", qualify for their state's entire package of Medicaid benefits and also receive assistance from Medicaid with their Medicare premiums and cost sharing.
Other dual eligible beneficiaries, referred to as "partial dual eligible beneficiaries", do not receive Medicaid benefits directly. Instead, Medicaid provides "Medicare Savings Programs" through which beneficiaries receive assistance with some or all of their Medicare premiums, deductibles, and other cost-sharing requirements.[4]

Dual eligible beneficiaries are among the sickest and poorest individuals covered by either Medicare or Medicaid. Most dual eligible beneficiaries have very low-incomes. In 2009, fifteen percent of dual eligible beneficiaries received care in a long-term care facility, such as a nursing home. Forty-three percent had difficulty with at least one activity of daily living (such as dressing, bathing, or eating). The prevalence of many serious health conditions, such as cognitive or mental impairments, depression, and diabetes, is significantly higher for dual eligible beneficiaries than for non-dual Medicare beneficiaries. The composition of Medicare beneficiaries receiving some level of Medicaid assistance and the services they utilize that are paid by Medicare are studied in greater detail in the Kaiser Family Foundation brief *Medicare's Role for Dual Eligible Beneficiaries*.[5]

Table 1

Common Medicaid Eligibility Pathways for Medicare Beneficiaries, 2013

	Income Eligibility	Asset Limit	Medicaid Benefits in 2013
Individuals Eligible for Full Medicaid Benefits ("Full Dual Eligible Beneficiaries")			
SSI Cash-Assistance-Related (mandatory)	Generally 74% of the FPL for individuals and 82% of FPL for couples[*1]	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Poverty-Related (optional)	Up to 100% of the FPL[*2]	$2,000 (individual) $3,000 (couple)[2]	Full Medicaid benefits, including long-term care, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Medically Needy (optional)	Individuals who spend down their incomes to state-specific levels.[2,3]	$2,000 (individual) $3,000 (couple)[2]	"Wrap around" Medicaid benefits (may be more limited than those for SSI beneficiaries). Medicaid may also pay Medicare premiums and cost sharing, depending on income.
Special Income Rule for Nursing Home Residents (optional)	Individuals living in institutions with incomes up to 300% of the SSI federal benefit rate.[4]	$2,000 (individual) $3,000 (couple)[2]	Full Medicaid benefits, including long-term care, that 'wrap around' Medicare benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Home and Community Based Service Waivers (optional)	Individuals who would be eligible if they resided in an institution. Several states do not use the special income rule for waivers, so eligibility levels may be lower than 300% of the SSI federal benefit rate.		Full Medicaid benefits, including long-term care, that 'wrap around' Medicare benefits. Medicaid may also pay Medicare premiums and cost sharing.
Medicare Savings Programs ("Partial Dual Eligible Beneficiaries")			
Qualified Medicare Beneficiaries[6] (QMB) (mandatory)	Up to 100% of the FPL[*2]	$7,080 (individual) $10,620 (couple)[2]	No Medicaid benefits. Medicaid pays Medicare premiums (Part B and if needed, Part A) and cost sharing.[5]
Specified Low-Income Medicare Beneficiaries[6] (SLMB) (mandatory)	Between 100% and 120% of the FPL.[*2]	$7,080 (individual) $10,620 (couple)[2]	No Medicaid benefits. Medicaid pays Medicare Part B premium.
Qualified Disabled Working Individuals (QDWI) (mandatory)	Working, disabled individuals with income up to 200% of the FPL.[*]	$4,000 (individual) $6,000 (couple)	No Medicaid benefits. Medicaid pays Medicare Part A premium.
Qualifying Individuals (QI) (mandatory)	Greater than or equal to 120% and less than135% of the FPL.[*2]	$7,080 (individual) $10,620 (couple)[2]	No Medicaid benefits. Medicaid pays Medicare Part B premium. Federally funded, no state match. Participation may be limited by funding.

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Centers for Medicare and Medicaid Services (CMS).

* In 2013, 100% of the federal poverty level (FPL) was $958 for individuals and $1,293 for couples per month in the 48 contiguous states and the District of Columbia. Higher FPLs apply in Alaska and Hawaii.

1. The maximum SSI federal benefit rate in 2013 was $710 per month for individuals and $1,066 per month for couples. People with incomes below these levels who meet Social Security's disability criteria generally qualify for benefits. SSI disregards the first $20 of income from any source, plus the first $65 and half of all remaining earned income, so eligibility levels can be higher. However, few SSI recipients have earned income, so most qualify at or below the income levels shown. Some states using the "209(b) option" use different (often more restrictive) income or asset requirements for Medicaid eligibility for SSI recipients.

2. Section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are "less restrictive" than those that would otherwise apply, enabling states to effectively expand eligibility above this standard.

3. Individuals eligible under the medically needy option have incomes that are too high to qualify under SSI or poverty-related pathways. Unless their incomes fall below their state's medically needy standards for their family size, these individuals must incur sufficient medical expenses to reduce their income below those standards. Most states use medically needy income limits that are below SSI-related eligibility pathways.

4. In 2013, 300% of the SSI federal benefit rate was $2,130 per month for an individual. Several states do not use the Special Income Rule, and a few other states use income limits that are below 300% of the SSI federal benefit rate.

5. States are not required to pay for Medicare cost-sharing if the Medicaid payment rates for a given service are sufficiently lower than the Medicare payment rates.

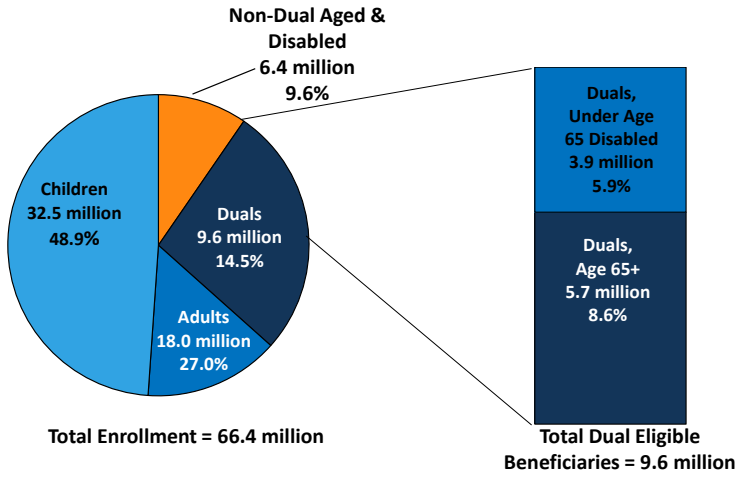
6. QMB Plus and SLMB Plus categories were created when Congress changed eligibility criteria for QMBs and SLMBs to eliminate the requirement that QMBs and SLMBs could not otherwise qualify for Medicaid. Individuals in these "Plus" categories meet QMB or SLMB eligibility requirements, but also meet the financial criteria for full Medicaid coverage in their state. These individuals DO receive full Medicaid benefits.

How Many Dual Eligible Beneficiaries are Enrolled in Medicaid?

Over 9 million Medicare beneficiaries were enrolled in Medicaid in 2010 (Figure 1 and Table 2). This includes both those who qualified for full Medicaid benefits ("full dual eligible beneficiaries") and those who received only assistance with Medicare premiums and cost sharing ("partial dual eligible beneficiaries"). These partial dual eligible beneficiaries did not qualify for non-Medicare covered Medicaid services, such as hearing, vision, dental, and long-term care. Nearly one in six Medicaid enrollees (14%) was dually eligible in 2010 (Figure 1). Of these dual eligible beneficiaries, 7 million (75%) were full dual eligible beneficiaries while the remaining 25 percent were partial.

Figure 1

Medicaid Enrollment, FY 2010



Source: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS. 2009 MSIS data were used for CO, ID, MO, NC, and WV, because 2010 data were unavailable.

While dual eligible beneficiaries account for 14 percent of all Medicaid enrollees nationally, there is significant variation in their share of each state's Medicaid enrollment. Dual eligible beneficiaries account for 20 percent of all Medicaid enrollees in Alabama, Kentucky, Mississippi, New Jersey, and West Virginia. In Maine, dual eligible beneficiaries account for 26 percent of all Medicaid enrollees. In other states – Alaska, Arizona, California, and Utah – dual eligible beneficiaries make up less than 12 percent of the state's Medicaid enrollees. These variations reflect a state's demographic profile as well as state policy choices affecting the extent of Medicaid coverage provided to their residents who are seniors or have disabilities versus non-disabled adults and children. There is also great variation among states in the share of dual eligible beneficiaries who receive full or partial Medicaid assistance. In states such as Delaware and Alabama, which cover many individuals through Medicare Savings Programs, more than half of all dual eligible beneficiaries in the state are partial dual eligible beneficiaries. In states such as Alaska and California, on the other hand, where relatively fewer have been enrolled in Medicare Savings Programs, nearly all dual eligible beneficiaries qualify for full Medicaid benefits (Table 2).

Nearly 60 percent of dual eligible beneficiaries (5.7 million) were "elderly," or individuals age 65 and over, while the remaining beneficiaries (3.9 million) were younger individuals with disabilities (Table 3). Ninety-one percent of elderly Medicaid enrollees are eligible for Medicare, with the remaining nine percent being ineligible for Medicare because their own or others' work histories were not sufficient to qualify.[6,7,] A much larger share (60%) of Medicaid's non-elderly enrollees with disabilities do not meet eligibility criteria for Medicare, a significant portion of whom may be in the 2-year waiting period between first receiving federal Social Security Disability Insurance (SSDI) and becoming eligible for Medicare coverage.[8] As shown in Table 3, at least 95 percent of aged Medicaid enrollees were dually eligible for Medicare in 23 states. The share of Medicaid enrollees with disabilities who were dual eligible beneficiaries averaged 40 percent nationally, but the share was 50 percent or more in six states.

Table 3

Aged and Disabled Dual Eligible Beneficiaries by State, FY 2010

State	Aged Dual Eligibles	Aged Duals as a Share of… All Dual Enrollees	Aged Duals as a Share of… Aged Enrollees	Disabled Dual Eligibles Under Age 65	Disabled Duals Under Age 65 as a Share of… All Dual Enrollees	Disabled Duals Under Age 65 as a Share of… Disabled Enrollees
United States	5,716,930	59%	91%	3,909,181	41%	40%
Alabama	115,799	56%	98%	90,045	44%	42%
Alaska	7,422	54%	84%	6,418	46%	39%
Arizona	89,346	58%	92%	63,515	42%	44%
Arkansas	67,301	54%	96%	57,513	46%	39%
California	887,334	70%	87%	374,052	30%	36%
Colorado	43,695	61%	88%	27,449	39%	34%
Connecticut	86,987	65%	94%	46,178	35%	60%
Delaware	13,923	54%	95%	12,054	46%	47%
District of Columbia	15,448	60%	90%	10,192	40%	27%
Florida	440,389	65%	94%	235,100	35%	41%
Georgia	160,271	59%	93%	111,905	41%	39%
Hawaii	23,683	68%	96%	11,038	32%	40%
Idaho	15,957	50%	94%	16,178	50%	41%
Illinois	194,827	56%	91%	151,100	44%	47%
Indiana	81,127	49%	90%	84,677	51%	48%
Iowa	42,990	50%	99%	42,664	50%	52%
Kansas	34,763	51%	92%	33,671	49%	43%
Kentucky	93,993	51%	98%	91,014	49%	39%
Louisiana	111,041	58%	98%	79,542	42%	36%
Maine	63,134	60%	94%	41,742	40%	38%
Maryland	68,024	57%	88%	51,736	43%	35%
Massachusetts	142,953	53%	83%	126,704	47%	47%
Michigan	131,001	48%	92%	144,238	52%	40%
Minnesota	77,417	54%	80%	65,666	46%	49%
Mississippi	88,514	56%	99%	69,053	44%	41%
Missouri	89,915	50%	95%	90,778	50%	45%
Montana	10,955	55%	99%	8,791	45%	41%
Nebraska	22,209	53%	94%	20,044	47%	52%
Nevada	26,532	59%	97%	18,144	41%	41%
New Hampshire	14,885	46%	94%	17,758	54%	59%
New Jersey	137,590	66%	91%	70,759	34%	40%
New Mexico	41,450	60%	97%	27,661	40%	41%
New York	541,376	68%	88%	255,695	32%	37%
North Carolina	178,923	56%	98%	137,992	44%	45%
North Dakota	9,298	58%	98%	6,724	42%	57%
Ohio	164,381	50%	91%	161,868	50%	41%
Oklahoma	64,331	54%	97%	55,349	46%	45%
Oregon	56,349	56%	96%	43,815	44%	45%
Pennsylvania	226,478	55%	94%	188,720	45%	32%
Rhode Island	24,416	58%	84%	17,603	42%	41%
South Carolina	83,633	54%	100%	71,372	46%	46%
South Dakota	12,585	59%	99%	8,740	41%	47%
Tennessee	140,049	52%	98%	128,513	48%	47%
Texas	420,464	65%	94%	222,395	35%	35%
Utah	13,337	44%	88%	16,850	56%	40%
Vermont	16,082	55%	72%	13,007	45%	52%
Virginia	103,850	57%	95%	79,768	43%	45%
Washington	93,304	54%	97%	78,396	46%	38%
West Virginia	41,224	50%	99%	40,530	50%	35%
Wisconsin	80,138	50%	55%	79,151	50%	47%
Wyoming	5,837	52%	99%	5,314	48%	47%

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS. 2009 MSIS data were used for Colorado, Idaho, Missouri, North Carolina, and West Virginia, because 2010 data were unavailable.

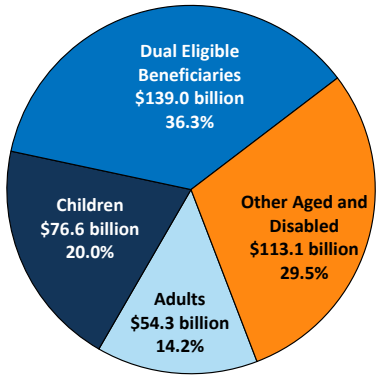
NOTE: Enrollees with a dual code equal to "09" were not considered to be dual eligible enrollees. There were 57,466 enrollees in Wisconsin in FY 2010 with a dual code equal to "09." They are thought to be enrollees in the SeniorCare program.

How Much Does Medicaid Spend on Services for Dual Eligible Beneficiaries?

Dual eligible beneficiaries account for 14 percent of Medicaid enrollment, and due to their more intensive need for services, 36 percent ($139 billion) of all Medicaid expenditures for medical services (including Medicare premiums) were made on their behalf in 2010 (Figure 2). Sixty-five percent of Medicaid expenditures for dual eligible beneficiaries ($90.3 billion) were for long-term care services (Figure 3).

Figure 2

Medicaid Spending by Group, Services Only, FY 2010



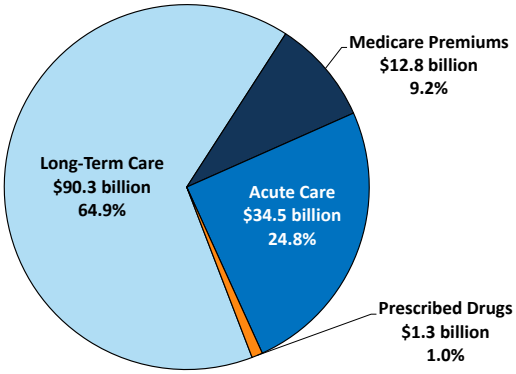
Total Spending = $383.0 billion

NOTE: Expenditures Include Premiums.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. Because 2010 data were unavailable, 2009 MSIS data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS-64 spending levels.

Only 1 percent of 2010 expenditures for dual eligible beneficiaries ($1.3 billion) were for prescription drugs, as nearly all prescription drug spending for dual eligible beneficiaries was absorbed into Medicare in January 2006 with the implementation of Medicare Part D. However, states are required to make a substantial contribution towards this benefit through monthly "clawback" payments to the federal treasury.[9]

Figure 3

Medicaid Expenditures for Dual Eligible Beneficiaries, FY 2010



Total Spending = $139.0 billion

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. Because 2010 data were unavailable, 2009 MSIS data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS-64 spending levels.

Another $12.8 billion in expenditures on dual eligible beneficiaries went toward Medicare premiums. Finally, approximately $34.5 billion was spent on acute care services. This includes both Medicaid's financing of Medicare-covered acute care services (e.g., hospital, physician, and lab/x-ray services) and acute care services not covered by Medicare, but covered by Medicaid at state option, such as dental care, vision, and hearing services.

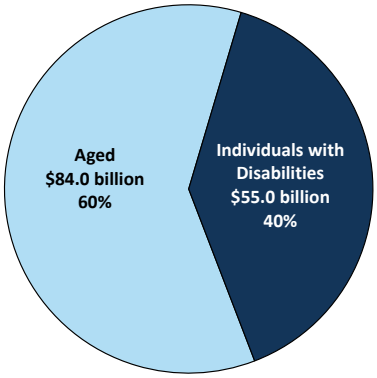
As with enrollment, dual eligible beneficiaries' share of total spending and the distribution of spending on dual eligible beneficiaries across services varied significantly across the states (Tables 4a and 4b). Spending on dual eligible beneficiaries accounted for at least half of Medicaid spending in Connecticut, Maine, and North Dakota. Long-term care spending was at least 80 percent of spending on dual eligible beneficiaries in Connecticut, New Hampshire, North Dakota, and Pennsylvania.

Medicaid spending per dual eligible beneficiary per year (which reflects spending per full-year-equivalent, dual eligible enrollee) averaged $16,460 for the nation in 2010 (Table 4a). However, several states –the District of Columbia, Minnesota, New York, and North Dakota – averaged more than $26,000 per dual eligible beneficiary per year. The range of per capita spending on a per enrollee, per year basis is wide, with Alabama and Georgia spending less than $10,000 per dual eligible beneficiary per year in 2010.

Sixty percent of total Medicaid spending on dual eligible beneficiaries is for aged beneficiaries. Table 5 and Figure 4 show spending on aged and younger dual eligible beneficiaries with disabilities. Spending per aged dual eligible beneficiary per year is slightly higher than spending per disabled dual per year. Even when looking within eligibility groups, the range of per capita spending on dual eligible beneficiaries across states is wide. Spending per aged dual eligible beneficiary per year ranged from less than $11,000 in Alabama, Georgia, and Louisiana to more than $28,000 in Montana, New York, North Dakota, and Wisconsin. Among dual eligible beneficiaries with disabilities, per capita spending ranged from less than $7,000 in Alabama to more than $38,000 in New York.

Figure 4

Distribution of Medicaid Expenditures Among Aged and Disabled Dual Eligible Beneficiaries, FY 2010



Total Spending = $139.0 billion

NOTE: Medicare premium costs were allotted to aged and disabled enrollees based on their relative proportions of enrollees.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. Because 2010 data were unavailable, 2009 MSIS data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS-64 spending levels.

Table 5

Medicaid Expenditures for Aged and Disabled Dual Eligible Beneficiaries by State, FY 2010

State	Aged			Individuals with Disabilities Under Age 65		
	Total (in millions)	Spending Per Aged Dual Eligible Per Year[1]	Percent of Dual Eligible Expenditures	Total (in millions)	Spending Per Disabled Dual Eligible Per Year[1]	Percent of Dual Eligible Expenditures
United States[2]	$83,967	$16,754	60%	$55,017	$16,031	40%
Alabama	1,069	10,280	68%	495	6,230	32%
Alaska	175	25,979	54%	150	26,003	46%
Arizona	1,086	13,012	58%	773	13,446	42%
Arkansas	1,073	18,219	60%	708	14,064	40%
California	10,506	13,077	68%	4,981	14,946	32%
Colorado	878	23,394	62%	543	22,510	38%
Connecticut	1,653	23,977	59%	1,171	28,914	41%
Delaware	211	17,245	58%	154	14,440	42%
District of Columbia	329	27,956	60%	221	30,243	40%
Florida	4,459	11,686	64%	2,479	12,399	36%
Georgia	1,472	10,257	66%	750	7,534	34%
Hawaii	405	19,519	73%	149	15,493	27%
Idaho	209	15,244	51%	203	13,984	49%
Illinois	2,191	12,935	54%	1,830	13,573	46%
Indiana	1,382	21,391	54%	1,180	16,785	46%
Iowa	706	19,592	50%	704	18,480	50%
Kansas	527	18,227	53%	472	16,188	47%
Kentucky	1,015	12,277	58%	736	9,348	42%
Louisiana	1,087	10,873	57%	834	11,577	43%
Maine	657	11,831	56%	513	13,893	44%
Maryland	1,253	21,395	59%	878	19,658	41%
Massachusetts	3,070	24,433	60%	2,030	17,847	40%
Michigan	2,279	20,718	59%	1,578	12,812	41%
Minnesota	1,640	25,591	50%	1,642	28,160	50%
Mississippi	976	12,383	66%	512	8,421	34%
Missouri	1,475	20,036	53%	1,310	17,461	47%
Montana	265	29,644	68%	124	16,490	32%
Nebraska	402	22,020	54%	340	19,438	46%
Nevada	255	11,312	63%	152	10,056	37%
New Hampshire	291	23,843	52%	270	18,339	48%
New Jersey	2,651	21,704	63%	1,555	24,277	37%
New Mexico[3]	N/A	N/A	N/A	N/A	N/A	N/A
New York	13,535	28,031	61%	8,619	38,105	39%
North Carolina	2,037	12,797	58%	1,501	12,092	42%
North Dakota	219	28,504	57%	166	28,117	43%
Ohio	3,494	24,871	58%	2,517	17,953	42%
Oklahoma	705	12,665	54%	604	12,480	46%
Oregon	994	20,632	68%	470	12,066	32%
Pennsylvania	4,103	21,150	61%	2,629	15,721	39%
Rhode Island	338	16,019	50%	335	21,443	50%
South Carolina	1,025	13,791	60%	680	10,728	40%
South Dakota	176	16,292	60%	119	15,304	40%
Tennessee	1,358	11,170	55%	1,104	9,936	45%
Texas	4,703	12,398	65%	2,482	12,478	35%
Utah	179	15,472	39%	283	19,465	61%
Vermont	226	16,406	56%	177	15,656	44%
Virginia	1,207	13,403	56%	949	13,536	44%
Washington	1,306	16,642	60%	880	13,131	40%
West Virginia	615	17,471	63%	359	10,211	37%
Wisconsin	1,983	29,433	61%	1,247	17,893	39%
Wyoming[4]	127	26,342	52%	116	25,490	48%

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64 reports. Because 2010 data were unavailable, 2009 MSIS data were used for Colorado, Idaho, Missouri, North Carolina, and West Virginia, and then adjusted to 2010 CMS-64 spending levels.

1. Medicare premium expenditures were allotted based on the relative proportions of disabled and aged enrollees in the dual population.

2. The national totals include New Mexico spending by service.

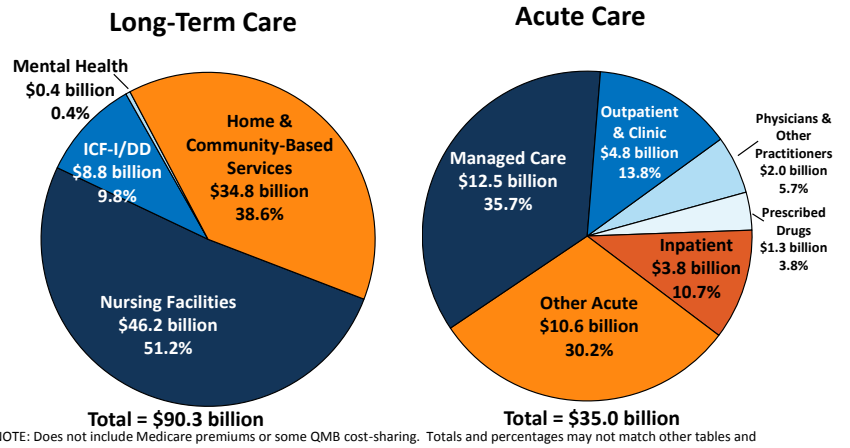
3. With the exception of Medicaid payments for Medicare premiums, we are unable to report New Mexico spending data for dual eligible beneficiaries due to data quality issues.

4. Enrollees with a dual code equal to "09" were not considered to be dual eligible enrollees. There were 57,466 enrollees in Wisconsin in FY 2010 with a dual code equal to "09." They are thought to be enrollees in the SeniorCare program.

When Medicare premiums are excluded along with some QMB coinsurance and deductibles,[10] 72 percent of Medicaid spending on dual eligible beneficiaries in 2010 was for long-term care services. Table 6 and Figure 5 provide detailed data on expenditures by type of service (excluding Medicare premiums and some QMB cost-sharing). Fifty-one percent of long-term care spending ($46.2 billion of $90.3 billion) was on nursing facilities. Most of the remaining long-term care spending was on home and community based services (HCBS). Since prescription drugs and some acute care services are covered primarily by Medicare, there is relatively low Medicaid spending on prescription drugs and on services such as inpatient and outpatient hospital and physician services. However, within acute care, spending on managed care now represents the largest share of spending. It has grown more quickly than any other long-term or acute care service since FY 2008,[11] in part because of state decisions to expand managed care to new Medicaid populations, such as persons with disabilities.[12]

Figure 5

Medicaid Spending by Type of Service for Dual Eligible Beneficiaries, FY 2010



NOTE: Does not include Medicare premiums or some QMB cost-sharing. Totals and percentages may not match other tables and figures that include premium data.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64 reports. Because 2010 data were unavailable, 2009 MSIS data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS-64 spending levels.

Among dual eligible beneficiaries under age sixty-five, spending was greater for long-term care than for acute care services ($33.3 billion vs. $16.2 billion). Forty percent of spending on this group was for HCBS and another 27 percent was on long-term care in an institutional setting (ICF-I/DD, nursing facility, or mental health facility). The remaining 33 percent of spending was distributed among the various acute care services.

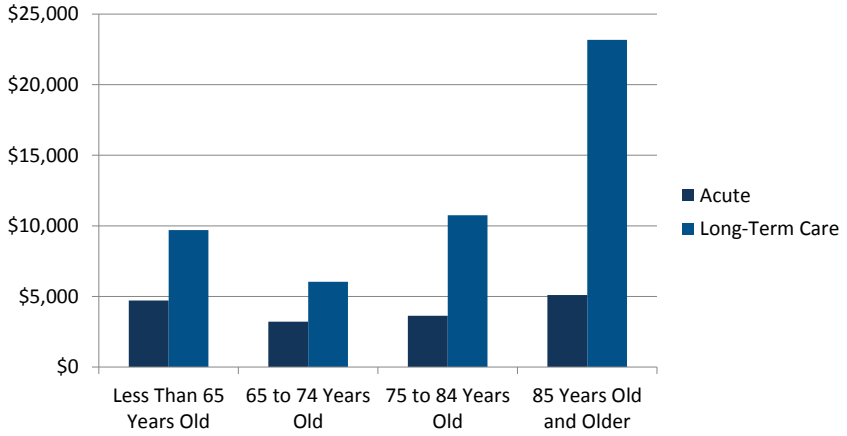
The composition of spending for those aged 65 to 74 was similar to those younger than 65, with the notable exception that spending for those aged 65 to 74 was more concentrated in institutional rather than community-based long-term care settings. In addition, this age bracket was more reliant on nursing facilities than on ICFs-I/DD. In older age cohorts, this concentration in institutions and reliance on nursing home facilities grows more pronounced. For those aged 75 to 84, 75 percent of expenditures were on long-term care services and the remainder on acute care services. Among those aged 85 and older, 82 percent of expenditures were towards long-term care services. The share of expenditures on nursing homes increased from 35 percent among the 65 to 74 year olds to 52 percent among the 75 to 84 year olds, and then to 67 percent among the 85 year olds and older. Overall, dual eligible beneficiaries age 75 and over accounted for $55.8 billion in expenditures; those under age 65 accounted for $49.5 billion.

Per enrollee per year spending varies widely across age categories, as shown in Figure 6 and Table 6. On a per enrollee per year basis, spending for those aged 85 and older amounted to over $28,000 per year. Of this total, about $23,000 per year was spent on long-term care services, mostly for nursing home care. Per enrollee spending among those aged 75 to 84 and among those below the age of 65 averaged more than $14,000 per enrollee per year. However, the distribution of spending between long-term care and acute care differed between these two age

brackets. For those younger than 65 (i.e., individuals with disabilities), about two thirds of this spending was for long-term care services, of which more than half ($5,821) was HCBS. Acute care services for dual eligible beneficiaries with disabilities amounted to $4,708 per enrollee per year, more than acute care spending for the older age groups. For those 65 to 74 years old, per enrollee per year spending was far lower ($9,243) reflecting a lower level of health care need compared to either the older groups or those eligible due to disability.

Figure 6

Medicaid Spending Per Enrollee by Age Group for Dual Eligible Beneficiaries, FY 2010



NOTE: Does not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. Because 2010 data were unavailable, 2009 MSIS data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS-64 spending levels.

Table 6

Medicaid Expenditures for Dual Eligible Beneficiaries by Type of Service and Age Group, FY 2010

Service/Service Group	Less Than 65 Years Old		65 to 74 Years Old		75 to 84 Years Old		85 Years Old and Older		All		65 Years Old or Older	
	(in millions)		(in millions)		(in millions)		(in millions)		(in millions)		(in millions)	
Long-term Care Services	**$33,299**	**67%**	**$13,115**	**65%**	**$18,959**	**75%**	**$24,904**	**82%**	**$90,277**	**72%**	**$56,978**	**75%**
Nursing Facilities	5,695	12%	7,057	35%	13,229	52%	20,265	67%	46,246	37%	40,550	53%
ICF-I/DD	7,566	15%	869	4%	316	1%	85	0%	8,836	7%	1,270	2%
Mental Health	63	0%	203	1%	75	0%	15	0%	356	0%	293	0%
HCBS	19,975	40%	4,985	25%	5,339	21%	4,540	15%	34,840	28%	14,865	20%
Acute Care Services	**$16,158**	**33%**	**$6,973**	**35%**	**$6,400**	**25%**	**$5,487**	**18%**	**$35,017**	**28%**	**$18,859**	**25%**
Inpatient Services	1,839	4%	890	4%	624	2%	396	1%	3,750	3%	1,911	3%
Prescribed Drugs	834	2%	311	2%	118	0%	74	0%	1,338	1%	504	1%
Physician and Other Practitioners	1,095	2%	451	2%	301	1%	162	1%	2,010	2%	914	1%
Outpatient and Clinic	3,184	6%	935	5%	491	2%	211	1%	4,821	4%	1,636	2%
Managed Care	4,694	9%	2,612	13%	2,741	11%	2,460	8%	12,507	10%	7,813	10%
Other Acute Services	4,511	9%	1,774	9%	2,123	8%	2,184	7%	10,592	8%	6,081	8%
Total Spending	**$49,457**	**100%**	**$20,088**	**100%**	**$25,359**	**100%**	**$30,391**	**100%**	**$125,294**	**100%**	**$75,837**	**100%**

Spending Per Enrollee Per Year

Service/Service Group	Less Than 65 Years Old		65 to 74 Years Old		75 to 84 Years Old		85 Years Old and Older		All		65 Years Old or Older	
Long-term Care Services	**$9,703**	**67%**	**$6,035**	**65%**	**$10,748**	**75%**	**$23,173**	**82%**	**$10,692**	**72%**	**$11,369**	**75%**
Nursing Facilities	1,660	12%	3,247	35%	7,500	52%	18,856	67%	5,477	37%	8,091	53%
ICF-I/DD	2,205	15%	400	4%	179	1%	79	0%	1,046	7%	253	2%
Mental Health	18	0%	93	1%	42	0%	14	0%	42	0%	58	0%
HCBS	5,821	40%	2,294	25%	3,027	21%	4,224	15%	4,126	28%	2,966	20%
Acute Care Services	**$4,708**	**33%**	**$3,208**	**35%**	**$3,628**	**25%**	**$5,105**	**18%**	**$4,147**	**28%**	**$3,763**	**25%**
Inpatient Services	536	4%	410	4%	354	2%	369	1%	444	3%	381	3%
Prescribed Drugs	243	2%	143	2%	67	0%	69	0%	158	1%	101	1%
Physician and Other Practitioners	319	2%	208	2%	171	1%	150	1%	238	2%	182	1%
Outpatient and Clinic	928	6%	430	5%	278	2%	196	1%	571	4%	327	2%
Managed Care	1,368	9%	1,202	13%	1,554	11%	2,289	8%	1,481	10%	1,559	10%
Other Acute Services	1,315	9%	816	9%	1,204	8%	2,032	7%	1,254	8%	1,213	8%
Total Spending	**$14,411**	**100%**	**$9,243**	**100%**	**$14,377**	**100%**	**$28,278**	**100%**	**$14,839**	**100%**	**$15,132**	**100%**

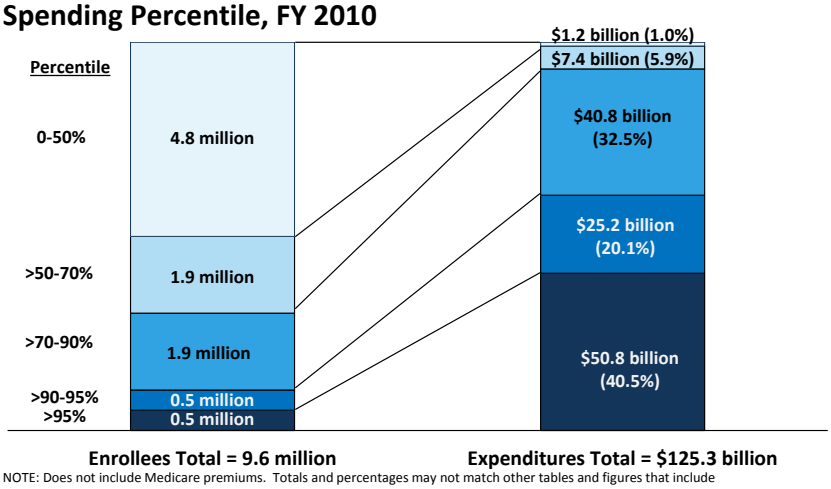
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 and CMS-64 reports.
Because 2010 data were unavailable, 2009 MSIS data were used for Colorado, Idaho, Missouri, North Carolina, and West Virginia, and then adjusted to 2010 CMS-64 spending levels.

NOTE: Expenditures do not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.
There were a small number of aged dual enrollees whose exact age was not provided, and as a result could not be included in the "65 to 74 Years Old", the "75 to 84 Years Old", or the "85 Years Old and Older" groups. However, their spending was small and the effect of omitting these enrollees is non-observable.

Like health spending more generally, Medicaid spending on dual eligible beneficiaries is skewed toward those with the greatest health and long-term care needs. Past research has shown that relatively small numbers of Medicaid beneficiaries account for a significant share of program spending.[13] Table 7 and Figure 7 demonstrate that spending on dual eligible beneficiaries is highly concentrated, with the top 10 percent of spenders accounting for more than 60 percent of all spending, and the top 5 percent accounting for more than 40 percent. Spending for this small group of very high-cost beneficiaries totaled nearly $51 billion, accounting for nearly 14 percent of all 2010 Medicaid expenditures. The 4.8 million dual eligible beneficiaries in the bottom 50 percent of the spending distribution accounted for just 1 percent of all Medicaid spending on dual eligible beneficiaries.

Figure 7

Dual Eligible Enrollment and Medicaid Spending by Per Enrollee Spending Percentile, FY 2010



NOTE: Does not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. Because 2010 data were unavailable, 2009 MSIS data were used for CO, ID, MO, NC, and WV, and then adjusted to 2010 CMS-64 spending levels.

This skewed spending is illustrated in the percentile distributions of per enrollee spending on per year basis (Table 7). Dual eligible beneficiaries above the 95th percentile of per enrollee per year spending had an average of $109,511 in Medicaid spending. Those in the 90 to 95th percentiles of spending had $54,663 in per enrollee per year spending, those in the 70th to 90th percentiles had $24,261 in per enrollee per year spending, and those in the 50th to 70th percentiles had $4,322 in per enrollee per year spending. The bottom half of spenders averaged just $295 per enrollee per year.

The 13 percent of dual eligible beneficiaries who were in an institutional long-term care setting for some period in FY 2010 accounted for nearly half (49.9%) of all spending on dual eligible beneficiaries and over a sixth (16.9%) of all Medicaid expenditures. Dual eligible beneficiaries with institutional spending spent an average of $57,766 per enrollee per year.

However, 87 percent of dual eligible beneficiaries did not have any institutional care in 2010. These individuals accounted for the other half of dual eligible beneficiary expenditures and 17.0 percent of total Medicaid program spending. Medicaid spending in this group averaged $8,525 per enrollee per year in 2010.

Table 7

Medicaid Enrollment and Expenditures for Dual Eligible Beneficiaries by Per Enrollee Spending Percentile, FY 2010

	Per Enrollee Expenditure Percentile	Enrollees (in thousands)	% of Dual Enrollees	% of All Enrollees	Expenditures (in millions)	% of Dual Expenditures	% of All Expenditures	Spending Per Enrollee Per Year
ALL DUAL ELIGIBLE BENEFICIARIES	**United States**	**9,628**	**100.0%**	**14.5%**	**$125,321**	**100.0%**	**33.9%**	**$14,840**
	>95%	481	5.0%	0.7%	50,774	40.5%	13.7%	109,511
	>90-95%	481	5.0%	0.7%	25,179	20.1%	6.8%	54,633
	>70-90%	1,926	20.0%	2.9%	40,781	32.5%	11.0%	24,261
	>50-70%	1,926	20.0%	2.9%	7,368	5.9%	2.0%	4,322
	0-50%	4,814	50.0%	7.2%	1,219	1.0%	0.3%	295
WITH INSTITUTIONAL CARE	**United States**	**1,276**	**13.3%**	**1.9%**	**$62,565**	**49.9%**	**16.9%**	**$57,766**
	>95%	299	3.1%	0.4%	30,181	24.1%	8.2%	104,339
	>90-95%	332	3.5%	0.5%	17,523	14.0%	4.7%	54,888
	>70-90%	538	5.6%	0.8%	14,425	11.5%	3.9%	34,699
	>50-70%	91	0.9%	0.1%	434	0.3%	0.1%	8,858
	0-50%	17	0.2%	0.0%	2	0.0%	0.0%	194
WITHOUT INSTITUTIONAL CARE	**United States**	**8,352**	**86.7%**	**12.6%**	**$62,756**	**50.1%**	**17.0%**	**$8,525**
	>95%	183	1.9%	0.3%	20,593	16.4%	5.6%	118,089
	>90-95%	149	1.5%	0.2%	7,656	6.1%	2.1%	54,057
	>70-90%	1,388	14.4%	2.1%	26,356	21.0%	7.1%	20,831
	>50-70%	1,835	19.1%	2.8%	6,934	5.5%	1.9%	4,188
	0-50%	4,797	49.8%	7.2%	1,217	1.0%	0.3%	295

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2010 MSIS and CMS-64 reports. Because 2010 data were unavailable, 2009 MSIS data were used for Colorado, Idaho, Missouri, North Carolina, and West Virginia, and then adjusted to 2010 CMS-64 spending levels.

NOTE: Expenditures do not include Medicare premiums. Totals and percentages may not match other tables and figures that include premium data.

Looking Forward

Dual eligible beneficiaries are among the sickest and poorest individuals covered by either the Medicaid or Medicare programs. This brief documents that 36 percent of all Medicaid spending in FY 2010 was on behalf of the 9.6 million Medicare beneficiaries who qualified for both programs. Other analysis has demonstrated that combined per capita Medicaid and Medicare spending is much higher for dual eligible beneficiaries than for non-dual eligible Medicare beneficiaries.[14]

There exists significant variation in dual eligible beneficiaries' share of total Medicaid spending and enrollment across the states, reflecting both variation in states' demographic profiles as well as state policy choices affecting the extent of Medicaid coverage provided to seniors and people with disabilities versus non-disabled adults and children.

Discussions of strategies to address spending growth in Medicare and Medicaid invariably include dual eligible beneficiaries due to their high costs, complex health needs, and reliance on both programs. However, these strategies also need to take into account a challenging array of physical and mental health issues uncommon in other populations, together with service delivery systems that are often limited by Medicaid and Medicare's bifurcated financing structure. Efforts to improve care delivery for this population require adequate safeguards to ensure that this fragile population does not experience unavoidable disruptions in their care. Recognition also needs to be given to the challenge of reducing the heavy reliance of dual eligible beneficiaries on institutional care, particularly among those seniors over age 75.

Much of Medicaid's spending on dual eligible beneficiaries (65%) was for long-term care services, which generally are not covered by Medicare or private insurance and have high ongoing rather than episodic costs. Some states have been moving forward with efforts to expand access to home and community-based services, thereby reducing reliance on institutional care, for this population, including providing options newly created or expanded in the Affordable Care Act (ACA).[15]

The ACA also creates several new initiatives that may help improve coordination of acute and long-term care for dual eligible beneficiaries.[16] The ACA established two new federal entities that are involved in efforts to study and improve care for dual eligible beneficiaries: the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation (CMMI), both housed within the Centers for Medicare and Medicaid Services (CMS). The Medicare-Medicaid Coordination Office brings together staff from the Medicare and Medicaid programs within CMS to improve coordination between Medicare and Medicaid, and the federal government and the states. This office is charged with ensuring that dual eligible beneficiaries have full access to the benefits and long-term services to which they are entitled under the Medicare and Medicaid programs. In conjunction with the Medicare-Medicaid Coordination Office and selected states, CMMI is testing innovative payment and delivery models seeking to lower costs and improve care quality for all Medicare and Medicaid beneficiaries, including initiatives to integrate care and align financing for the dual eligible beneficiaries.[17] As of August, 2013, six states (CA, IL, MA, OH, VA, WA) have received CMS approval to implement a financial alignment demonstration for dual eligible beneficiaries, and additional states' proposals remain pending with CMS. The demonstrations will last for three years and will affect nearly one million dual eligible beneficiaries.[18]

Additionally, over the past several years, policymakers have been discussing revisions to the benefit structure of Medicare Parts A and B. Because Medicaid pays for some or all of Medicare Parts A and B premiums of dual eligible beneficiaries, as well as some of their cost-sharing, restructuring the Medicare benefit design would have implications on Medicaid's financial responsibility for dual eligible beneficiaries.[19]

Given their complex health needs, high level of spending, and use of long-term services and supports, dual eligible beneficiaries will continue to be a focus of state and federal policy. Improving care coordination and payment structures across the range of acute and long term-services for dual eligible beneficiaries while ensuring beneficiary safeguards will be an essential component of efforts to strengthen both the Medicare and Medicaid programs in the years ahead.

Katherine Young, Rachel Garfield, and MaryBeth Musumeci are with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. Lisa Clemans-Cope and Emily Lawton are with the Urban Institute.

Appendix: Data Sources and Estimation Methods

Most data used in this analysis come from the federal fiscal year (FY) 2010 Medicaid Statistical Information System (MSIS) maintained by the Centers for Medicare and Medicaid Services (CMS). The MSIS contains demographic, eligibility, and Medicaid expenditure information for every Medicaid enrollee. These source data are person-level and enable classifying each individual's spending into 30 service categories. Enrollees were grouped into five broad eligibility categories: non-disabled adults, non-disabled children, adults and children with disabilities, the elderly (all Medicaid enrollees over age 64), and those eligible for Medicaid through unknown pathways. This analysis also uses the Form CMS 64, which states compile quarterly to account for Medicaid expenditures eligible for federal reimbursement. It does not include enrollment information or qualitative data on the individual enrollee. This paper focuses on individuals who are dually eligible for Medicaid and Medicare ("dual eligible beneficiaries"), comparing them to those who are eligible for Medicaid only. Dual eligible beneficiaries are composed of individuals in the people with disabilities and elderly categories.

All enrollment and eligibility calculations in this paper are based on the FY 2010 MSIS. Data were limited to the 66.4 million enrollees who had valid information for one of the broad eligibility categories. From this base Medicaid population, dual eligible beneficiaries were defined as those who had valid information indicating dual eligibility. We classified individuals with a dual code equal to "09" as Medicaid-only beneficiaries. There were 57,466 beneficiaries in Wisconsin in FY 2010 with a dual code equal to "09." We believe that these individuals are enrollees in the SeniorCare program. Of the total base population, there were 697 enrollees with missing dual eligibility information. Their expenditures totaled less than $4 million. Because the Form CMS 64 is regarded as a more accurate reflection of Medicaid program spending than the MSIS, we adjust MSIS-derived spending levels to those reported in 2010 on the Form CMS 64. In addition, MSIS data do not include premium payments that Medicaid makes to Medicare, as well as some QMB coinsurance and deductibles. Premium data and additional QMB coinsurance and deductibles from the Form CMS 64 are included in this analysis.

Endnotes

[1] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Cost and Use file, 2009.

[2] Due to data constraints, we are unable at this time to separate the Medicare acute care cost-sharing from the acute care not covered by Medicare.

[3] Some full dual eligible beneficiaries may receive a more limited set of Medicaid benefits.

[4] Medicare consists of Part A, which primarily covers inpatient care; Part B, which pays for physician services, outpatient care, lab and x-ray services, durable medical equipment and some other services; and Part D, which provides coverage for prescription drugs. Each part requires participants to pay premiums, deductibles and coinsurance for services they receive. Dual eligible beneficiaries receive Medicaid assistance with premiums and out-of-pocket costs for Medicare Parts A and B.

[5] Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Cost and Use file, 2009. See also Jacobsen et al., *Medicare's Role for Dual Eligible Beneficiaries,* Kaiser Family Foundation, April 2012, available at: http://www.kff.org/medicare/issue-brief/medicares-role-for-dual-eligible-beneficiaries/.

[6] Medicare eligibility generally requires an individual or his or her spouse (or parent, in the case of adult children with significant disabilities with an onset prior to age 22) to have paid Medicare payroll tax for at least 40 calendar quarters (10 years).

[7] In FY 2010, there were about 573,000 elderly Medicaid enrollees who were not Medicare beneficiaries, of which nearly half lived in California, New York, and Wisconsin.

[8] Federal law requires individuals with significant disabilities to wait 24 months after beginning receipt of Social Security Disability Insurance (SSDI) before becoming eligible for Medicare coverage. A 2003 study estimated that 1.2 million non-elderly individuals with disabilities (nearly 400,000 of whom were uninsured) were currently in the two-year waiting period, and that eliminating this waiting period would save states roughly $1.8 billion (Dale and Verdier, "Elimination of Medicare's Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs", The Commonwealth Fund, July 2003).

[9] States also have the option of providing (and receiving federal matching funds for) Medicaid coverage of drugs that were explicitly excluded from Medicare Part D by statute. A list of these drugs or classes of drugs can be found in section 1927(d)(2) of the Social Security Act. (There are a few exceptions to this list: the Medicare prescription drug benefit does cover smoking cessation drugs; barbiturates if used in the treatment of epilepsy, cancer, or a chronic mental health disorder; and benzodiazepines.)

[10] The FY 2010 Form CMS 64 data reports $857 million in coinsurance and deductibles for QMBs and $12.8 billion in Medicaid payments for Medicare premiums. Because this data is not included in the FY 2010 MSIS, we have added the coinsurance and deductibles for QMBs in with the MSIS acute care spending and included the Medicare payments towards Medicare premiums as a separate spending category in Tables 4a and 4b. However, we are unable to include this spending in Figures 5 and 6 or Tables 6 or 7, because the Form CMS 64 data neither identify on which type of acute care service the QMB cost sharing and deductibles were being implemented, nor provide information about the beneficiary.

[11] Kaiser Commission on Medicaid and the Uninsured and the Urban Institute estimates based on data from FY 2008 and FY 2010 MSIS and CMS-64 reports.

[12] See Young et al., *Enrollment Driven Expenditure Growth: Medicaid Spending during the Economic Downturn, FY 2007-2011*, Kaiser Commission on Medicaid and the Uninsured, April 2013, available at http://www.kff.org/medicaid/report/enrollment-driven-expenditure-growth-medicaid-spending-during/.

[13] Sommers and Cohen, *Medicaid's High Cost Enrollees: How Much Do They Drive Medicaid Spending?*, Kaiser Commission on Medicaid and the Uninsured, March 2006, available at http://www.kff.org/medicaid/upload/7490.pdf.

[14] Coughlin et al. in *The Diversity of Dual Eligible Beneficiaries: An Examination of Services and Spending for People Eligible for Both Medicaid and Medicare*, Kaiser Commission on Medicaid and the Uninsured, April 2012, available at http://www.kff.org/medicaid/issue-brief/the-diversity-of-dual-eligible-beneficiaries-an/.

[15] See Watts et al. in *How is the Affordable Care Act Leading to Changes in Medicaid Long-Term Services and Supports (LTSS) Today? State Adoption of Six LTSS Options*, Kaiser Commission on Medicaid and the Uninsured, April 2013, available at http://www.kff.org/medicaid/issue-brief/how-is-the-affordable-care-act-leading-to-changes-in-medicaid-long-term-services-and-supports-ltss-today-state-adoption-of-six-ltss-options/.

[16] For more information on the ACA's long-term services and supports provisions, see Watts et al., 2013.

[17] See Musumeci, *Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: California, Illinois, Massachusetts, Ohio, and Washington*, Kaiser Commission on Medicaid and the Uninsured, May 2013, available at http://www.kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/; Musumeci, *Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries*, Kaiser Commission on Medicaid and the Uninsured, Sept. 2012, available at http://www.kff.org/medicaid/issue-brief/explaining-the-state-integrated-care-and-financial/.

[18] See Musumeci, *Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS*, Kaiser Commission on Medicaid and the Uninsured, July 2013, available at http://www.kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/.

[19] See Neuman, *Rethinking Medicare's Benefit Design: Opportunities and Challenges*, Kaiser Family Foundation, Prepared for the Energy & Commerce Committee, Subcommittee on Health, June 2013, available at http://www.kff.org/medicare/issue-brief/testimony-rethinking-medicares-benefit-design-opportunities-and-challenges/.

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THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters
2400 Sand Hill Road
Menlo Park, CA 94025
Phone 650-854-9400 Fax 650-854-4800

Washington Offices and
Barbara Jordan Conference Center
1330 G Street, NW
Washington, DC 20005
Phone 202-347-5270 Fax 202-347-5274

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