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A CRS Series on Medicaid: Dual Eligibles

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Abstract. This report describes Medicaid's coverage of dual eligibles including demographic information on these beneficiaries, the high cost and intensive service needs of dual eligible individuals and associated Medicaid spending, the delivery and administration of dual eligible services and assistance with Medicare cost sharing. Some features of the Medicare program are described to compare the two programs and discuss their interaction.

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Dual Eligibles: A Review of Medicaid's Role in Providing Services and Assistance

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Summary

The term "dual eligibles" generally refers to individuals who qualify for both Medicare benefits and all Medicaid benefits offered in their state. Although dual eligibles represent about one-eighth of Medicaid and one-sixth of Medicare beneficiaries, the high cost, significant needs, and considerable challenges in delivering Medicaid and Medicare services to this group have drawn the attention of both state and federal policymakers.

In FY2002, about 6.6 million individuals were considered dual eligibles (including those who only received assistance with Medicare premiums and cost-sharing). These individuals comprise a disproportionate care of Medicaid spending — representing 13% of Medicaid beneficiaries and 41% of Medicaid spending. In 2002, Medicaid spent $91.7 billion on dual eligibles including $86.5 billion for Medicaid services and Medicare cost-sharing and $5.2 billion for Medicare premiums. Of the spending for Medicaid services and Medicare cost-sharing, 69% was for long-term care services, followed by 17% for prescription drugs.

This report also provides an overview of dual eligible individuals and discusses the specific role of Medicaid in serving this group. Dual eligibles are more likely to be female, in a minority group, have less education, and have higher levels of functional limitations than the average Medicare beneficiary.

Several current issues exist in providing services to dual eligibles, such as the challenges in coordinating the delivery of Medicaid and Medicare services. Some efforts have been made by states and the federal government to increase the coordination of these services; several of these efforts are discussed in the report.

Another significant policy issue is the implications for dual eligibles of the new Medicare prescription drug benefit enacted by the 108th Congress, (P.L. 108-173). Starting in January 2006, dual eligibles will be required to enroll in the new Medicare Part D benefit for coverage of their prescription drugs.

Finally, states must also cover the Medicare premiums and/or cost-sharing for certain groups of low-income Medicare beneficiaries (some of whom may also qualify for Medicaid). States also have the option of covering the Medicare premiums of other individuals who are enrolled in the state's Medicaid program. Despite the variety of groups covered, identifying and enrolling these low-income Medicare beneficiaries remains challenging.

To assist Congress in reviewing policy alternatives and understanding the current status of Medicaid programs, the Congressional Research Service (CRS) has produced a number of reports on various aspects of Medicaid including current programs and policies. This report will be updated.

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Introduction

The term "dual eligibles" generally refers to individuals who qualify for both Medicare benefits and those Medicaid benefits offered in their state. Persons qualify for Medicare because they are either age 65 or older, or under age 65 and have a disability and have been receiving Social Security Disability Insurance (SSDI) for two years.[1] Persons qualify for Medicaid because they meet one of the categories specified in federal law (e.g., aged, blind, or disabled) *and* meet the income and asset standards states use for eligibility under this means-tested program.

However, the Centers for Medicare and Medicaid Services (CMS)[2] also includes in the definition of "dual eligibles" certain low-income Medicare beneficiaries for whom Medicaid covers *only* certain Medicare premium and cost-sharing obligations. This latter group (also referred to as the 'Medicare Savings programs') consists of several subcategories of low-income Medicare beneficiaries. Congress requires state Medicaid programs to cover certain Medicare premiums, co-payments and/or deductibles for each of these groups, and gives states the option of covering premiums for other groups. Unless otherwise specified, all data on dual eligibles provided in this report include both those with full Medicaid benefits and the low-income Medicare beneficiaries receiving only premium and cost-sharing assistance from Medicaid.[3]

This report describes Medicaid's coverage of dual eligibles including demographic information on these beneficiaries, the high cost and intensive service needs of dual eligible individuals and associated Medicaid spending, the delivery and administration of dual eligible services and assistance with Medicare cost sharing. Some features of the Medicare program are described to compare the two programs and discuss their interaction, but a full discussion of Medicare expenditures for dual eligibles and Medicare program issues is outside the scope of this report.

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[1] Also qualifying for Medicare are persons who have End-Stage Renal Disease (ESRD).

[2] The federal agency administering Medicaid and Medicare within the Department of Health and Human Services (HHS).

[3] The data used in this report, provided by CMS, does not differentiate between Medicaid service expenditures and expenditures for Medicare co-payments and deductibles.

Current Issues

Dual eligibles represent about one in eight Medicaid beneficiaries and one in six Medicare beneficiaries. However, the high cost, significant needs, and considerable challenges in delivering Medicaid and Medicare services to this group have drawn the attention of both state and federal policymakers. This section provides a brief introduction of three key policy issues for dual eligibles — the cost of providing services, coordinating care for dual eligibles and the new Medicare drug benefit. Each of these issues is discussed in more detail later in the report.

Cost of Providing Services

Some policymakers have raised concerns about the overall expenditure growth in both Medicaid and Medicare. Because dual eligible individuals account for a disproportionate share of Medicaid and Medicare expenditures compared to other groups, policy alternatives for dual eligibles are often discussed as ways to address the growing cost of these programs. Some of these discussions include how to provide the services in a more cost-efficient manner, but they also include which unit of government (federal or state) should cover the cost of services for these individuals.

Coordinating Care for Dual Eligibles

States and the federal government have attempted to address costs and at the same time improve the quality of services through efforts to coordinate or integrate services for dual eligibles. Coordinating services for these individuals is a challenge because: (1) Medicare and Medicaid are administered and operated very differently from one another; (2) the two programs cover comparable services that differ in the eligibility requirements or scope; and (3) incentives exist to shift costs between the two programs which do not necessarily result in the best quality or continuity of care for the beneficiary.

Medicare Prescription Drug Benefit for Dual Eligibles

The 108th Congress enacted the *Medicare Prescription Drug, Improvement and Modernization Act of 2003* (MMA, P.L. 108-173). This legislation made several changes to the Medicare program including offering Medicare beneficiaries access to discounted prescription drugs during 2004 and 2005 and adding a voluntary prescription drug benefit under a new Medicare Part D beginning January 2006. These benefits include significant changes for dual eligibles and those who receive assistance with Medicare premiums and cost-sharing. In 2006, dual eligible individuals will no longer be eligible for prescription drug benefits provided under the Medicaid state plan.[4] To receive

[4] The Medicaid state plan is the document that states submit to the federal government for (continued...)

prescription drug coverage, dual eligibles must enroll in a private drug plan authorized to provide the new Medicare Part D benefit.[5]

Who Are the Dual Eligibles?

Definition and Eligibility Requirements

As noted above, the term "dual eligibles" refers to persons qualifying for both Medicare and Medicaid benefits. In FY2002, about 6.6 million individuals were considered dual eligibles (including those who *only* received assistance with Medicare premiums and cost-sharing).[6] In order to qualify for Medicare, individuals or their spouses (or, in some cases, their parents) must have worked and paid Medicare taxes, and they are either elderly or they are under age 65 and have blindness or a disability as determined by Social Security law.[7]

Persons qualify for Medicaid if they have limited income and resources and meet other eligibility requirements. For a Medicare beneficiary to qualify for all state Medicaid benefits, he or she must meet the Medicaid eligibility criteria in that state. A common pathway into Medicaid for a Medicare beneficiary is through his or her eligibility for the Supplemental Security Income (SSI) program which, in most states, provides automatic Medicaid eligibility.[8] SSI is a cash welfare program providing assistance to low-income individuals. Another common Medicaid eligibility pathway for a Medicare beneficiary is through the "medically needy" option. Under this option, the state sets an income standard and allows certain individuals whose income exceeds that standard to "spend down" to the qualifying level, by deducting the amount of incurred medical expenses from the person's income before determining eligibility for Medicaid.

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[4] (...continued)
approval which describes the eligibility groups covered and the services provided.

[5] For additional information, see CRS Report RS21837, *Implications of the Medicare Prescription Drug Benefit for Dual Eligibles and State Medicaid Programs,* by Karen Tritz; and CRS Report RL32902, *Medicare Prescription Drug Benefit: Low-Income Provisions*, by Jennifer O'Sullivan.

[6] FY2002 are the latest data available for analyzing the eligibility and services of dual eligibles.

[7] To be considered to have blindness or a disability under Social Security law, an individual must meet certain functional criteria depending upon the type of disability and have countable earnings less than $830 for a disability and $1,380 for blindness in 2005.

[8] The SSI income standard is about 73% of the federal poverty level.

The majority of dual eligibles are eligible for both Medicare benefits[9] and *all* Medicaid benefits provided within state guidelines (including help with Medicare premiums and cost-sharing charges). A smaller percentage of Medicare beneficiaries are eligible *only* for Medicare premium and cost-sharing assistance. Individuals who qualify for such assistance are generally those who have limited income and resources, but do not meet the state's Medicaid eligibility criteria.

Congress requires state Medicaid programs to cover the Medicare premiums and/or cost-sharing for certain groups of low-income Medicare beneficiaries (some of whom may also qualify for Medicaid). States also have the option of covering the Medicare premiums of other Medicaid beneficiaries.

These five groups are introduced below to provide context for the remaining discussion, but are described in more detail later in this report.

- Qualified Medicare Beneficiary (QMB) program includes individuals who have Part A Medicare benefits and whose income does not exceed 100% of the federal poverty level (FPL).
- Specified Low-Income Medicare Beneficiary (SLMB) program includes individuals who would otherwise be QMBs but whose income is more than 100% but less than 120% of FPL.
- The Qualifying Individual (QI-1) program covers persons who meet the other criteria but whose income is less than 135% of FPL.
- Qualified Working Disabled program (QDWI) includes persons who were entitled to Medicare, but lost that entitlement because of earnings from work and whose income is below 200% of FPL; and
- Traditional Medicare Buy-In covers persons who are eligible for Medicaid but are not eligible for any one of the previously described groups. The state has the option of paying the Medicare Part B premiums for these individuals.

Demographic Information on Dual Eligibles

In FY2002, more than 98% of dual eligibles qualified for Medicaid through the eligibility pathways of elderly, blindness or disability (6.5 million individuals).[10] About 1.3% were persons who qualify under other Medicaid eligibility pathways such as children and non-disabled adults (about 88,000 individuals).

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[9] Medicare benefits are separated into Part A and Part B. Part A covers inpatient hospital services, up to 100 days of post-acute care in a skilled nursing facility following a hospital stay, some home health services, and hospice services. Part B covers services such as physicians, outpatient hospital, laboratory, durable medical equipment and some home health care.

[10] Includes dual eligibles who qualified for full Medicaid benefits and those who qualified just for assistance with Medicare premiums and cost-sharing.

In FY2002, 92% of all elderly Medicaid beneficiaries were dually eligible (3.6 million individuals), and 39% of Medicaid beneficiaries who were blind or had a disability were dually eligible (2.9 million individuals). Some Medicaid beneficiaries with disabilities do not qualify for Medicare because they do not have a sufficient work history in which they paid Medicare taxes or do not qualify under a parent's or spouse's earnings record. Many of these individuals include persons with mental retardation and/or developmental disability.

Compared to non-dually eligible Medicare beneficiaries, dually eligible individuals were more likely to be female, in a minority group, have less education, and have more and higher levels of functional limitations than the average Medicare beneficiary (see **Table 1**).[11] Some of these demographic differences have implications for the types and amounts of services needed by dual eligibles and the strategies for outreach and beneficiary education compared to other Medicare beneficiaries. For example, a lower level of formal education in this group may mean that beneficiary education materials should be targeted to a certain reading level.

Table 1. Comparison of Dual Eligible to Non-Dual Eligible Medicare Beneficiaries by Key Demographic Factors, 2002

	Dually eligible beneficiaries (percent of beneficiaries)	Non-dually eligible Medicare beneficiaries (percent of beneficiaries)
Gender		
Female	64%	55%
Male	36%	45%
Race/ethnicity		
White	57%	84%
Black	22%	7%
Hispanic	13%	6%
Other	8%	3%
Years of schooling		
0-8 years	37%	10%
9-12 years (no diploma)	24%	15%
High school graduate	23%	32%
Voc/Tech	3%	7%
Some college	7%	16%
College degree	6%	20%
Functional limitations		
None	24%	55%
IADL only[a]	18%	15%
1-2 ADLs[b]	27%	20%

[11] A report by the Medicare Payment Advisory Commission (MEDPAC) also found that 38% of dual eligible beneficiaries had a cognitive or mental impairment. This could include a variety of conditions including mental retardation, mental illness, dementia, etc. MEDPAC, *Report to the Congress: New Approaches in Medicare*, June 2004.

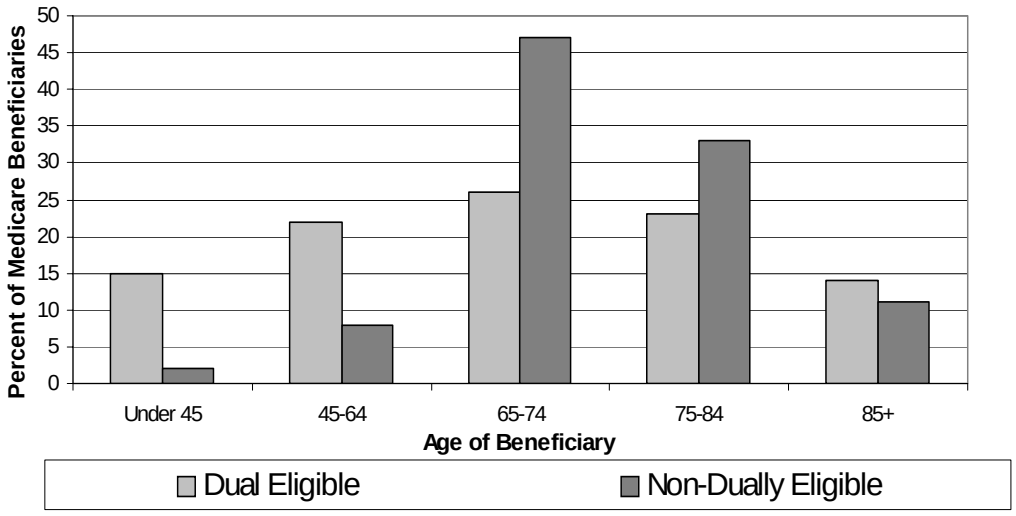
	Dually eligible beneficiaries (percent of beneficiaries)	Non-dually eligible Medicare beneficiaries (percent of beneficiaries)
3-5 ADLs	31%	11%

Source: Centers for Medicare and Medicaid Services, *Characteristics and Perceptions of the Medicare Population*, 2002, pp. 36-39, at [http://www.cms.hhs.gov/MCBS/CMSsrc/2002/sec8.pdf].

a. IADLs refer to Instrumental Activities of Daily Living including managing one's money, shopping for groceries, doing housework, etc.
b. ADLs refer to Activities of Daily Living including eating, bathing, dressing, etc.

A disproportionate number of dual eligible beneficiaries tend to be under age 65 or over age 85 compared to the general Medicare population (see **Figure 1**). Individuals under age 65 likely qualify for Medicare because they have a disability that either they were born with or that has been acquired such as by means of an accident.

Figure 1. Dually and Non-Dually Eligible Medicare Beneficiaries by Age, 2002



Source: Centers for Medicare and Medicaid Services, Characteristics and Perceptions of the Medicare Population, 2002, pp. 36-39. [http://www.cms.hhs.gov/MCBS/CMSsrc/2002/sec8.pdf].

Estimates of Growth in Dual Eligible Population

In FY2002, about 6.6 million individuals were considered dual eligibles (including those who only received assistance with Medicare premiums and/or cost-sharing). *Assuming that the proportion of dual eligibles in the total Medicaid population remains constant, the number of dual eligibles would grow from an* estimated 8.4 million in FY2004 to 11.1 million in FY2015. This projected growth in the number of dual eligibles would result in additional challenges for federal and state governments because of the increased cost to Medicaid and Medicare given the higher than average cost per person and the

increased demand for care coordination. See **Table 2** below for an estimate of the growth in the number of dual eligibles by category of Medicaid eligibility.[12]

[12] The recent addition of the Medicare prescription drug benefit, described above, is reflected in these estimates of the dual eligible population.

Table 2. Estimated Growth in the Number of Dual Eligibles, FY2004-2015, by Basis of Medicaid Eligibility
(in millions)

Fiscal year	Total	Basis of Medicaid eligibility		
		Aged	Individuals with blindness or disability	Other
2004	8.4	4.7	3.5	0.2
2005	8.8	5.0	3.6	0.2
2006	9.0	5.1	3.7	0.2
2007	9.2	5.3	3.8	0.2
2008	9.5	5.4	3.8	0.2
2009	9.7	5.5	3.9	0.2
2010	9.9	5.7	4.0	0.2
2011	10.1	5.8	4.1	0.2
2012	10.4	6.0	4.2	0.2
2013	10.5	6.1	4.2	0.2
2014	10.8	6.3	4.3	0.2
2015	11.1	6.5	4.4	0.2

Sources: CRS analysis based on Congressional Budget Office, Mar. 2005 baseline projections for total Medicaid enrollment and the Medicaid Statistical Information System, (MSIS), FY2002 data which provides percentage of dual eligibles by basis of eligibility.

Medicaid Services for Dual Eligibles

Overview

Both Medicare and Medicaid offer comprehensive coverage for acute medical care services. Medicare benefits are separated into Part A and Part B. Part A covers inpatient hospital services, up to 100 days of post-acute care in a skilled nursing facility following a hospital stay, some home health services, and hospice services. Part B covers services such as physicians, outpatient hospital, laboratory, durable medical equipment and some home health care. Medicaid covers a similar array of acute care benefits. However, Medicaid covers several additional categories of services not covered by Medicare but needed by many elderly individuals and those with disabilities. Long-term care, including both institutional and community-based services, is one such category of services covered by states. Prescription drugs have also been covered by states, but will be covered by Medicare beginning in 2006.

For individuals who are eligible for full Medicaid benefits and Medicare benefits, Medicare is the primary payer. Medicaid benefits not available under Medicare (e.g., long-term care services, medical transportation) are paid by

Medicaid unless there is a third-party to cover the cost. Medicaid is generally the payer of last resort.

Within broad federal guidelines, states can design the scope and availability of Medicaid benefits. Medicaid law requires states to provide certain services such as hospital and physician services. Within federal guidelines, states may, at their option, cover other services, and limit the amount, duration or scope of any Medicaid service. For example, a state may limit Medicaid coverage of a particular service to a certain number of hours or days or make a service available only to those with a particular condition (e.g., individuals who need at least 10 hours of personal care per week).

Total Medicaid Expenditures for Dual Eligibles

In FY2002, Medicaid spent $91.7 billion on dual eligibles including $86.5 billion for Medicaid services and Medicare coinsurance and deductibles and $5.2 billion for Medicare premiums.[13] The majority of expenditures, $59.5 billion, or 69%, were for long-term care services. The second highest category of Medicaid spending for dual eligibles was prescription drugs at $14.9 billion, or 17%. **Table 3** provides the estimated Medicaid expenditures for dual eligibles by category of Medicaid service. (See **Appendix A** for state-by-state estimates.)

Nationwide 6.6 million dual eligibles received Medicaid services or assistance with Medicare cost-sharing in FY2002.[14] **Table 4** provides the estimated number of dual eligibles who had Medicaid expenditures for selected types of services within the broad categories of acute care, long-term care, prescription drugs and managed care. This is *not* a comprehensive list of all Medicaid services but is intended to illustrate the variation among the utilization of certain types of services. (See **Appendix B** for state-by-state estimates.)

There are three caveats to keep in mind about the data presented in this section. First, the amounts shown represent Medicaid expenditures for both Medicaid services and Medicare co-payments and deductibles. The data source (the Medicaid Statistical Information System, MSIS)[15] does not permit a breakdown of these two spending components. Amounts paid for Medicare premiums are not included in MSIS. Second, the MSIS data on dual eligibles has some substantial limitations and is not always consistently reported by states. These issues are discussed at the end of this report. Finally, managed care expenditures cannot be broken down by service type. Under managed care, states

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[13] Expenditure data for Medicare premiums from CMS-Form 64, FY2002. Expenditure data for Medicaid services and Medicare premiums and cost-sharing from CMS, MSIS, FY2002. The MSIS data does not include spending for Medicare premiums. The analysis of Medicaid spending by category of service does not include expenditures for Medicare premiums.

[14] Does not include those who *only* received assistance with Medicare premiums.

[15] The MSIS is the primary federal datasource for information on Medicaid beneficiaries. This federal database is compiled by CMS from eligibility and claims information submitted quarterly by the states and the District of Columbia.

pay an organization a fixed, monthly payment per enrollee to provide all the services specified under the managed care contract. Data reported to the federal government generally show only the fixed, monthly, per person payment amount and do not itemize expenditures for specific types of services. This is particularly true in states that have widespread use of managed care such as Tennessee and Arizona.

Table 3. Estimated Medicaid Expenditures for Dual Eligibles by Category of Service, FY2002

Category of service	Medicaid expenditures (in billions)	Percentage of total expenditures
Acute care	$7.1	8.2%
Long-term care	$59.5	68.8%
Prescription drugs[a]	$14.9	17.2%
Managed care	$3.9	4.5%
Unknown	$1.1	1.3%
Total[b]	**$86.5**	**100%**

Source: CRS analysis based on Centers for Medicare and Medicaid Services, MSIS data, FY2002.

a. The amounts shown do not reflect rebates paid to states by pharmaceutical manufacturers. In FY2002, total Medicaid drug expenditures for all beneficiaries were offset by 20% due to rebates.
b. Does not include $5.2 billion in expenditures for Medicare Part B premiums.

Table 4. Estimated Number of Dually Eligible Recipients for Selected Service Types, FY2002

(in thousands)

Category of service	Number of Medicaid recipients (in thousands)	Percentage of total number of dual eligible recipients
Acute care		
Inpatient hospital	1,212.0	18%
Outpatient hospital	2,537.4	39%
Physician	3,942.2	60%
Long-term care		
Nursing facility	1,329.2	20%
Intermediate care facilities for individuals with mental retardation (ICF-MR)	72.4	1%
Personal care	512.9	8%
Prescription drugs	5,376.5	82%
Managed care		
Comprehensive HMO	883.4	13%
Total[a]	**6,577.3**	**100%**

Source: CRS analysis based on Centers for Medicare and Medicaid Services, MSIS data, FY2002

Note: Included in the beneficiary totals are dual eligible beneficiaries receiving a service listed above that was funded under a home and community-based program under Section 1915(c) or Section 1929 of the Social Security Act.

a. Includes all dual eligibles except those for which Medicaid paid Medicare premiums *only*.

Long-Term Care

Dually eligible individuals often rely on Medicaid for most or all of their long-term care services and supports because Medicare provides a very limited array of services for individuals with long-term care needs. Of all Medicaid spending for dual eligibles, 69% was for long-term care ($59.5 billion), primarily for nursing facilities as shown in **Table 5** below. In addition, long-term care spending for dual eligibles represented 72% of all Medicaid long-term care spending in FY2002 ($82.5 billion). This section describes in more detail several of the more frequently used Medicaid long-term care services for dual eligibles. If Medicare covers a comparable benefit, the similarities and differences are described.

It should be noted that the number of dual eligible enrollees and the expenditures shown in **Table 5** do not include long-term care services for Medicaid beneficiaries enrolled in a Medicaid managed care program. In these cases, states generally report the enrollees and expenditures in the managed care category of service.

Table 5. Estimated Number of Recipients and Spending on Medicaid Long-Term Care Services for Dual Eligibles, FY2002

Type of service	Number of dual eligible recipients (in thousands)	Total spending (in billions)
Total	n/a[a]	$59.5
Nursing facilities	1,329	$34.4
ICF/MR	72	$6.7
Personal care	513[b]	$3.4
Home health services	406[b]	$1.6
Rehabilitation	222[b]	$1.0
Home- and community-based waiver services	n/a[c]	$9.3
Other services[d]	n/a	$2.3

Source: CRS analysis based on Centers for Medicare and Medicaid Services, MSIS data, FY2002. Numbers may not total due to rounding.

a. The data do not allow for an unduplicated count of the number of individuals who received long-term care services.
b. Includes individuals who may be receiving the service under a Medicaid home- and community-based waiver program.
c. The FY2002 MSIS data do not allow for a reliable determination of the number of individuals who are receiving home- and community-based waiver services.
d. Includes targeted case management ($.5 billion), inpatient mental health services ($.3 billion), private duty nursing ($.1 billion), and prosthetics and eyeglasses ($2.3 billion). The data

do not allow for an unduplicated count of individuals who received services in the 'Other' category.

Nursing Facility Services. Nursing facility services are covered by both Medicaid and Medicare. However, the Medicare nursing facility benefit is more narrowly defined as a post-hospitalization, short-term benefit. The Medicaid nursing facility benefit is much broader in scope and is often used as the long-term payer for nursing facility services. Medicare pays for approximately 9% of all patient days in a nursing home compared to Medicaid which pays for about 65% of all days.[16] Medicaid is the single largest public payer for nursing home care. The remainder may be paid for by the individual or, to a much lesser extent, private insurance.

In general, Medicare covers nursing facility services for those individuals who need skilled services following a hospitalization of at least three days. Medicare will pay for up to 100 days of nursing facility services per "spell of illness."[17] Beneficiaries are not required to make co-payments for this service for the first 20 days of care, but must pay a daily co-payment for days 21 through 100 ($114 in 2005).[18]

Under Medicaid, states are required to offer nursing facility services to all Medicaid beneficiaries over age 21 who require this service. As of September 2003, all states except New Mexico also covered nursing facility services for individuals under age 21.[19] There are no limits on the number of days of services that Medicaid will cover. Medicaid requires that a beneficiary in a nursing facility contribute all of his or her income above a minimal allowance (generally between $30 and $60 per month) to offset the cost of his or her care, referred to as "post-eligibility treatment of income."[20]

In FY2002, Medicaid spent $34.4 billion on nursing facility services for 1.3 million dually eligible individuals (which is 20% of all dual eligibles). The expenditures represent 40% of all Medicaid spending for dually eligibles and 88% of all Medicaid expenditures for nursing facilities.

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[16] 67 *Federal Register* 49816, July 31, 2002.

[17] A spell of illness begins when a beneficiary is furnished inpatient hospital or skilled nursing facility care and ends when the beneficiary has not been an inpatient of a hospital or in a Medicare-covered nursing facility for 60 consecutive days. A beneficiary may have more than one spell of illness per year.

[18] See CRS Report RS21465, *Medicare's Skilled Nursing Facility Payment* by Julie Stone-Axelrad for additional information.

[19] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicaid At-a-Glance, 2003: A Medicaid Information Source*, CMS-11024-03. (Hereafter referred to as CMS, *Medicaid At-a-Glance, 2003*.)

[20] In the case of an individual who has a spouse who is still living in the community, Medicaid law allows a certain level of protected income and resources for that spouse so that he or she is not impoverished.

Intermediate Care Facilities for Individuals with Mental Retardation. Intermediate care facilities for individuals with mental retardation (ICF/MR) are provided by all state Medicaid programs at their option.[21] ICF/MR facilities provide ongoing training, treatment and health and rehabilitative services to individuals with mental retardation or a related condition who reside in that facility. These facilities are also governed by federal certification regulations that outline standards for participating facilities. These include the availability of physicians, nurses, and other staff, the living environment, and food and nutrition services among other requirements. Medicare does not cover a comparable service.

In FY2002, approximately 72,000 dually eligible beneficiaries received this type of service. Medicaid expenditures for ICF/MR services for dual eligible individuals totaled $6.7 billion. This amount represents 8% of all Medicaid spending for dually eligibles and 62% of all Medicaid expenditures for ICF/MR services.

Personal Care Services. States also have the option of covering personal care services under Medicaid. Personal care includes a range of human assistance provided to individuals with a disability or chronic condition. This assistance generally includes activities of daily living such as eating, bathing, dressing, toileting, and transferring. Other supportive services may include light housework, laundry, meal preparation, transportation, grocery shopping and medication or money management.

As of September 2003, 36 states and the District of Columbia covered Medicaid personal care services for at least some Medicaid beneficiaries. Many states, however, limit the number of hours of personal care service (e.g., 20 hours per week) or the setting (limited to services provided in the home).[22]

In FY2002, Medicaid spent $3.4 billion on personal care services for about 513,000 dually eligible individuals. This amount represents 4% of all Medicaid expenditures for dual eligibles and 74% of Medicaid spending for personal care services.

Home Health. Home health services are covered by both Medicaid and Medicare. However, the specific eligibility requirements and covered activities differ between the two programs.

Medicare beneficiaries are eligible for home health care if they are homebound and need intermittent skilled nursing care, physical therapy, or speech/language pathology services. For beneficiaries receiving at least one of these services, Medicare also covers occupational therapy and the services of home health aides and medical social workers. Beneficiaries may continue to receive occupational therapy after they no longer need other skilled nursing care

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[21] States are not required to provide ICF/MR services, but it is one of the optional services that state Medicaid programs can choose to cover.

[22] [http://207.22.102.105/medicaidbenefits/personalcare.html].

or therapies and may receive home health aide or social worker services as long as they receive occupational therapy.

Under Medicaid, states are required to provide home health services to individuals who are entitled to nursing facility services. For other individuals, coverage of home health services is optional. Like Medicare, home health services are provided in the individual's place of residence and include intermittent nursing services, home health aides, and medical supplies and appliances for use in the home. States may also provide therapies as part of the home health benefit (e.g., physical therapy, speech and language therapy). Unlike Medicare, individuals are not required to be homebound to receive home health services. Several states limit the availability of home health services to a certain number of visits or require beneficiaries to make nominal co-payments.

In FY2002, Medicaid spent $1.6 billion on home health services for approximately 406,000 dually eligible individuals (which is 6% of all dual eligibles). The expenditures represent 2% of all Medicaid spending for dual eligibles and 44% of all Medicaid expenditures for home health services.

Rehabilitation. Rehabilitation services under Medicaid may include any medical or remedial services recommended by a physician or other licensed practitioner within the scope of his/her practice under state law for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level. The definition for Medicaid rehabilitation service is broad and may cover various Medicaid groups (i.e., elderly, individuals with disabilities, adults, and children). Many states used this service to provide mental health services to Medicaid beneficiaries; as of September 2003, 45 states have used this benefit to provide mental health rehabilitation or stabilization to certain Medicaid beneficiaries.[23]

In FY2002, Medicaid spent $1.0 billion on rehabilitation services for about 222,000 dually eligible individuals. This amount represents 1% of all Medicaid expenditures for dual eligibles and 20% of Medicaid spending for rehabilitation services.

Home- and Community-Based Waivers. States also have the option of requesting permission from the Secretary of HHS to provide home- and community-based services for individuals who would otherwise require the level of care provided in a nursing home, hospital or ICF/MR. This option is referred to as a "Home- and Community-Based (HCBS) waiver" and is authorized under Section 1915(c) of the Social Security Act. The HCBS waiver allows states to limit the number of individuals served and to offer the services on a less-than-statewide basis. In 2003, there were 275 such waivers in operation in all states except Arizona.[24] These waivers may include a broad range of services such as case management services, homemaker/home health aide services, personal care

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[23] CMS, *Medicaid At-A-Glance, 2003.*

[24] Arizona offers similar long-term care services under a Section 1115 research and demonstration waiver.

services, adult day health services, habilitation services, respite care, home modifications, and home-delivered meals.[25]

In FY2002, Medicaid spent about $9.3 billion for dual eligibles on those home- and community-based waiver services.[26] This amount represents 11% of spending for dual eligibles and 60% of Medicaid spending for home- and community-based services.

Prescription Drugs and Changes Resulting from the Addition of a Medicare Drug Benefit

After long-term care, the second largest category of Medicaid expenditures for dual eligibles is prescription drugs. As of March 2005, all 50 states and the District of Columbia, at their option, covered prescription drugs for at least some Medicaid beneficiaries. State Medicaid programs are also permitted to impose nominal cost-sharing on non-institutionalized Medicaid beneficiaries. As of March 2005, 40 states and the District of Columbia imposed cost-sharing charges for Medicaid beneficiaries who received prescription drugs.[27] Generally, cost sharing ranged from $.50 to $3.00 per prescription.

In FY2002, Medicaid paid for prescription drugs for 82% of dually eligible recipients totaling $14.9 billion. This represents 17% of spending for dual

[25] *Adult day health services* refers to a type of service that provides assistance to multiple individuals with a disability in a group setting that generally operates during the daytime hours. Generally, the individuals who receive services in this type of setting have a severe cognitive or physical disability. *Habilitation* services means those services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home- and community-based settings. *Respite* services provide temporary services to an individual with a disability to give the normal caregiver a break from providing care. *Home modifications* refer to items such as a ramp to a home, or bars installed in the shower that the individual can hold onto while bathing.

[26] A small portion of this spending is for the home- and community-based program for the functional disabled and elderly authorized under Section 1929 of the Social Security Act. Only Texas offers this type of program; in FY2002, Medicaid expenditures for Texas' program were approximately $198,000.

[27] [http://www.cms.hhs.gov/medicaid/drugs/pre0305.pdf].

eligibles and 52% of all Medicaid spending on prescription drugs. This total does not include discounts from rebates on Medicaid prescription drugs.[28, 29]

As mentioned earlier, the Medicare drug benefit creates significant changes for individuals who are dual eligibles and those who receive assistance with Medicare cost-sharing. Starting in 2004, certain Medicare beneficiaries received discounts on the drugs they purchased through a HHS-endorsed, privately-sponsored drug discount card. Dual eligible beneficiaries who receive Medicaid prescription drug benefits were ineligible for the drug discount card, their prescription drugs continued to be covered by Medicaid with little or no cost-sharing. However, individuals who *only* receive assistance with Medicare premiums and cost-sharing were eligible to receive the discount card and could receive up to $600 in both 2004 and 2005 to purchase prescription drugs.

Starting in 2006 dual eligible individuals will no longer receive their prescription drug benefits through Medicaid. They will be required to enroll in the new Medicare Part D prescription drug benefit to receive coverage. Individuals will be required to enroll in a private drug plan in their geographic region that has received approval from HHS to offer the Part D benefit. This new prescription drug benefit, enacted under the *Medicare Prescription Drug, Improvement and Modernization Act* (MMA), will have some significant changes for the scope of coverage and cost-sharing requirements for dual eligibles. It also has some important implications for state Medicaid programs.

Changes to the Scope of the Prescription Drug Benefit. Medicaid currently covers a broad range of prescription drugs. States may create lists of preferred drugs or require advance (prior) approval for non-preferred drugs, but statutory requirements insure that Medicaid covers a comprehensive list of drugs. Most states limit coverage of prescription drugs through the quantity of the prescription that can be filled at one time (e.g., 30-day supply), the number of refills, or the number of prescriptions within a given time period.

MMA defines covered drugs as those drugs also covered by Medicaid — with a few exceptions. However, the private drug plans that will provide the Medicare Part D benefit will be permitted to establish a formulary as long as it includes drugs within each therapeutic category and class of covered Part D drugs. A drug plan does not have to cover *all* drugs within a category or class. The drug

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[28] Medicaid law requires drug manufacturers that wish to have their drugs available for Medicaid enrollees to enter into rebate agreements with the Secretary of HHS, on behalf of the states. Under these agreements, manufacturers must provide state Medicaid programs with rebates on prescription drugs used by Medicaid beneficiaries and paid for by Medicaid. In exchange, states are required to cover all drugs offered by those manufacturers. In addition, a few states have negotiated supplemental rebates in addition to the federal agreements. In FY2002, drug rebates negotiated by federal and state officials reduced Medicaid drug expenditures by 20%.

[29] For additional information, see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid* by Jean Hearne, and *Pharmaceutical Benefits Under State Medical Assistance Programs* by the National Pharmaceutical Council.

plan can use the list of therapeutic categories and classes developed by United States Pharmacopeia,[30] or can propose to CMS an alternative therapeutic categorization. CMS must review and approve the formularies of the private drug plans and is to be reviewing the extent to which the formularies provide adequate coverage for drugs that are used to treat particular diagnoses such as HIV/AIDS and mental illness. In June 2005, CMS indicated that it is requiring coverage of all or substantially all of the drugs in the antidepressant, antipsychotic, anticonvulsant, anticancer, immunosuppressant and HIV/AIDS categories.

If a state wishes to cover other drugs in a therapeutic class or category included under MMA, the state may not use Medicaid funding. This differs from other benefits covered by both Medicaid and Medicare in which Medicaid can supplement Medicare coverage.

From the individual's perspective, it is likely that the scope of benefits will change, but the extent of the change and the process for beneficiaries are unknown at this time. It is unclear if all drug plans will implement formularies or what the scope of the formularies will be. Unlike the Medicaid program, MMA will not limit the number of prescriptions an individual can receive, but an individual may have access to only certain drugs on a drug plan's formulary. For example, a drug plan formulary may cover a cholesterol drug that differs from the one an individual is currently using; in this case, he or she may have to change prescriptions. MMA will give individuals grievance and appeal rights to access a particular drug not covered by the formulary.[31]

Changes to Premiums and Cost-Sharing Requirements for Prescription Drugs. Currently, most dual eligibles do not pay a premium to enroll in Medicaid, but they may have nominal co-payment requirements for the services they use.[32] To enroll in the Medicare drug benefit, most persons will have to pay drug plans a premium for coverage and cost-sharing amounts when they use benefits. MMA, however, establishes special rules for low-income individuals. All dual eligibles will qualify for low-income subsidies for premiums and co-payments. Full benefit dual eligibles are entitled to a premium subsidy equal to the weighted average premium of all drug plans in the region, or if greater, the lowest premium for a plan in the region. If a dual eligible chooses a drug plan with a higher premium than the amount of the subsidy, he or she will be required to pay the difference.

Under MMA, cost-sharing requirements differ for dual eligibles depending upon whether or not the individual resides in an institution such as a nursing

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[30] Section 1860D-4(b)(3)(C) of the *Social Security Act* as added by P.L. 108-173.

[31] To appeal coverage of a drug not on the formulary, the individual's prescribing physician must determine that all covered drugs on the formulary would not be as effective for the individual as the non-covered drug or would have adverse effects for the individual.

[32] A few Medicaid eligibility groups for working individuals with a disability permit states to charge premiums for enrollment.

facility. Individuals who reside in an institution have no additional cost-sharing obligations under MMA (e.g., deductible, co-payment for drugs).[33]

For dual eligibles who do not reside in an institution, the amount that they pay for prescription drugs may change. Currently, state Medicaid programs are permitted to impose nominal cost-sharing on non-institutionalized Medicaid beneficiaries, as discussed above. Under MMA, the prescription drug benefit permits drug plans to charge non-institutionalized dual eligibles (among others) co-payments for prescription drugs.

- Dual eligibles whose income (as calculated by the Supplemental Security Income (SSI) program) is less than 100% of the FPL can be charged up to $1 for a generic drug or a preferred drug that is considered a "multiple source"[34] drug and $3 for any other drug. This co-payment amount will be adjusted annually, beginning in 2007, based on the Consumer Price Index (CPI).
- For dual eligibles whose income is higher than 100% FPL, their co-payments will be $2 for a generic drug or a preferred drug that is considered a "multiple source" drug and $5 for any other drug. These co-payment amounts will be increased annually, beginning in 2007, based on the percentage increase in per capita expenditures for the Medicare Part D benefit.

No co-payments apply after a beneficiary has total drug costs of $5,100 in 2006; this amount is also increased in subsequent years by the increase in Medicare per capita drug spending. At this writing, it is unclear how cost-sharing requirements will change for the average dual eligible beneficiary. Any changes may be magnified over time as the cost-sharing amounts are increased each year.

Phase-Down State Contribution. States are responsible for a portion of the funding for the new Medicare prescription drug benefit under a provision called the "phase-down state contribution," often referred to as the "clawback."[35] The funding level for each state is a function of the number of persons eligible for both full Medicaid benefits in the state and the Medicare drug benefit (the "dual eligibles"); the state spending on prescription drugs for dual eligibles in 2003; the state share of Medicaid funding; inflation (for prescription drugs); and a statutorily determined annual factor. The annual factor is designed to provide a partial shifting of prescription drug spending on dual eligibles from the states to the federal government over time; the factor is 90% for 2006 and gradually declines to 75% for years after 2014.

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[33] Medicaid beneficiaries residing in institutions are required to contribute most of their income to the cost of their care (referred to as "post-eligibility treatment of income"). MMA does not change this requirement.

[34] A "multiple source drug" is a drug for which there are two or more approved, therapeutically equivalent drug products also on the market. See Section 1927(k)(7)(A)(i) of the *Social Security Act*.

[35] States will also be responsible for covering a share of the cost of the eligibility determinations for the low-income subsidy under Medicare Part D.

Although the program rules for covering prescription drugs for dual eligibles under the Medicare program have been outlined through legislation, regulation and policy guidance from CMS, questions remain about which drug plans will participate, what types of drugs will be included in the formularies, and how this will impact dual eligible beneficiaries.

Cost of Providing Services to Dual Eligibles

As mentioned earlier, dual eligible individuals account for a disproportionate share of Medicaid and Medicare expenditures compared to other groups of individuals enrolled in these programs. In 2002, dual eligibles represented 13% of Medicaid beneficiaries, but accounted for about 41% of Medicaid expenditures ($86.5 billion).[36] In Medicare, based on 2001 data (the most recent available), dual eligibles account for 15% to 17% of Medicare beneficiaries and 22% to 26% of Medicare spending (depending on the method used to determine dual eligibility).[37] Based on the percentages above and assuming total Medicare expenditures of $212 billion in FY2001,[38] Medicare spending for dual eligibles was estimated to be $47 to $55 billion.

The Congressional Budget Office (CBO) projects that under current law federal expenditures for Medicaid will grow at 7% per year from FY2004 through FY2015, and Medicare will grow at 8% per year from FY2005 through FY2015.[39] Facing significant growth in the total program costs of Medicaid and Medicare and the high cost of dual eligibles, some state and federal policymakers explored policy options that would, for example, change the way services are delivered for these individuals.

From a state perspective, rapidly increasing Medicaid spending has strained state budgets since states are required to match federal Medicaid dollars (on average, 43% of total expenditures). Many states faced significant budget shortfalls particularly from 2001 through 2004, and still view Medicaid's expenditure growth as unsustainable. In most states, the law prohibits the state from having a budget deficit — in which the state spends more than it receives in revenue. State Medicaid expenditures (excluding federal matching funds)

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[36] CRS analysis of CMS, Medicaid Statistical Information Systems (MSIS), FY2002.

[37] MEDPAC, *A Data Book: Healthcare Spending and the Medicare Program*, June 2004, [http://www.medpac.gov/publications/congressional_reports/Jun04DatabookSec2.pdf].

[38] [http://www.cms.hhs.gov/MCBS/CMSsrc/2001/sec4.pdf]

[39] CRS calculations from the Congressional Budget Office, March 2005 Baseline for Medicaid and Medicare.

accounted for 12.6% of all state spending in state fiscal year (SFY) 2003.[40] To address budget shortfalls, many states have cut Medicaid eligibility and/or services, raised beneficiary cost-sharing, or reduced provider payment rates.

In the past, some state governors have proposed that the federal government assume all the costs of providing services to dual eligibles. In a 2003 letter to the Senate Finance Committee, the governors argued that (1) providing services and supports that target Americans age 65 and older is generally a federal responsibility while states generally serve low-income non-elderly and working individuals; (2) the quality of services would improve because one program would be responsible for integrating and coordinating acute care and long-term care services; and (3) the states no longer have the capacity to fund both education and health care.[41,42] Congress has not considered this type of proposal, and the Medicare prescription drug legislation (P.L. 108-173), discussed earlier, has reinforced states' financial commitment to pay for health care services for dual eligibles.

Coordinating or Integrating Medicaid and Medicare Services

Issues in Care Coordination

Coordinating Medicare and Medicaid services for dual eligibles has been a significant challenge for state and federal policy makers for three primary reasons (1) the program administration and operations of Medicare and Medicaid are very different from one another; (2) Medicaid and Medicare may cover similar, but slightly different services; and (3) there are significant incentives to shift beneficiaries' care to Medicaid or Medicare even if this does not result in the highest quality of care or the greatest continuity of care for an individual.

Program Administration and Operations. The Medicare and Medicaid programs have a very different history and purpose which affect the program interaction and the coordination of services. The programs are operated by different levels of government and have different payment structures, service definitions, and data systems. These differences can create administrative complexity for policymakers and providers and confusion for beneficiaries.

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[40] CRS Report RL31773, *Medicaid and the Current State Fiscal Crisis*, by Christine Scott, updated Jan. 21, 2005.

[41] This approach has been advocated by some governors for several years, and a letter to the Senate Finance Committee outlines the rationale for this approach. Letter to Senate Finance Committee Chairman, the Honorable Charles E. Grassley and Ranking Member, Honorable Max Baucus, from the Chairman (Governor Paul E. Patton) and Vice-Chairman (Governor Dirk Kempthorne) of the National Governors Association, June 5, 2003.

[42] There are both examples of federal programs that serve the low-income non-elderly and working individuals (such as the Temporary Assistance for Needy Families (TANF) program), and state programs that serve individuals age 65 and older (such as state pharmacy assistance (SPAP) programs). The letter also does not discuss individuals with disabilities.

Medicare is a federally-funded health care program in which the benefits provided are primarily acute care and skilled care services, and benefits are uniform nationwide. Medicare is operated by CMS which establishes program guidelines and contracts with intermediaries and carriers who handle day-to-day operations for Medicare within a specific geographic area.[43] Using the federal guidelines, these intermediaries and carriers pay Medicare claims, interpret CMS policy about what services are covered, and interact with Medicare providers.

The Medicaid program, on the other hand, varies widely by state, and provides a wide array of both health and supportive services (particularly in the area of long-term care). Medicaid is funded through a combination of federal and state funding, and states administer the program and set Medicaid policy within broad federal guidelines established by CMS. In addition, many states have split up the administration of Medicaid among different state agencies. For example, there may be separate state agencies for determining Medicaid eligibility, administering the general acute care program and administering Medicaid long-term care services.

Coverage of Similar Services. As mentioned earlier, Medicare and Medicaid cover several of the same services or related services. However, these services may differ in the scope of coverage or the eligibility requirements which can be confusing for policymakers, providers and beneficiaries to navigate. For example, providers may have difficulty knowing whether to bill Medicaid or Medicare for a particular service.

For example, to be eligible for Medicare home health services, beneficiaries must be homebound and require intermittent skilled nursing care, physical therapy, or speech/language pathology. If a beneficiary meets these criteria, Medicare will also cover occupational therapy and the services of home health aides and medical social workers. Federal Medicare guidelines determine the payment rate for home health providers. Medicaid's home health coverage rules are similar to Medicare, but do not include the homebound requirement.

Shifting Costs. There are also incentives and opportunities for providers and states to shift costs from Medicaid to Medicare and vice versa. For example, if a dual eligible, who is residing in a nursing facility that Medicaid pays for, has a condition that worsens and he or she needs additional care, the nursing home may have a financial incentive to transfer that individual to a hospital even if the nursing home could meet the individual's needs. If the nursing home transfers the individual to the hospital, the nursing home would not be responsible for the cost of the individual's care while the individual was in the hospital, and the hospital stay and the post-hospital nursing facility stay would be paid for by Medicare.

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[43] CMS contracts with intermediaries to administer certain Medicare Part A services such as inpatient hospitals and with carriers to administer Medicare Part B services such as physician services. Recent Medicare legislation (P.L. 108-173) simplified the contracting process for selecting Medicare intermediaries and carriers. Under the new law, the Secretary is able to competitively contract with any entity to serve as a Medicare contractor and the distinction between intermediaries and carriers has been removed.

Strategies to Coordinate or Integrate Services

Several state and federal initiatives have tried to address the challenges of coordinating care. These initiatives have generally included (1) developing a formal structure or service that coordinates the two programs such as care coordination; (2) integrating Medicaid and Medicare into one delivery system through managed care; or (3) a combination of the two approaches. The purpose of these efforts is to reduce the fragmentation and duplication of services and increase the quality of services delivered to dual eligibles.[44]

Care Coordination. Care coordination can be defined broadly as a service provided to a beneficiary in which an individual other than the service provider has responsibility for beneficiaries' health care services. For example, care coordinators may have responsibility for prior authorization of services, communications with Medicare and Medicaid service providers, beneficiary education in managing a chronic condition, or reviewing service utilization to identify duplication or inefficiencies.

Depending upon the type of program, the care coordinator may have different levels of interaction with Medicare providers. Some states have developed care coordination programs that focus on dually eligible individuals and work with Medicare providers. One example is the *Vermont Independence Project* in which case managers (funded by Medicaid) are co-located at the offices of primary care physicians to specifically assist with care coordination for dually eligible individuals.

Care coordination differs from managed care described below in that providers of care coordination are not financially responsible for the services used by dually eligible individuals, but may receive bonus payments for meeting benchmarks such as a reduction in utilization.[45] Care coordination may be more difficult in a fee-for-service setting than in managed care, because there is no direct responsibility for the actual services used.

Managed Care. As described previously in this report, most dual eligibles are not enrolled in managed care (about 3% are enrolled in a Medicare HMO, and 13% are in a comprehensive Medicaid managed care program). Although there are significant and pervasive coordination challenges for most

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[44] The Robert Wood Johnson Foundation has established the *Medicare/Medicaid Integration Project* which provides grants and technical assistance to states to assist them in restructuring the way they finance and deliver acute and long-term care for dual eligibles. For additional information and a description of state programs see [http://www.hhp.umd.edu/AGING/MMIP/].

[45] S. Bratesman and P. Saucier, *Applying Managed Fee-for-Service Delivery Models to Improve Care for Dually Eligible Beneficiaries: A Technical Assistance Paper of the Robert Wood Johnson Foundation Medicare/Medicaid Integration Program*, May 2002, Muskie School of Public Services, University of Southern Maine.

dual eligibles enrolled in managed care,[46] a few programs have developed managed care models *specifically* to enhance coordination and integration of services for dual eligibles.

Depending on the program's goals and structure, most managed care programs require some form of federal approval from Medicaid and/or Medicare under one of several possible program authorities. A full discussion of each of these managed care authorities is outside the scope of this report.[47] A brief discussion, however, is provided here to outline program options and the accompanying decisions as it relates to managed care for dual eligibles.

Under Medicaid, managed care programs are available using the following program authorities:

- ***Pre-paid health plans:*** These are generally used if a state wants to include only a few services in a managed care arrangement. Enrollment in the program must be voluntary.
- ***Section 1932 of the Social Security Act:*** A managed care option in the Medicaid state plan; it does not require a waiver. States may not use this option to require dually eligible individual(s) to enroll in managed care. States may use this option to offer voluntary managed care enrollment.
- ***Section 1915(b) waiver***: This waiver allows states to require that dually eligible individuals enroll in a managed care program to receive their services. The waiver must be cost-effective[48] over a two-year period.
- ***Section 1115 waiver****:* This waiver authority is very broad. In this context, it allows states to expand Medicaid eligibility, and require dually eligible individuals to enroll in managed care to receive services. The waiver must be budget neutral over five years.
- ***Program of All-Inclusive Care for the Elderly (PACE) program:*** The Medicaid component is authorized under Section 1934 of the Social Security Act and is a Medicaid state plan option. This does not require a waiver. This program is described in more detail below.

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[46] The Medicare and Medicaid data systems are not integrated, which delays access to current eligibility and enrollment information, and beneficiaries have little access to information about how their benefits are affected by their dual eligible status. See E. Walsh, et al., *Case Studies of Managed Care Arrangements for Dually Eligible Beneficiaries*, RTI International, CMS Contract No. CMS-500-95-0048, Sept. 26, 2003 for additional information.

[47] For additional information see CRS Report RL30813, *Federal and State Efforts to Integrate Acute and Long-Term Care: Issues & Profiles*, by Edward Miller, Jan. 22. 2001.

[48] To be cost-effective, the waiver must not cost the Medicaid program more than it would have cost without the waiver.

Under Medicare, managed care programs are available using the following program authorities:

- ***Medicare Advantage:*** In general, the program makes monthly payments in advance to participating private health plans for each enrolled Medicare beneficiary in a payment area (typically a county). In exchange, the plans agree to furnish all Medicare-covered items and services to each enrollee. Generally, Medicare Advantage plans have been unable to limit enrollment to only certain types of Medicare beneficiaries (such as dually eligible individuals).[49]
- ***PACE:*** The Medicare component of PACE is authorized under Section 1894 of the Social Security Act and is specifically focused on dual eligibles. A more complete description of the PACE program is provided below.
- ***Section 222 waiver:*** [50] This demonstration waiver allows agencies and organizations to develop projects that evaluate changes in methods of payment or reimbursement. A demonstration project under this authority could enroll only dually eligible individuals; however, dual eligibles cannot be required to enroll in managed care. The waiver must be budget neutral, and generally will require a lengthy federal review process.
- ***Special Needs Medicare Managed Care Plans:*** The 108th Congress established a new type of Medicare managed care plan under Section 231 of the *Medicare Prescription Drug, Improvement and Modernization Act* (MMA, P.L. 108-173). This new type of managed care may replace the need for a Section 222 waiver to develop managed care programs for dual eligibles. Congress is permitting Medicare managed care plans to limit enrollment to certain groups of Medicare beneficiaries with special needs including dual eligibles.

Managed care approaches to improve coordination and services for dual eligibles have taken a variety of forms. Some states have chosen to require Medicaid managed care programs to coordinate with Medicare ("a partially integrated model"). Other programs have combined Medicare and Medicaid services into a single delivery system where one agency can manage all aspects of service delivery to provide the most efficient and highest quality services ("a fully integrated model.")

A partially integrated managed care model for dual eligibles is one in which a Medicaid managed care program has specific responsibilities for coordinating

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[49] Although non-dual eligibles were not prohibited from enrolling, some Medicare managed care plans created disincentives for non-dual eligibles to enroll, for example, charging a monthly premium to enrollees and providing no additional Medicare benefits. Dual eligibles were also charged a premium, but the Medicaid program would cover the cost of that premium.

[50] Refers to Section 222 of P.L. 92-603.

with Medicare even though the two programs are still operating separately. Several states have implemented these types of managed care programs. For example, Arizona's program operates under the authority of a Medicaid Section 1115 waiver which provides all Medicaid services through private managed care plans. These managed care plans are responsible for coordinating with Medicare services offered under either Medicare fee-for-service or a Medicare managed care plan.

Other programs have tried to fully integrate all Medicaid and Medicare benefits into one service delivery system (both acute and long-term care services). Some of the challenges in developing these types of programs include reconciling the different administrative structures, different providers and trying to make the delivery of Medicare and Medicaid services more coherent. Because of the different rules and regulations in Medicaid and Medicare and the federal waivers required, many of these programs have taken a significant investment of time by states and providers.

One example is the Program of All-Inclusive Care for the Elderly (PACE). The PACE program provides all Medicare and Medicaid services through a treatment team that is located at a day health center. The PACE project started as a demonstration project in the mid-1980s. In 1997, the Balanced Budget Act established PACE as a permanent model within Medicare and as a state option under the Medicaid state plan. A PACE provider must be a not-for-profit agency and have an agreement with both the state Medicaid agency and the Secretary of the HHS.[51]

Several state Medicaid programs have also developed other fully integrated programs such as the Minnesota Senior Health Options program and the Wisconsin Partnership Program. Both Minnesota's and Wisconsin's programs provide all Medicare and Medicaid primary, acute and long-term care services under a managed care model.

Individuals Who Receive Assistance with Medicare Premiums and Cost-Sharing

Dual eligibles can be eligible for all Medicaid benefits that the state provides (as described earlier in this report) and/or eligible for assistance with Medicare premiums and/or cost-sharing. This section describes in more detail the five groups that can qualify for assistance with Medicare premiums or cost-sharing from Medicaid.

Medicare beneficiaries (including dual eligibles) are required to pay a portion of the cost of their Medicare services through premiums and cost-sharing charges, as described in **Table 6**. Such charges could pose a potential hardship

[51] For additional information see the National PACE Association web site at [http://www.npaonline.org/].

for some persons, especially those who do not have supplementary protection either through an individually purchased "Medigap" policy or employer-based retiree coverage.

Table 6. An Overview of Medicare Premiums and Cost-Sharing Requirements, 2005

Type of Medicare premiums and cost-sharing	Amount
Premium	
Medicare Part A	Generally $0. A limited number of persons without sufficient work in covered employment (or whose spouse has not worked in covered employment) pay a monthly premium of $206 or $375 per month.
Medicare Part B	$938.40 per year ($78.20/month)
Deductible	
Medicare Part A	$912 per benefit period
Medicare Part B	$110 per year
Coinsurance	
Hospital	
1-60 day	$0 per day
61-90 day	$228 per day
91-150 day	$456 per day
Skilled nursing facility	
1-20 day	$0 per day
21-100 day	$114 per day
Medicare Part B Services	Varies by type of service.

Sources: CMS, *Medicare and You Handbook, 2005* and HHS press release, Sept 3, 2004, at [http://www.medicare.gov/publications/pubs/pdf/10050.pdf], and [http://www.hhs.gov/news/press/2004pres/20040903a.html].

Since the inception of the Medicaid program in 1965, states have had the option of paying for the Medicare Part B premium for Medicaid beneficiaries (referred to in this report as the "traditional Medicare buy-in"). In 1986, Congress also *permitted* state Medicaid programs to pay the Medicare cost sharing charges for individuals *who were not otherwise eligible for Medicaid* and whose incomes were up to 100% of the FPL.

On several occasions since 1988, Congress has *required* state Medicaid programs to cover Medicare premiums and cost-sharing for four groups of low-income Medicare beneficiaries. In addition, states continue to have the option of paying the Medicare premiums of other Medicaid beneficiaries.

For most of these groups, the federal and state government share the cost of the Medicare premiums, deductibles, and coinsurance based on the federal

medical assistance percentage rate (FMAP).[52] On average the federal government pays 57% of total expenditures. The federal share, which ranges from 50% to 76% is determined according to a formula based on the state's per capita income. Each of the groups that qualify for Medicare premiums and cost-sharing assistance are discussed below.

Qualified Medicare Beneficiaries (QMB). In 1988, Congress established the Qualified Medicare Beneficiary (QMB) program (Section 301 of the *Medicare Catastrophic Coverage Act*[53]). This bill removed the earlier criteria of the 1986 provision that the individual could not be otherwise eligible for full Medicaid benefits and required states to cover these low-income individuals.

Qualified Medicare Beneficiaries are individuals who are elderly or who have a disability, are entitled to Medicare Part A Hospital Insurance coverage and have incomes at or below 100% of the FPL ($818 a month for an individual and $1,090 for a couple in 2005).[54] Beneficiaries' assets may not exceed $4,000 for an individual and $6,000 for a couple; although, states may apply Section 1902(r)(2) of the *Social Security Act* to disregard additional assets, as described later in this section. Included in QMBs is the relatively small group of aged individuals who are not automatically entitled to Part A coverage, but who have bought Part A protection by paying a monthly premium.[55]

Under the QMB group, Medicaid covers the costs of Medicare premiums, deductibles, and coinsurance for Medicare-covered benefits. States may charge QMBs' nominal co-payments for Medicare services provided that they are the same charges applied to other Medicaid beneficiaries for comparable services.

CMS refers to individuals who qualify for both Medicare premiums and cost-sharing assistance under QMB and who qualify for full Medicaid benefits as "QMB-Plus." Individuals who *only* qualify for Medicare premiums and cost-sharing assistance are referred to as "QMB-only."

Specified, Low-income Medicare Beneficiary (SLMB). In 1990, Congress required states to cover Medicare Part B premiums for additional low-income Medicare beneficiaries beginning in January 1993, (Section 4501(b) of OBRA 1990, P.L. 101-508). To be eligible under the SLMB pathway, a Medicare

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[52] If a state chooses to pay the Part B premiums of certain Medicaid beneficiaries whose income is above levels that qualify them for premiums and cost-sharing assistance (certain institutionalized or medically needy persons) which is not required by federal law, the state must use 100% state funds. For the group of individuals categorized as Qualifying Individuals the federal government pays 100% of the expenditures not related to administering the program.

[53] Most of this act, not including this provision, was subsequently repealed by P.L. 101-234.

[54] References to 2005 income limits in this section include a $20 monthly income disregard which is the standard disregard for the SSI program. The SSI methodology is used for counting an individual's income for the Medicare premiums and cost-sharing groups.

[55] A QMB must also meet the general nonfinancial eligibility requirements for Medicaid such as providing a Social Security number and proving residency.

beneficiary's income may not exceed 120% of the FPL ($977 a month for an individual, $1,302 for a couple in 2005) and assets cannot exceed $4,000 for an individual and $6,000 for a couple.

CMS refers to individuals who qualify for both Medicare premium assistance under SLMB and who qualify for full Medicaid benefits as "SLMB-Plus." Individuals who *only* qualify for Medicare premium assistance are referred to as "SLMB-only."

Qualified Disabled and Working Individuals (QDWIs). Congress also required state Medicaid programs to provide some assistance with Medicare Part A premiums for Qualified Disabled and Working Individuals (Section 6408(d) of the Omnibus Budget Reconciliation Act of 1989, P.L. 101-239). QDWIs are persons who were previously entitled to Medicare on the basis of a disability, who lost their entitlement based on earnings from work, but who continue to have a disabling condition. These individuals are still entitled to enroll in Medicare Part A or Part B but are responsible for the payment of premiums unless they are low-income and receive assistance under this group.

Medicaid must pay the Medicare Part A premium for individuals whose monthly income is below 200% of FPL ($3,275 a month for an individual and $4,363 for a couple in 2005),[56] whose resources are below $4,000 for an individual and $6,000 for a couple, and who are not otherwise eligible for Medicaid.

If the individual has income from 150% to 200% of the FPL, the state may charge the individual a premium according to a sliding scale. The scale "must be based on percentages increasing from 0% to 100%, in reasonable increments, as the individual's income increases from 150% to 200% of the FPL."[57] The state may terminate the eligibility of a QDWI for nonpayment of the premium.

Qualifying Individual-1 (QIs). The Balanced Budget Act of 1997 (BBA97) added another mandatory eligibility group of low-income Medicare beneficiaries who receive assistance with Medicare premiums known as "Qualifying Individuals 1 (QI-1)."[58] The QI-1 group was originally set to expire

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[56] Includes additional earnings disregards.

[57] State Medicaid Manual 3485.7.

[58] A second group was also added by BBA97 referred to as "Qualifying Individuals-2 (QI-2)." The QI-2 group expired in Dec. 2002, but it is included in this section for reference. To have been eligible as a QI-2, an individual must have been entitled to Medicare Part A and had income of at least 135% of the FPL but less than 175% of the FPL and whose resources were below $4,000 for an individual and $6,000 for a couple, and who was not otherwise eligible for Medicaid. Under the QI-2 program, states were required to pay a portion of the Medicare Part B premium consisting of a percentage of the increase in the Medicare Part B premiums attributable to the shifting of some home health care from Medicare Part A to Medicare Part B which occurred in 1997. The benefit was $3.91 per month in 2002. Although the federal government covered 100% of the cost of this benefit,

(continued...)

in December 2002; however, Congress has subsequently extended the expiration date, most recently in the 108th Congress, until September 30, 2005 (P.L. 108-448).

Individuals are eligible as a QI-1 if they are entitled to Medicare Part A and their incomes are at least 120% of the FPL, but less than 135% ($1,097 a month for an individual and $1,464 for a couple in 2005) whose resources are below $4,000 for an individual and $6,000 for a couple, and *who are not otherwise eligible for Medicaid*.

The Medicaid benefit for QI-1s consists of payment of the full Medicare Part B premium. QI-1s are entitled to three months of retroactive coverage if they were eligible during those months and the retroactive month does not fall before January of a calendar year.

Allocation and Expenditures. To fund the QI-1 benefit, BBA97 established an annual capped allocation for each state for five years beginning in January 1998. Due to the limited amount of funding, this program did not establish an individual entitlement. Rather, individuals receive benefits on a first-come, first-serve basis. A state is only required to cover the number of persons that would bring its spending on these groups in a year up to its allocation level. The total allocation to states for FY2005 is $400 million.

The state's allocation is a percentage of the total federal funds available; this percentage is calculated using the average number of Medicare beneficiaries in that state over a three-year period who are not enrolled in Medicaid and who fall within the income guidelines and dividing that average by the total number of Medicare beneficiaries nationwide who are not enrolled in Medicaid and meet the income criteria.[59]

In most other areas of Medicaid expenditures, both states and the federal government contribute funds. However, 100% of the expenditures under the QI-1 program is covered by the federal government (from the Medicare Part B trust fund) up to the state's allocation level. However, similar to other areas of Medicaid, states are required to fund 50% of the administrative costs.

Traditional Medicare Buy-In. If a Medicaid beneficiary is eligible as a QMB or SLMB, the state is required to cover his or her Medicare premiums and cost-sharing charges as outlined above. However, if a Medicaid beneficiary is *not* eligible for either of these groups, the state has the option of paying the Medicare

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[58] (...continued)
this was a very unpopular benefit among states who cited the high administrative costs relative to the size of the benefit.

[59] Department of Health and Human Services, "Medicaid Program; State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals: Federal Fiscal Year 2002," 68 Federal Register, 50790, Aug. 22, 2003.

Part B premiums under a buy-in agreement[60] which has been available to states since the inception of Medicaid in 1966. Under a buy-in agreement, states may enroll dual eligibles in Medicare Part B and pay the premium on their behalf. States may also elect to include payment of Part A premiums under their buy-in agreements.

All states have buy-in agreements with the federal government. It is to a state's advantage to purchase Part B for some individuals. Federal Medicaid rules prohibit states from receiving the federal share of Medicaid expenditures, referred to as "federal financial participation" (FFP), for Medicaid services that are also covered by Medicare Part B which could have been covered under Part B had the individual been enrolled.

States must decide which groups of Medicaid beneficiaries they want to cover in their buy-in agreement. Certain eligibility groups must be covered if the state has a buy-in agreement; other groups are optional to cover. The state receives FFP for the Medicare Part B premiums for *only* certain Medicaid beneficiaries under the buy-in agreement. Generally these beneficiaries include individuals who are receiving federally-funded cash benefits or who are deemed to be receiving these cash benefits. If the state chooses to pay the Part B premium for other groups of individuals (e.g., certain institutionalized individuals and medically needy), the state must use 100% state funds. In April 2004, 30 states reported payment for Part B premiums for certain groups of individuals using 100% state funds.[61]

Total Number of Individuals Receiving Medicare Premium Assistance through Medicaid. **Table 7** below shows the number of individuals who received assistance with Medicare premiums in April 2004. The totals shown in **Table 7** do not include individuals in the QDWI group who received assistance with the Part A premium[62] or those QMBs in which a state chooses a separate payment mechanism for the Medicare Part A premiums. In addition, the data provided is based on a single month. One would expect that an annual count of all individuals who received premiums and cost-sharing assistance at some point during the year would be greater than the number reported here for a single month.

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[60] Section 1839 of the Social Security Act.

[61] CMS, *Third Party Premium Billing File*, Apr. 2004.

[62] CMS officials estimate that less than 50 individuals nationwide participate in the QDWI program. This rate is not entirely surprising because very few individuals with disabilities lose their Social Security Disability Insurance (SSDI) cash benefit as a result of earnings.

Table 7. Number of Individuals Receiving Assistance with Medicare Premiums, April 2004

State	Part A QMBs	Part B Buy-Ins[a]
Alabama	2,081	162,817
Alaska	666	10,249
Arizona	842	93,236
Arkansas	2,441	85,674
California	137,276	965,821
Colorado	341	59,581
Connecticut	2,724	66,146
Delaware	305	15,605
District of Columbia	848	15,588
Florida	46,221	394,181
Georgia	2,898	197,044
Hawaii	3,736	22,763
Idaho	504	21,805
Illinois	2,343	186,918
Indiana	1,855	103,496
Iowa	887	57,292
Kansas	618	45,663
Kentucky	2,551	124,003
Louisiana	4,014	130,286
Maine	15	43,363
Maryland	8,698	74,301
Massachusetts	18,475	168,330
Michigan	14,184	159,862
Minnesota	5,976	76,435
Mississippi	4,868	131,658
Missouri	750	102,515
Montana	377	13,581
Nebraska	0	22,971
Nevada	1,883	26,220
New Hampshire	31	10,761
New Jersey	7,433	153,388
New Mexico	301	45,216
New York	854	441,984
North Carolina	10,635	239,435
North Dakota	0	6,575
Ohio	5,088	192,778
Oklahoma	3,258	71,989
Oregon	75	69,153

State	Part A QMBs	Part B Buy-Ins[a]
Pennsylvania	15,884	229,884
Rhode Island	353	25,268
South Carolina	1,209	118,613
South Dakota	704	13,956
Tennessee	4,786	206,198
Texas	46,137	419,010
Utah	77	19,150
Vermont	87	14,954
Virginia	3,280	121,541
Washington	8,735	108,058
West Virginia	3,010	50,445
Wisconsin	3,794	79,196
Wyoming	152	7,448
Total[b]	**384,263**	**6,222,404**

Source: Centers for Medicare and Medicaid Services, *Third Party Premium Billing File*, Apr. 2004.

a. Part B Buy-Ins include QMBs, SLMBs, QI-1s and traditional Medicare Buy-In recipients.
b. Total does not include the five U.S. territories: American Samoa, Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands.

Issues in Providing Assistance with Medicare Premiums and Cost-Sharing

This section discusses issues that federal and state policymakers face in providing Medicare premiums and cost-sharing assistance for the various groups described above including:

- the counting of income and resources for determining eligibility for assistance;
- the challenges in covering premiums and cost-sharing assistance for dual eligibles who are enrolled in Medicare managed care;
- the intersection of differing provider payments under Medicare and Medicaid and the amount of coinsurance Medicaid is obligated to pay; and
- reaching persons who are eligible for, but not receiving, premiums and cost-sharing assistance.

Use of More Liberal Methods of Counting Income and Resources

When a state determines eligibility for assistance with Medicare premiums and cost-sharing, it generally uses the same guidelines for counting income and

resources as are used in the SSI program.[63] However, Section 1902(r)(2) of Medicaid law allows states to establish more generous methods for counting income and resources through additional disregards for certain Medicaid eligibility groups. Section 1902(r)(2) can be applied to all mandatory Medicare Savings program groups except Qualified Working Disabled Individuals (i.e., QMB, SLMB and QI-1).[64]

Table 8 below describes the extent to which states have applied additional disregards for these groups. A few examples of additional income disregards include a deduction for children and irregular or infrequent income. Examples of additional resource disregards include additional amounts for burial expenses, the value of a life insurance policy under a certain level and income producing property. A few states disregard all resources for purposes of determining eligibility for Medicare premiums and cost-sharing.[65] States may disregard all resources because the administrative requirements for collecting the paperwork documenting a person's resources may be burdensome for both the state and the individual and may not result in a significant number of individuals becoming ineligible for the program.

Table 8. States Using Less Restrictive Income or Resource Methodology for Determining Eligibility for QMB and SLMB in 2001

State	Uses less restrictive methods for counting income	Uses less restrictive methods for counting resources
Alabama	X	X - excludes all resources.
Alaska	X	
Arizona	X	X- excludes all resources.
Arkansas		X
California	X	X
Colorado		
Connecticut	X	X- excludes all resources for QI-1.
Delaware	X	X- excludes all resources.

[63] The SSI guidelines are generally used for Medicaid eligibility pathways relating to individuals who are elderly or have a disability. However, there are 11 states that use more restrictive methods for counting income or resources than those used in the SSI program (referred to as "209(b) states"). Congress has prohibited states from applying these more restrictive standards to determine whether an individual is eligible for Medicare premiums and cost-sharing assistance.

[64] Section 1902(r)(2) does not specifically apply to individuals who receive premium assistance through a traditional Medicare buy-in, because the traditional Medicare buy-in is not a separate Medicaid eligibility group.

[65] The 108th Congress enacted the *Social Security Protection Act of 2003* (P.L. 108-203) which includes provisions to exclude additional types of income and resources in SSI eligibility determinations such as certain types of infrequent or irregular income and certain interest or dividend income. These new provisions also apply to eligibility determinations for QMB and SLMB, and QI-1 and may render a few states' previously established 1902(r)(2) provisions unnecessary.

State	Uses less restrictive methods for counting income	Uses less restrictive methods for counting resources
District of Columbia		
Florida	X	X
Georgia	X	X
Hawaii		X
Idaho	X	
Illinois	X	X
Indiana		X
Iowa		
Kansas	X	X
Kentucky		
Louisiana		
Maine	X	X
Maryland		
Massachusetts		
Michigan		
Minnesota	X	X
Mississippi	X	X- excludes all resources.
Missouri		X
Montana		X
North Carolina		
North Dakota		
Nebraska		
New Hampshire		
New Jersey		
New Mexico		
Nevada		
New York		
Ohio		
Oklahoma		
Oregon		
Pennsylvania		
Rhode Island		X
South Carolina		X
South Dakota	X	
Tennessee	X	X
Texas		
Utah		
Vermont	X	X
Virginia		X
Washington	X	
Wisconsin		
West Virginia		
Wyoming	X	

Source: National Association of State Medicaid Directors, Aged, Blind and Disabled Survey, 2001, at [http://www.nasmd.org/eligibility/introduction.asp].

Coverage of Medicare Managed Care Premiums and Cost-Sharing

The Medicare Advantage program (previously known as the Medicare + Choice program) is a voluntary Medicare managed care program for Medicare beneficiaries (including those who are dually eligible). Generally, dually eligible individuals have had low enrollment in Medicare managed care. The General Accounting Office (GAO) estimated that 3% of dual eligibles received their Medicare benefits through Medicare managed care.[66]

For those dually eligible individuals who are eligible as a QMB and enrolled in Medicare managed care, states must cover the coinsurance and deductibles those plans charge enrollees. These are in lieu of the Medicare coinsurance and deductibles which would be paid if the individual were not enrolled in managed care and instead were in the traditional fee-for-service program.[67] The requirement to pay coinsurance and deductibles has been difficult for states and Medicare managed care plans to implement because (1) most states do not have reliable ways of knowing which dual eligibles are enrolled in a Medicare managed care plan, and (2) many managed care plans do not have reliable information on dual eligible status. A 1999 report found that fewer than half of the states that have Medicare managed care plans pay dual eligible individuals' co-payments for services provided.[68] As a result, dual eligible beneficiaries may be inappropriately charged for co-payments that Medicaid should cover.

Amount of Medicaid Coinsurance for QMBs

State Medicaid programs frequently have payment rates that are lower than those used by Medicare for comparable services. Federal program guidelines permit states to limit Medicare cost-sharing for QMBs to the difference between what Medicare has already paid the provider and the rate that *Medicaid* would have paid for that service. For example, if the recognized payment amount for a Medicare physician visit is $100, Medicare would reimburse the provider 80% of the amount of that Part B service ($80). If the state's Medicaid rate for a similar service was $85, the state would only be required to pay the Medicare provider an additional $5. This is $15 less than the Medicare provider would receive if the beneficiary did not receive cost-sharing assistance from Medicaid and had been liable to the provider for the $20 coinsurance.

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[66] General Accounting Office (GAO), *Medicare and Medicaid: Implementing State Demonstrations for Dual Eligibles Has Proven Challenging*, GAO/HEHS-00-94, Report to U.S. Senate, Special Committee on Aging, Aug. 2000.

[67] States at their option may also pay any additional enrollment premiums that may be charged to dual eligibles for participating in the managed care plan.

[68] P. Nemore, *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update*, National Senior Citizens Law Center, Dec. 1999. (Hereafter referred to as Nemore, *1999 Buy-In Practices*)

In 1997, a state survey reported that 12 states had a policy of not reimbursing providers the full Medicare coinsurance amount.[69] Several providers sued states to try to receive the full Medicare amount. In response to these lawsuits, Congress specified in BBA97 that states are not required to pay Medicare cost-sharing to the extent that the payment would exceed the rate that Medicaid would have paid. A follow-up survey in 1999 found that the number of states that had instituted a policy reimbursing providers only what Medicaid would have paid (less than the full Medicare coinsurance rate) had grown to 30.[70]

Congress was concerned that this reduction in Medicaid payments to Medicare providers would affect Medicare beneficiaries' access to services and requested a review of this issue in 2000 by the HHS.[71] HHS found "a statistically significant correlation" between the reductions in states' payments to Medicare providers for cost-sharing and beneficiary service utilization. Specifically, the study found that for every 10% decrease in Medicaid payment of Medicare cost-sharing, there was a 1% reduction in the probability of a Medicare outpatient physician visit occurring and a 3% reduction in the probability of a Medicare outpatient mental health visit occurring. The study concluded that the impact on utilization was "relatively small" and "the effect on health outcomes is unknown."[72] The study did not propose a specific cause for the decrease in service utilization.

Outreach for Medicare Premiums and Cost-Sharing Assistance

The final issue discussed in this section is the number of participants who are currently receiving assistance with Medicare premiums and cost-sharing versus the number of individuals who would be eligible for these programs. Estimates of individuals who actually participate in QMB or SLMB compared to the number who are eligible to participate range from 47% to 57%.[73] Although the estimated participation rate of eligibles for QMB and SLMB together is about one-half, other studies have found significant differences in participation *between*

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[69] P. Nemore, *Variations in State Buy-In Practices for Low-Income Medicare Beneficiaries*, National Senior Citizens Law Center, Nov. 1997.

[70] Nemore, *1999 Buy-In Practices*.

[71] Section 125 of the *Medicare, Medicaid and SCHIP Benefits Improvement an Protection Act of 2000* (BIPA).

[72] HHS, *Report to Congress: State Payment Limitations for Medicare Cost Sharing*, 2003.

[73] GAO, *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment*, Apr. 1999 GAO/HEHS-99-61; Actuarial Research Corporation, *Estimating the Universe of Medicare Beneficiaries Potentially Eligible for Medicaid Buy-In*, Feb. 1999; and The Barents Group LLC, *A Profile of QMB-Eligible and SLMB-Eligible Medicare Beneficiaries*, Apr. 1999.

the QMB and SLMB groups. The estimated participation rate for QMBs was 78%, and the participation rate for SLMBs was 16%.[74]

A survey of states found several possible reasons for the low enrollment of eligible QMBs and SLMBs including a lack of understanding about the programs, language and/or cultural barriers, the physical accessibility or lack of familiarity with the county Medicaid office where they may have to go to apply the complex enrollment process including the documentation of income and assets, and the welfare stigma which may be associated with applying for assistance at a county office.[75] The estate recovery provisions of some states may also deter participation among some beneficiaries.

A study by the Barents Group found that those Medicare beneficiaries who were more likely to seek assistance with Medicare premiums and cost-sharing may have had greater contact with the local human service system, may be able to access program information and enrollment assistance, or may not be deterred by the application process or applying for the assistance at a county office.

Those who were less likely to enroll in the Medicare Savings program fell into two categories. The first category was those who were considered "hard-to-reach." Individuals in this category tended to be very elderly, Hispanic-Latino beneficiaries, and beneficiaries who used fewer services and had less contact with the health care systems. The second group of individuals were those who had somewhat more income and assets than the first group but still met the income and asset guidelines for the program. These individuals tended to be married, had relatively high levels of formal education, were homeowners, were in relatively good health, and had private supplemental insurance.[76]

In 1999, CMS made a concerted effort to raise the number of eligible Medicare beneficiaries. This was in response to the Government Performance Review and Accountability Act (GPRA) measure to "Improve Access to Care for Elderly and Disabled Medicare Beneficiaries Who Do Not Have Public or Private Supplemental Insurance." CMS established state specific goals, conducted a series of regional seminars, developed outreach materials, awarded grants to states, sponsored conferences, and engaged in other efforts to raise awareness of the assistance available to low-income Medicare beneficiaries.[77] The Social Security Administration (SSA) is also required to conduct outreach mailings to potential QMBs, SLMBs, and QI-1s. These efforts have increased participation in the programs by a few percentage points, but the number of individuals who are receiving assistance with premiums and cost-sharing continues to fall well below

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[74] M. Moon, et al., "Options for Aiding Low-income Medicare Beneficiaries," *Inquiry — Blue Cross and Blue Shield Association*; fall 1998, pp. 346-356.

[75] H. Shaner, *Dual Eligible Outreach and Enrollment: A View from the States*, Mar. 1999.

[76] The Barents Group LLC, *A Profile of QMB-Eligible and SLMB Eligible,* Apr. 1999.

[77] For additional information on CMS activities to increase participation see State Medicaid Director Letter dated Jan. 13, 2000 at [http://www.cms.hhs.gov/states/letters/smd11300.asp]

the number who are considered eligible based on population estimates of this group.

Many policymakers believe that the addition of a new Medicare prescription drug benefit in 2006 will increase participation in the QMB and SLMB programs. Under the legislation, states are required to screen individuals for eligibility in QMB and SLMB if the individual applies for financial assistance with premiums and cost-sharing for the Medicare prescription drug benefit.

Summary of Premiums and Cost-Sharing Assistance Groups

Table 9 summarizes Medicare premiums and cost-sharing assistance for the groups of beneficiaries discussed in this section. It outlines the various types of Medicare premiums and cost-sharing charges and describes who is responsible for covering each of these components.

Table 9. Summary of Medicare Premiums and Cost-sharing Coverage by Assistance Group

Category (income criteria)	Type of Medicare premiums and cost-sharing					
	Medicare fee-for-service				Medicare managed care	
	Part A premium	Part A deductible, coinsurance, co-payments	Part B premium	Part B deductible, coinsurance, co-payments	Additional enrollment fee (if applicable)	Coinsurance, deductible
QMB (at or below 100% FPL)	Generally, no cost to beneficiary or state. But if required, state must cover the cost.	State required to cover the cost up to equivalent Medicaid rate.	State required to cover the cost.	State required to cover the cost up to equivalent Medicaid rate.	State option to cover. Otherwise individual pays.	State required to cover the cost.
SLMB (below 120% FPL)	Generally, no cost to beneficiary or state. But if required, the individual must cover the cost.	Individual covers the cost.	State required to cover the cost.	Individual covers the cost.	State option to cover. Otherwise individual pays.	Individual covers the cost.
QDWI (below 200% FPL)	State required to cover if individual's income is below 200% FPL, but may require that the individual pay part of the premium if his/her income is between 150% and 200% FPL.	Individual covers the cost.	Individual covers the cost.	Individual covers the cost.	Individual covers the cost.	Individual covers the cost.
QI-1 (below 135% FPL)	Generally, no cost to beneficiary or state. But if required, the individual must cover the cost.	Individual covers the cost.	State covers the cost through 100% federal dollars up to state allotment.	Individual covers the cost.	State option to cover. Otherwise individual pays.	Individual covers the cost.
Traditional Medicare Buy-In (determined by the state)	Generally, no cost to beneficiary or state. But if required, the state has the option to cover.	Individual covers the cost.	States choosing the buy-in option, must cover the costs for some groups and have the option for other groups.	Individual covers the cost.	State option to cover. Otherwise individual pays.	Individual covers the cost.

Administration and Data Issues for Dual Eligible Programs

Administering claims for Medicaid services and assistance with Medicare premiums and cost-sharing for dually eligible individuals as described in this report is complex. State Medicaid programs must develop systems to determine what bills Medicare has paid and the amount that should be paid to providers. States must also determine who is eligible for assistance with Medicare premiums and cost-sharing. This section discusses the administration of dual eligible programs and some of the complexity involved in this process.

Administration of Claims Payment for Dual Eligibles

State Medicaid agencies must "cost avoid" or reject any claims that may be paid by a third party, including Medicare. For those dual eligibles for whom a service may be paid for by Medicare, the provider first submits the bill for services to Medicare. If Medicare accepts the claim, the Medicaid agency would only be required to pay the beneficiary cost-sharing charges. In billing the Medicaid agency for the cost-sharing charges, either the Medicare fiscal intermediary or carrier would send a bill to the state Medicaid agency, or the Medicare provider would be required to bill the state Medicaid agency for the cost-sharing amount.

If Medicaid pays a claim and the state subsequently becomes aware that it could have been paid by a third party such as Medicare, then the state must seek recovery from that third party (referred to as "pay and chase"). To help ensure that Medicaid only pays when it's appropriate, states may educate providers to explain when Medicare is billed versus Medicaid, review paid claims to check for potential third-party payment sources, resubmit selected cases to Medicare for payment, or, in a few cases, appeal denied Medicare claims.[78]

Administration of Medicare Premium Assistance

To enable the administration of Medicare premium assistance, there are several contractual and data-related agreements among states, SSA and CMS. One of the contractual agreements (discussed previously) is the traditional Medicare buy-in between states and CMS. Under the buy-in agreement, dually eligible individuals are automatically enrolled in Medicare. This system can include not only the traditional Medicare buy-in group, but also QMB and SLMB. Beneficiaries who are covered under the buy-in agreement are not subject to the

[78] W. Anderson, et al., "Adoption of Retrospective Medicare Maximization Billing Practices by State Medicaid Home Care Programs," *Journal of Health Politics, Policy and Law*, vol. 28, no. 5, Oct. 2003.

traditional restrictions on when an individual can enroll in Medicare Part B, thus avoiding penalties for late enrollment.[79]

Most states have also entered into contractual agreements with the SSA under Section 1634 of the Social Security Act to automate part of the Medicare premium and cost-sharing process. The 32 states which have entered into a "1634 agreement" automatically consider SSI-eligible individuals to be eligible for a Medicare Part B buy-in. SSA sends a monthly list to CMS of individuals who should receive Medicare premium and cost-sharing assistance based on their SSI status. CMS verifies the information, automatically enrolls these individuals in Medicare Part B, and bills the states via a data file for the Medicare premiums.

For all individuals who reside in states without a 1634 agreement and for those individuals who reside in a state with a 1634 agreement but who are not eligible for SSI, the state Medicaid agency determines eligibility for Medicare Savings Programs and transmits that information to CMS. CMS then combines the data received from SSA with the state determinations and bills the states on a monthly basis for the Medicare premiums attributable to those beneficiaries. This data file is referred to as the "Third Party Premium Billing File."

Certain individuals are not included in the Third Party Premium Billing File. All QDWIs and QMBs in certain states must enroll themselves in Medicare and may be subject to enrollment restrictions and penalties. Unlike other groups, these individuals are not automatically enrolled in Medicare. After the individual enrolls in Medicare Part A and the state Medicaid program verifies that the individual is eligible for cost-sharing assistance, CMS bills the states on a monthly basis for the Part A premiums. These individuals are included in the "group payer" category and are not included in national data on the number of individuals receiving assistance with Medicare premiums.

Data Issues

Gathering reliable and consistent federal data on dual eligibles is a challenge because there is no common definition of dual eligibles or reliable method of estimating enrollment of dual eligibles, particularly the number of individuals in specific subcategories (e.g., QMBs, SLMBs). Some policymakers include individuals who only receive assistance with Medicare cost-sharing in the definition of dual eligibles, others define dual eligibles as only those who are receiving full Medicaid benefits.

In addition, individuals may be enrolled in more than one Medicaid group which is not always reflected in the data that states send to the federal government on the Medicaid Statistical Information System (MSIS). For example, an individual may be receiving assistance with Medicare cost-sharing as a QMB and

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[79] L. Carpenter, "Evolution of Medicaid Coverage of Medicare Cost Sharing," *Health Care Financing Review*, winter 1998, pp. 11-18.

may be receiving full Medicaid benefits due to the receipt of SSI cash benefits. Often, states will report the eligibility code to the federal government as SSI. The individual's QMB status is not included. Therefore, the number of individuals reported on MSIS as QMB may under count the number of individuals who actually receive assistance through this category.

For example, based on documentation of FY2002 MSIS data, 18 states could not identify the dual eligible status of 15% or more of Medicaid enrollees or had another problem that made their dual eligibility reporting unreliable. Even when states are able to identify an enrollee as a dual eligible, they may not be able to identify a specific category of dual eligibility (QMB/SLMB only, QMB/SLMB with full benefits, QDWI, etc.). In FY2002, 17 states could not identify a category of eligibility for 25% or more of the dual eligibles, and nine could not identify a category for 50% or more of the dual eligibles. These data issues make it difficult to fully understand the role of Medicaid in providing services to dual eligibles and create challenges in the implementation of the new Medicare drug benefit or other policy changes that may affect this group of individuals.

Conclusion

Dual eligibles represent a small share of Medicare and Medicaid beneficiaries, but these individuals have significant health and long-term care needs that are served by two very different and very complex programs. Significant challenges remain to ensure that beneficiaries can access a coordinated, understandable package of Medicare and Medicaid services and low-income assistance, and that program administrators and providers can easily navigate the administration and operations of these two programs.

Appendix A. Estimated Medicaid Expenditures for Dual Eligibles by State and Category of Service, FY2002

(in millions)

State	Total	Acute care	Long-Term care	Prescription drugs[a]	Managed care	Other/ unknown
Alabama	1,180.13	110.69	828.18	213.99	6.72	20.55
Alaska	172.73	19.19	112.83	35.53	0.00	5.18
Arizona	767.23	25.56	17.11	1.10	717.90	5.56
Arkansas	1,017.37	237.97	597.45	165.77	3.27	12.91
California	8,798.91	681.91	5,217.46	1,970.53	820.19	108.81
Colorado	930.78	45.66	658.80	129.05	78.32	18.95
Connecticut	1,990.43	79.59	1,659.68	244.94	0.55	5.67
Delaware	242.34	15.06	189.62	29.47	2.99	5.19
District of Columbia	263.97	37.85	185.86	32.96	0.96	6.35
Florida	3,701.42	217.50	2,293.41	948.06	129.31	113.14
Georgia	1,531.51	198.02	998.04	309.86	2.39	23.21
Hawaii	238.32	19.09	171.27	45.90	0.54	1.52
Idaho	158.39	16.66	104.21	34.03	0.17	3.31
Illinois	2,990.72	217.26	2,143.72	577.79	2.94	49.01
Indiana	1,734.20	139.90	1,219.41	345.47	0.23	29.20
Iowa	900.19	68.21	658.53	157.84	12.27	3.33
Kansas	747.15	38.32	571.70	129.27	0.08	7.79
Kentucky	1,182.11	127.81	732.35	265.63	36.57	19.75
Louisiana	1,154.16	92.63	763.98	281.45	0.01	16.08
Maine	640.44	42.11	451.69	138.25	0.01	8.38
Maryland	1,300.64	113.24	949.79	205.22	19.90	12.49
Massachusetts	3,326.58	203.87	2,490.97	524.77	52.08	54.89
Michigan	1,800.73	68.60	1,217.37	473.27	28.64	12.86
Minnesota	2,210.82	100.58	1,686.78	170.37	225.37	27.73
Mississippi	1,117.46	159.28	590.77	338.19	0.00	29.23
Missouri	1,836.67	168.52	1,184.61	459.39	3.83	20.32
Montana	208.73	19.13	148.21	40.62	0.01	0.75
Nebraska	576.18	47.25	420.74	104.29	0.80	3.11
Nevada	211.38	23.62	142.59	41.99	0.11	3.08
New Hampshire	399.41	46.72	293.63	56.89	0.02	2.16
New Jersey	2,757.64	214.45	1,996.03	468.01	31.67	47.49
New Mexico	125.28	12.19	92.81	14.59	3.42	2.27
New York	14,637.75	1,798.34	10,822.88	1,466.63	355.47	194.43
North Carolina	2,585.93	283.53	1,674.11	603.24	1.69	23.37
North Dakota	259.84	9.74	216.60	32.05	0.00	1.45
Ohio	4,296.47	266.93	3,331.78	621.97	2.33	73.47
Oklahoma	948.09	77.99	694.69	168.66	5.46	1.29

State	Total	Acute care	Long-Term care	Prescription drugs[a]	Managed care	Other/ unknown
Oregon	791.35	23.23	444.43	156.75	155.30	11.64
Pennsylvania	3,862.92	69.01	2,743.48	445.00	604.88	0.54
Rhode Island	592.22	21.01	487.46	80.91	1.84	1.00
South Carolina	1,024.20	238.64	556.80	210.82	10.63	7.32
South Dakota	217.82	14.81	165.53	35.54	0.94	1.00
Tennessee	1,663.42	106.82	985.91	265.85	290.93	13.89
Texas	4,019.32	183.44	2,974.00	724.13	72.45	65.30
Utah	256.46	9.28	147.54	56.22	40.45	2.98
Vermont	240.73	17.65	154.81	65.37	0.02	2.89
Virginia	1,336.60	119.32	915.35	286.68	7.35	7.90
Washington	876.62	89.41	491.06	285.37	3.89	6.88
West Virginia	576.88	33.06	435.40	98.97	0.03	9.42
Wisconsin	1,973.75	98.43	1,380.39	301.14	171.79	22.00
Wyoming	121.99	6.71	97.30	17.84	0.00	0.15
Total[b]	**86,496.37**	**7,075.78**	**$59,509[b]**	**14,877.58**	**3,906.75**	**1,127.18**

Source: CRS analysis based on Centers for Medicare and Medicaid Services, MSIS data, FY2002.

a. The amounts shown do not reflect rebates paid to states by pharmaceutical manufacturers. In FY2002, total Medicaid drug expenditures for all beneficiaries were offset by 20% due to rebates.
b. Does not include $5.2 billion in expenditures for Medicare Part B premiums.

Appendix B. Estimated Number of Dually Eligible Recipients for Selected Service Types by State, FY2002

(in thousands)

State	Total number of dual eligibles	Selected acute care services			Selected long-term care			Prescription drugs	Selected managed care program
		Inpatient hospital	Outpatient hospital	Physician	Nursing facility	ICF-MR	Personal care		Comprehensive HMO
Alabama	126.5	32.0	12.5	96.6	23.8	0.4	0.0	96.4	0.0
Alaska	9.9	2.0	6.4	7.5	0.6	0.0	1.9	9.1	0.0
Arizona	68.8	1.8	6.9	2.3	0.6	0.0	0.7	1.4	62.2
Arkansas	109.5	26.6	57.2	89.7	18.1	1.1	16.0	83.1	0.0
California	946.2	95.6	288.1	527.9	94.5	5.1	188.9	721.9	136.5
Colorado	63.0	7.5	22.9	14.0	14.2	0.1	0.0	43.2	11.5
Connecticut	77.5	16.3	43.1	50.3	26.7	1.1	10.5	69.7	0.5
Delaware	13.2	2.4	6.0	10.6	3.0	0.2	0.0	9.3	1.2
Dist. of Columbia	23.7	5.6	7.4	6.0	4.1	0.6	0.1	18.5	0.4
Florida	357.6	91.9	165.5	161.6	68.5	2.1	0.0	314.9	29.7
Georgia	178.4	39.1	110.2	156.6	34.1	0.8	0.0	134.4	0.0
Hawaii	22.9	0.6	1.0	20.1	9.3	0.1	0.0	21.3	0.5
Idaho	12.4	2.8	7.1	10.7	1.2	0.2	2.6	9.9	0.0
Illinois	210.3	20.3	90.7	140.3	62.1	6.7	7.8	189.1	0.4
Indiana	107.2	25.8	61.6	80.8	35.6	3.6	0.0	94.3	0.2
Iowa	60.9	13.3	32.7	43.9	19.0	1.3	0.0	53.6	0.1
Kansas	42.5	5.9	14.2	27.2	12.8	0.6	13.7	38.0	0.1
Kentucky	122.1	30.2	63.2	94.8	24.2	0.5	0.0	83.9	12.4
Louisiana	117.0	71.7	7.5	93.8	27.1	3.1	0.1	93.4	0.0
Maine	76.6	0.7	5.9	34.1	7.6	0.2	1.2	74.6	0.0
Maryland	80.2	19.2	37.3	63.6	18.9	0.3	3.6	71.9	5.1
Massachusetts	194.6	17.1	118.3	141.8	47.8	1.1	2.8	181.3	1.8
Michigan	190.8	14.6	64.9	95.9	40.3	0.1	7.7	178.9	11.7
Minnesota	98.8	16.9	45.0	55.9	31.4	2.4	15.7	61.2	43.6
Mississippi	136.3	38.6	85.0	121.2	17.7	1.4	0.0	131.6	0.0
Missouri	146.3	30.8	90.1	89.8	34.7	0.9	34.2	134.1	0.7
Montana	15.8	3.3	8.3	12.0	4.3	0.1	2.0	14.3	0.0
Nebraska	34.3	7.2	19.0	25.6	10.5	0.5	0.9	32.5	0.2

State	Total number of dual eligibles	Selected acute care services			Selected long-term care			Prescription drugs	Selected managed care program
		Inpatient hospital	Outpatient hospital	Physician	Nursing facility	ICF-MR	Personal care		Comprehensive HMO
Nevada	21.9	2.6	8.7	0.0	3.8	0.1	2.0	15.8	0.1
New Hampshire	18.7	1.5	10.3	10.9	6.7	0.0	0.1	17.4	0.0
New Jersey	146.9	33.5	74.0	67.2	37.1	2.5	16.7	135.1	9.0
New Mexico	32.3	11.4	2.8	20.5	4.3	0.2	0.1	20.7	1.9
New York	558.5	134.8	307.5	410.5	132.2	6.7	83.3	451.6	30.4
North Carolina	234.9	37.9	137.0	207.2	38.8	2.7	39.0	220.0	0.2
North Dakota	12.9	2.4	5.6	0.4	4.9	0.4	0.0	11.3	0.0
Ohio	206.4	55.9	119.7	174.6	68.9	5.4	0.0	185.1	1.5
Oklahoma	82.1	22.2	32.5	61.9	21.2	1.3	10.3	75.8	2.3
Oregon	76.4	1.5	16.8	27.5	9.7	0.0	9.7	59.2	32.2
Pennsylvania	272.7	25.6	12.1	76.2	68.8	3.2	4.3	147.4	144.2
Rhode Island	29.6	5.6	14.5	14.3	9.6	0.0	1.2	27.1	1.0
South Carolina	116.9	38.6	42.2	87.4	15.8	1.3	13.3	104.6	0.1
South Dakota	17.9	3.2	6.7	11.3	5.4	0.1	1.6	11.9	0.0
Tennessee	288.6	28.8	33.2	189.4	33.0	1.0	0.0	200.5	287.9
Texas	357.3	90.1	8.9	38.5	79.3	8.0	0.8	324.1	32.9
Utah	18.3	1.1	3.7	6.2	4.4	0.4	0.3	16.5	9.9
Vermont	26.8	3.0	10.0	14.0	3.2	0.0	0.0	25.9	0.0
Virginia	120.2	32.1	71.5	90.3	24.2	1.4	8.1	96.7	2.8
Washington	102.5	11.3	49.9	66.2	19.2	0.0	0.0	94.2	3.7
West Virginia	50.8	5.9	27.9	41.1	9.7	0.3	3.2	40.0	0.0
Wisconsin	134.5	22.1	59.8	46.5	33.6	2.3	8.5	124.2	4.4
Wyoming	7.1	1.5	4.1	5.6	2.2	0.1	0.0	5.6	0.0
Total[a]	**6,577.3**	**1,212.1**	**2,537.4**	**3,942.2**	**1,329.2**	**72.4**	**512.9**	**5,376.5**	**883.4**
Percentage of total number of dual eligibles		**18%**	**39%**	**60%**	**20%**	**1%**	**8%**	**82%**	**13%**

Source: CRS analysis based on Centers for Medicare and Medicaid Services, MSIS data, FY2002

Note: Included in the beneficiary totals are dual eligible beneficiaries receiving a service listed above that was funded under a home- and community-based program under Section 1915(c) or Section 1929 of the Social Security Act.

a. Includes all dual eligibles except those for whom Medicaid paid for Medicare premiums *only*.