THE HENRY J. KAISER FAMILY FOUNDATION

REPORT

# FACES OF DUALLY ELIGIBLE BENEFICIARIES:

## Profiles of People with Medicare and Medicaid Coverage

July 2013

# Table of Contents

# INTRODUCTION

Over nine million "dually eligible beneficiaries"[1] – low-income seniors and younger people with disabilities – rely on coverage under both Medicare and Medicaid to obtain critical medical and non-medical, supportive services. Dually eligible beneficiaries are a diverse beneficiary population and generally have lower incomes and are sicker than their counterparts with coverage under Medicare or Medicaid alone.[2,3] Beyond age and health status, these beneficiaries vary with respect to care preferences, service utilization across a continuum of care settings, and access to informal supports. Given their significant need for both medical services and care-related supports as well as relatively high average per capita costs, providing high quality, coordinated care for dually eligible beneficiaries continues to be of interest to federal and state policymakers who oversee the management and funding of the programs.

To provide insight into their unique experiences in accessing services across the Medicare and Medicaid programs, this report presents individual profiles of dually eligible beneficiaries residing in California, Florida, Massachusetts, Michigan, and Oklahoma. Based on a series of in-person interviews conducted by the Kaiser Family Foundation and PerryUrdem Research and Communication in 2012, these profiles illustrate how beneficiaries' day-to-day lives, finances, employment status, relationships, and well-being – in addition to their health care – are affected by their coverage under these two programs.

## BACKGROUND

To provide context for the beneficiary profiles, background on how dually eligible beneficiaries qualify for Medicare and Medicaid and what benefits are provided under each program as well as enrollment and spending data are included below. A glossary of eligibility and service delivery system terms is available in Appendix A.

Dually eligible beneficiaries qualify separately for Medicare and Medicaid. Individuals qualify for Medicare if they (1) are age 65 or older; (2) are under age 65 with a disability and have been receiving Social Security Disability Insurance for more than 24 months; or (3) have end-stage renal disease or Amyotrophic Lateral Sclerosis.[4] Medicare is the first payer for all dually eligible beneficiaries, and therefore the primary source of primary/acute care coverage. Medicaid serves as a safety net for low-income Medicare beneficiaries with limited assets, paying for Medicare Part B premiums, cost-sharing, and services excluded or limited under Medicare. Mandatory "state plan" services covered by each state Medicaid program include, but are not limited to, inpatient and outpatient hospital services; physician, midwife, and nurse practitioner services; nursing home care; and home health services. Many states also offer "optional" Medicaid services.[5] Notable services that Medicare does not cover, and which state Medicaid programs may elect to cover, include most long-term services and supports and dental and vision services.

In 2008, the majority (61%) of all dually eligible beneficiaries were age 65 and older.[6] Of the nine million dually eligible beneficiaries, approximately seven million individuals (or 77%) are "full duals" who receive the complete Medicaid benefit package as defined by the state in which the beneficiary resides, as well as Medicaid assistance with paying for Medicare premiums and cost-sharing (Appendix B). The remaining two million beneficiaries, so called "partial duals," receive assistance with Medicare cost-sharing and/or premiums only. Covered benefits for dually eligible individuals are listed on page 2.

## Benefits Provided by Medicare and Medicaid to Dually Eligible Beneficiaries, by Program

### Medicare Benefits

- Inpatient care in hospitals (Part A)
- Skilled nursing facility, hospice, and home health care (Part A)
- Physician and other providers' services (Part B)
- Outpatient care, physician-administered drugs, durable medical equipment, and home health care (Part B)
- Preventive services (Part B)
- Prescription Drugs (Part D)

### Medicaid Benefits

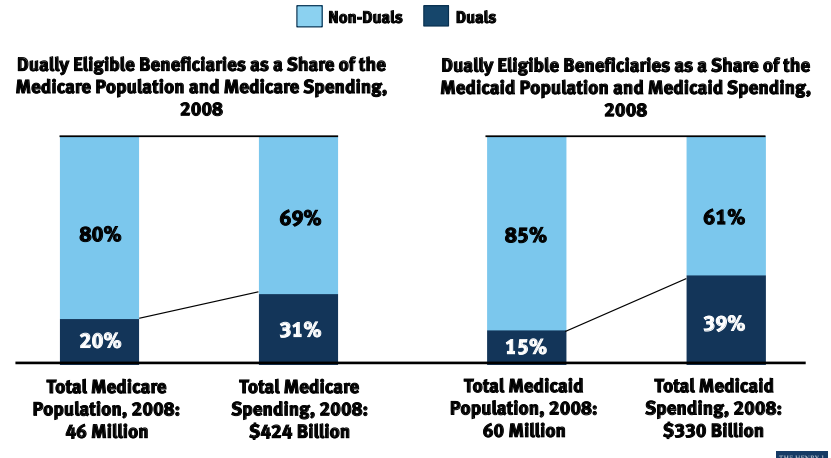
- "Full duals" receive complete Medicaid state plan benefits package and assistance with Medicare premiums, deductibles, and cost-sharing, and may also receive, at state option, additional home and community-based services, if eligible
- "Partial duals" receive Medicaid assistance with Medicare premiums and full or partial assistance with Medicare deductibles and other cost-sharing requirements through Medicare Savings Programs, but do not receive other Medicaid-covered services

Dually eligible beneficiaries receive Medicare (Part A/Part B) services through a traditional fee-for-service (FFS) or managed care model and separately receive Medicaid services through a FFS or managed care model. Enrollment in Medicare managed care through a Medicare Advantage (or Medicare Part C) plan is voluntary whereas states can require dually eligible beneficiaries to enroll in Medicaid managed care in certain cases. Dually eligible beneficiaries may receive integrated Medicare services via a special needs plan (or "SNP"), a type of Medicare Advantage plan that limits enrollment to specific subgroups of Medicare beneficiaries.[7] Also, eligible beneficiaries may receive coverage of prescribed medications through Medicare Part D prescription drug plans. These multiple care delivery and financing options add an additional layer of complexity for individuals covered under both Medicare and Medicaid and their providers, making it challenging for federal and state policymakers to develop plausible, effective strategies that promote high quality, seamless, and cost-effective care.

For many Medicare-Medicaid enrollees, spending is disproportionate to enrollment. Although dually eligible beneficiaries represent approximately 20 percent of the Medicare population and 15 percent of the Medicaid population nationwide, their care expenditures account for 31 percent and 39 percent of each program's spending, respectively (Figure 1).[8,9,10] In 2008, national Medicaid spending for dually eligible beneficiaries totaled $129 billion (Appendix C), and Medicare expenditures for dually eligible beneficiaries totaled

**Figure 1**

**Dually Eligible Beneficiaries Account for a Disproportionate Share of Medicare and Medicaid Expenditures**




Source: Kaiser Family Foundation analysis of the CMS Medicare Current Beneficiary Survey Cost and Use File, 2008 and Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 and Form CMS-64, 2012.

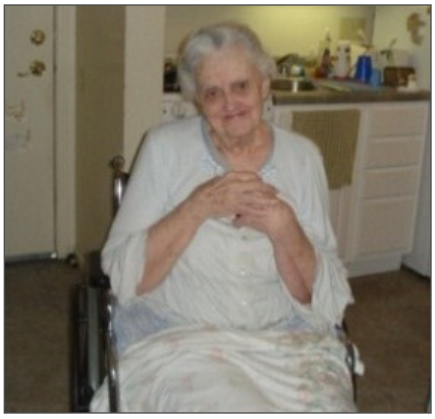
$132 billion. Average Medicare per capita spending was $14,169 (versus $7,933 for all other beneficiaries),[11] and average Medicaid per capita spending for full duals totaled $16,087 (versus $3,984 for Medicaid-only beneficiaries).[12] Of the total Medicaid expenditures for dually eligible beneficiaries for 2008, 69 percent was for long-term care, 16 percent was for Medicare acute care cost-sharing, nine percent was for Medicare premium assistance, five percent was for acute care not covered by Medicare, and one percent was for prescription drugs (Appendix C).[13] As is the case for total health care spending in the United States, spending for dually eligible beneficiaries is skewed toward those with greater health care needs and higher service utilization.

# Beneficiary Profiles

# WANDA, AGE 78

## TULSA, OKLAHOMA

**Thriving in her senior living community, Wanda feels that she is able access a primary care provider and, with support, manage her own care needs.**



Wanda was raised in California during the Great Depression and later moved with her family to Oklahoma where she helped run the family farm. Wanda has always loved animals, and in the years before her retirement, she worked at an animal sanctuary. Wanda worked past age 65, but she eventually had to retire when she needed surgery for her hip. Wanda has several health issues, including degenerative joint disease in her lower back, a replaced hip, and poor circulation in her lower legs. Wanda takes medication for her thyroid and blood pressure.

*"Anything I don't understand in my mail – I will call [my case manager] up and say 'What does this mean? Interpret it into plain English' and she does."*

*~ Wanda, age 78*

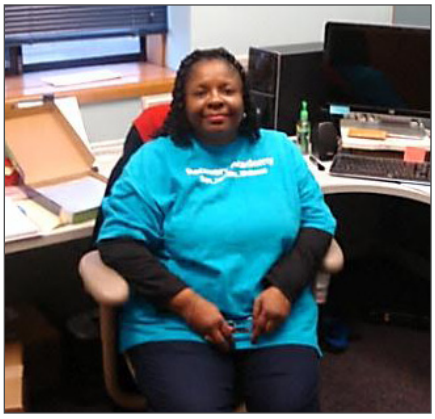
Wanda currently resides in a senior living community where she has been for the past four years. She describes herself as the "life of the party," and she has a great attitude toward life. Wanda is happy with her apartment and says that she feels like she is living in a real "community" where people look out for one another. She is very grateful to be out of the nursing home where she lived for nearly two years after her hip surgery. Wanda feels she did not get good medical care in the nursing home, that her medications were mismanaged, and that the nurses were too overworked to give residents the care they needed.

Wanda remembers enrolling in both Medicare and Medicaid several years ago after she realized she needed hip surgery. Wanda has traditional Medicare, and is also covered under a Medicare Part D prescription drug plan. Wanda's Medicaid coverage includes state plan and waiver services as well as financial assistance with Medicare premiums and cost-sharing. Before becoming a dually eligible beneficiary, Wanda was unable to afford regular doctor visits because she could not cover Medicare coinsurance requirements. She had to rely on a free clinic for her medical services and prescriptions (before Medicare Part D). Wanda now has a regular doctor who she likes very much, and sees other specialists. She also sees a podiatrist. Wanda has a case manager who helps arrange for her to get the supportive services she needs to stay at home, including an in-home aide who comes four times per week, home-delivered groceries, and transportation services to and from her doctor appointments. Wanda trusts and depends on her case manager to help make arrangements for the services she needs and to make sense of the paperwork from Medicare and Medicaid, which Wanda finds confusing.

Wanda feels like she is doing a good job of managing her health care with the in-home services she receives. She is happy that Medicaid has made it possible for her to be living on her own and not in a nursing home.

# SHARON, AGE 55
## GRAND RAPIDS, MICHIGAN

**Sharon's depression was undiagnosed prior to her enrolling in a Medicare Advantage plan. Managing her care on her own, Sharon has difficulty locating providers who accept her insurance.**



*"I think I need an advocate ... to talk to my doctor and let him know what's going on with me."*

*~ Sharon, age 55*

Sharon was diagnosed with scoliosis at age 15 and has two steel rods along her spine. This has caused Sharon to experience a lot of pain in her hips, making it difficult for her to walk or stand for long periods of time. She also suffers from depression and faces challenges with diabetes, high blood pressure, and high cholesterol. Sharon only recently enrolled in Medicare, but has had Medicaid for more than 30 years. Sharon is enrolled in a Medicare Advantage plan, and she also has a Medicare Part D prescription drug plan. Her Medicaid coverage is FFS. Sharon is generally pleased with her Medicare Advantage plan and the care she receives. She likes the fact that staff from the plan regularly check in with her.

Sharon gets emotional support from her family, but is on her own to manage her day-to-day life and health care needs. She has found it difficult to find and keep jobs due to her disabilities and health conditions. Sharon has four children and struggles financially because of her inability to work steadily. Currently, she works 17 hours per week at a mental health clinic where she also receives services.

Sharon is grateful that her Medicare Advantage plan referred her to a mental health clinic to be screened for depression. Prior to the screening, Sharon's depression was undiagnosed. She now sees a counselor at this clinic on a regular basis and takes medication to help manage her depression. Sharon says her depression is still "bad" but that it has improved significantly since she began receiving counseling services.

When Sharon first enrolled in her Medicare Advantage plan, she was surprised to learn that her plan would not cover her current primary care physician, and as a result, that she would have to find a new doctor. Sharon misses the bond she shared with her former doctor, and she explains that she and her new doctor are not on the same page when it comes treating and managing her hip pain. Sharon says that she feels like she needs an advocate or care coordinator to help her doctors understand her situation.

Since becoming a dually eligible beneficiary and enrolling in a Medicare Advantage plan, Sharon's main challenge has been finding specialists and dentists who will accept her coverage (especially Medicaid). She believes there are just not enough providers who accept Medicare and Medicaid in her area.

# EDWIN, AGE 69

## MATTAPAN, MASSACHUSETTS

**For Edwin, his Medicare and Medicaid coverage helps him access the providers he needs to help manage his health conditions, but, without steady employment, co-pays for his medications are often unaffordable.**

*"My doctors all communicate about my care. I feel like they are all working together and know what's what."*

*~ Edwin, age 69*

As a young adult, Edwin worked on the sugar cane fields in his native Jamaica. Edwin has lived in the Boston area since 1970, far from his children and grandchildren who still live in Jamaica. His only family member nearby is his brother. Edwin has lived with his brother for a long time, but his housing will soon be in flux as he will be moving out and is not sure where he will stay. Edwin hopes he will be able to find some housing assistance and that his friends will help him until he can find his own place. Edwin's primary sources of income are his Social Security benefits. Prior to the onset of his disabilities, Edwin had worked his entire life and finds it difficult to make ends meet without steady employment.

Edwin is not sure when he became eligible for Medicaid coverage; he believes it was around the time he lost his job years ago. He qualified for Medicare as a result of his disability status and work history. He is enrolled in a Medicare Advantage SNP, a fully integrated HMO that provides both Medicare and Medicaid benefits. Edwin is also enrolled in a Medicare Part D prescription drug plan.

Edwin's deteriorating health poses a significant challenge to carrying out his daily routines. Edwin, who takes many prescription medications, has asthma, stomach problems, multiple myeloma, and prostate cancer; he is currently undergoing radiation treatment for his prostate cancer. Recently, he also had several infections, including one that may have been caused by some of his cancer medications. One bad ear infection a few months ago resulted in some hearing loss. Edwin relies on his primary care physician's referrals for regular visits to specialists who assist in managing all of his health conditions.

Edwin sometimes finds it difficult to pay the co-payments for his prescription drugs. Edwin's Medicare Part D plan makes his drugs more affordable, but he is still responsible for some co-payments. Edwin recently learned that his Medicare drug plan will no longer cover some of his medications, and Edwin wonders how he will come up with the money for these drugs.

Edwin says he is doing "pretty well" due largely to coverage under Medicare and Medicaid and his own resourcefulness. Frequently, Edwin has turned to a local legal services organization when he needs help understanding his health care benefits or paperwork. Edwin also has a social worker he checks in with every six months. Although Edwin says he does not fully understand how Medicare and Medicaid work for him, he is grateful that these programs help him access the health care services he needs.

# BILL, AGE 71
## TAMARAC, FLORIDA

**The physical therapy Bill receives in the nursing home is essential to his recovery. Facing many serious health issues, he is concerned about potential cuts to his benefits.**

Originally from Brooklyn, New York, Bill now lives in a nursing home in Florida. He is an avid reader and bridge player, and has a Bachelor's degree in business administration from New York University. Bill grew up with severe hearing loss and has battled depression for much of his life. He started receiving Medicare in his 50s after he began receiving SSDI benefits based on his work history and disability status. He was enrolled in Medicaid following a hospitalization after a suicide attempt around the same time. He receives all of his Medicare benefits through a Medicare Advantage SNP, and he especially likes that the SNP offers transportation so he can get to his medical appointments (transportation is an expanded benefit that Medicare Advantage plans can offer). Bill also has a Medicare Part D prescription drug plan, and he has Medicaid FFS coverage.

*"[At the nursing home] they gave me physical therapy, walked me down the hall to the other end to the other nurse and then back. So I learned how to walk, but I could not get off the bed. Eventually I did it!"*

*~ Bill, age 71*

Bill has a number of health conditions. In addition to depression, Bill has diabetes and heart disease. Bill is also recovering from colon cancer. He sees at least five different doctors and a social worker therapist and takes about 10 to 15 prescriptions daily.

Bill moved into a nursing home in May 2011 after a difficult series of events following surgery for his colon cancer. With no one coordinating his care or transitions after surgery, Bill moved among various rehabilitation facilities. Bill feels he did not receive adequate care in the rehabilitation facilities, and at times was so weak and confused that he did not know where he was or what was going on. During one of his transitions between facilities, his dentures were lost; he can only eat soft foods now because neither Medicare nor Medicaid will pay for replacements. Frustrated with his experiences in the rehabilitation facilities, he checked himself out and returned home. Still very weak from surgery and home alone, he had a bad fall which led to another round of hospitalization and facility stays.

Now in a nursing home where he gets the care and attention that he needs, Bill is pretty happy. He explains that he could barely stand, lift anything, or even get out of bed when he first arrived at this facility. Upon his arrival at the nursing home, he began physical therapy. He regained strength back in his arms (as shown in his profile picture) and can now get out of bed and walk short distances.

Having Medicare and Medicaid to pay for his doctor visits, prescriptions, physical therapy, and nursing home care has been a saving grace for Bill. He has a very modest income and no family nearby. His closest living relatives are cousins who live abroad, and there is no one to look after him or help him. This is not lost on Bill who repeatedly expresses concern about potential cuts in the programs he says he depends on for much needed care.

# EDGAR, AGE 67
## LOS ANGELES, CALIFORNIA

**Edgar believes the ability to choose his own doctors is essential to his well-being. Finding specialists who accept Medicaid is difficult at times, and Medicare co-payments are burdensome.**

Edgar has Bachelor's and Master's degrees in economics. A father of four adult children, Edgar has lived in California for almost 40 years. He currently lives at home with his 71-year-old sister and 97-year-old mother. Edgar retired at age 62, and enrolled in both Medicare and Medicaid at about the same time at age 65. Edgar is currently enrolled in traditional Medicare. He also has a Medicare Part D prescription drug plan. Edgar's Medicaid coverage is also FFS.

Edgar has low iron levels and a back condition; he takes supplements and pain medications, respectively, for these conditions. He is at-risk for diabetes, and his doctors monitor him regularly for high blood pressure. While Edgar's Medicare Part D prescription drug coverage makes his medications much more affordable, he has a small co-payment.

*"After my brother died of a heart attack, I looked at my health differently. I have to make sure my body's not running out of gasoline. With Medicare, I can regularly go to the doctors I want for my preventive tests and exams."*

*~ Edgar, age 67*

Edgar says that he became more concerned about his health after his brother died suddenly of a heart attack. Edgar says his brother's death made him realize the importance of regular check-ups and undergoing necessary tests in maintaining his health. Edgar believes it is very important to have a good relationship with his primary care physician. Unfortunately, his primary care physician of 30 years recently died, and Edgar felt he was left "in limbo" without a doctor he could trust with his care.

Edgar's new primary care physician takes both Medicare and Medicaid, but not all of his specialists accept both types of coverage. When Edgar recently went to a cardiologist who did not accept Medicaid for a test, Edgar was forced to forgo the test because he had no way to cover the 20 percent Medicare coinsurance charge; he is doing his best now to save money for the test. Edgar notes that it is difficult to find specialists who will accept his Medicaid coverage, so he frequently goes to providers who accept Medicare and tries to cover the co-pays for his doctor visits. These co-payments present a large financial burden to Edgar, but nevertheless, he is grateful that Medicare gives him the freedom to choose his own doctors and specialists.

# DON, AGE 41
## OWOSSO, MICHIGAN

**Don is able to self-direct his Medicaid in-home services, and with the help of his sister and trusted caregivers, he is able to remain in the community and live independently.**

Don was born with developmental disabilities. According to his sister, Mary, who is also his legal guardian, Don "has been in special education his whole life." Don is one of six children; he has four brothers, and Mary is his only sister. Explaining why she volunteered to be Don's guardian, Mary says "I just have a passion for helping. I just get right in there." Don lived in a series of group homes when he was in his 20s after his mother became too ill to care for him. Mary says that these homes did not work well for Don, so he moved into his own apartment 10 years ago. Mary is a disabilities advocate, and she has been instrumental in helping Don access the services and resources that enable him to live independently in the community.

Don qualified for SSDI benefits at age 15 following the death of his mother and was enrolled in Medicaid in his late teens or early 20s. Due to an oversight, Don was not enrolled in Medicare until six or seven years ago; he is eligible for Medicare as a result of his disability status and his mother's work history. With Mary's help, Don qualified for self-directed services, which gives him the freedom to allocate his Medicaid dollars for approved services. Don uses most of these dollars to hire his own caregivers. Having caregivers who he trusts greatly improves Don's quality of life.

Don has a primary care physician who oversees his care. He also sees a psychiatrist. Don takes three medications regularly to stabilize his moods and to manage his obsessive-compulsive disorder. Don cannot find a local dentist who will accept Medicaid, so he sees a dentist who is one hour away from his home.

Mary has had to put together a complex array of services and supports over the years to enable Don to live independently. She sees changes to Medicaid or Medicare services, such as a recent push to install a personal emergency response system in Don's home and cut back on his caregiving service, as potentially harmful to Don's care arrangements and health. Mary fears more changes like this will be proposed given the current economic climate environment. She says that Don's quality of life could be negatively impacted by any changes that would reduce the amount and type of care that Don receives.

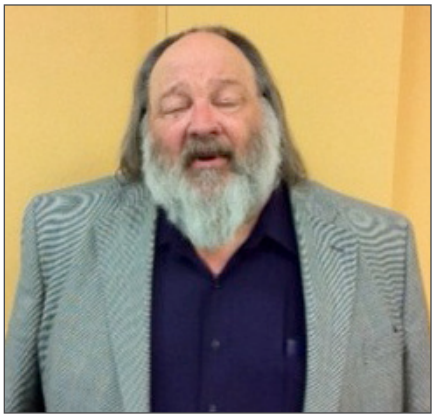
*Don "has lived in many, many group homes. He wasn't very happy. There are a lot of people who have been in their apartments for years that have come out of institutions and done really, really well." [It is most important for him to work towards] "independence and being safe," but "keeping the level of support he needs costs a lot."*

*~ Mary, Don's Sister and Guardian*

# WALTER, AGE 65

## LOS ANGELES, CALIFORNIA

**Having Medicare and Medicaid is crucial for helping Walter manage his numerous health issues. He believes an ombudsman could help him and other beneficiaries better navigate the programs.**



Walter lives alone in a studio apartment in Los Angeles. He is a new dually eligible beneficiary, having enrolled in Medicare about six months ago and in California's Medicaid Program, about three or four months ago. Prior to enrolling in Medicare and Medicaid, Walter was uninsured for several years. After going to a health clinic that would not accept his Medicare coverage, Walter applied for Medicaid. He later enrolled in a Medicare Advantage SNP.

Walter has a number of health issues, and is thankful to have coverage under both Medicare and Medicaid to help him get the care he needs. He takes 16 medications and four injections daily. He is largely on his own when it comes to managing his care; he has a daughter who lives about 50 miles away, but Walter does not want to bother her for help.

Having Medicare and Medicaid has been a relief for Walter, but he finds aspects of his coverage and care to be rather frustrating. He feels the health care system and available information are overwhelming and difficult to navigate at times. He has not read the booklets sent from Medicare and Medicaid. He says they are too long and complicated. Walter has a $900 spend-down with Medicaid, but does not know what that means or how it works. Walter is frustrated that he has to spend so much time figuring out his care. He wants less complex information about his plan and services, and thinks it would be good to have an advocate or ombudsman to help beneficiaries like him navigate the system.

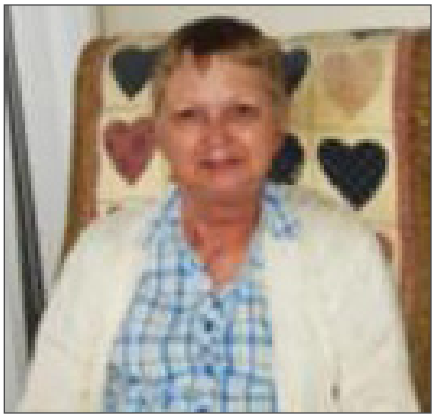
*"[Medicaid] sent me one [booklet] that thick. And Medicare sent me one [booklet] that thick. And it's like I could spend my entire day searching and making sure I was aware of all the stuff."*

*~ Walter, age 65*

Walter has difficulty accessing the physical therapy services he needs for his back problems. He found a physical therapist near his home, but his plan indicated that he should see a different physical therapist who is located two hours away by bus. Walter fought this and is ready to appeal if it does not work out as he cannot sit on a bus for a total of four hours with his bad back. He thinks factors like mobility limitations should be considered when assigning beneficiaries to providers.

# KELLI, AGE 64
## TULSA, OKLAHOMA

**Living independently in the community, Kelli relies on her home health aides and Medicaid caseworker to assist her in completing personal care and health-related tasks.**



Kelli lives with her pets in her own apartment. Prior to a work-related back injury in 1992, she worked as a charge nurse. Since then, Kelli has lived with depression and other mental health issues. In 1996, she was diagnosed with breast cancer and had a double mastectomy followed by reconstructive surgery. Kelli also has chronic obstructive pulmonary disease and insomnia, and recently she started having transient ischemic attacks.

The lawyer handling her worker's compensation case from her 1992 injury helped Kelli apply for SSDI, which qualified her for Medicare coverage after a 24-month waiting period. Medicare helped pay for her breast cancer treatment, but Kelli struggled to pay the 20 percent coinsurance Medicare requires until she qualified for Medicaid, which now covers these costs. Kelli does not remember exactly how she got enrolled in Medicaid, but she thinks a doctor or someone else involved in her care recommended that she apply. Kelli is currently enrolled in traditional Medicare and a Medicare Part D prescription drug plan. Her Medicaid coverage includes state plan services and additional home and community-based waiver services.

*"[Medicare Part D] has made a big difference because some of the medicine that I still take is pretty expensive and I just couldn't afford to get it. I would have to live in pain and misery."*

*~ Kelli, age 64*

The services and supports Kelli receives through the Medicare and Medicaid programs help keep Kelli in control of her life while living independently in the community. Kelli does not have any family or friends that she can turn to for help and support. Kelli says that her mental illness makes it difficult for her to make friends and trust people. Kelli has bonded with her home health aides who help out around her apartment with cleaning, laundry, grocery shopping, and cooking as well as her daily grooming routine, particularly showering. Kelli established a close relationship with her Medicaid caseworker. Having her caseworker's assistance has made such a positive difference for Kelli because, as she says, in regard to managing her care, "It can be very complicated because my mind just doesn't function like it used to anymore."

It took Kelli years to find doctors to treat all of her conditions who would also accept both Medicare and Medicaid. As a dually eligible beneficiary, Kelli now gets regular treatment for her depression and has experienced significant improvement in her mental health. Neither Medicare nor Oklahoma's Medicaid program offers dentures as a benefit; Kelli desperately wishes she could get a new pair of dentures because her current set does not fit and gives her sores, making it difficult to eat. Although Kelli says there is room for improvement, her Medicare Part D plan has made her many medications affordable.

# PHYLLIS, AGE 48
## QUINCY, MASSACHUSETTS

**As a result of her health conditions, Phyllis is unable to work; without Medicare and Medicaid she would not able to afford her prescriptions or get to her doctor appointments.**

Phyllis is struggling to make ends meet. She lives on SSDI and inconsistent child support payments, but this is frequently not enough to cover all of her expenses. She is barely able to afford her apartment, even with her subsidized housing benefit. Unable to cover all of her grocery expenses, Phyllis often has to turn to food banks to feed herself and her teenage son.

Phyllis has degenerative disc disease that results in extreme back pain. She also has asthma, chronic sinusitis, depression, and anxiety. She takes many prescription drugs on a daily basis. Phyllis says that it has been challenging to find the right medication regimen needed to manage with her many conditions, but she is working with her doctor to find the right prescriptions. Still, she often worries about whether the medication is covered by her Medicare Part D prescription drug plan. In addition to her drug plan, Phyllis is covered under traditional Medicare. She is also covered under Medicaid FFS.

Phyllis' health problems and pain make day-to-day activities difficult and have made it impossible for her to continue working. Phyllis finds it hard to keep up her apartment or complete simple tasks like carrying groceries upstairs due to her severe back problems. As for as managing her health-related tasks, Phyllis anticipates needing more assistance in the near future as her health deteriorates. She is interested in learning if there are services she could access that could provide in-home assistance.

Phyllis is grateful for the health care services she gets through Medicare and Medicaid. She would not have been able to afford health coverage on her own. Phyllis is able to get the care she needs, but she says that she could use more help when it comes to services like transportation and in-home assistance that are often covered by Medicaid but not Medicare. Phyllis often relies on Medicaid transportation services to get to doctor appointments; she has some frustration with the service as she frequently has to wait for long periods of time for a ride.

*"I've heard of cutbacks [to Medicare and Medicaid] down the line somewhere. If I have to pay for my prescriptions or even doctor visits [without assistance] there is no way I'm going to be able to do that. I can barely put food on my table. It is going to be impossible [to get the health care I need]."*

*~ Phyllis, age 48*

# JOE, AGE 66

## OKLAHOMA CITY, OKLAHOMA

**Joe faces challenges in meeting his basic needs. While Medicare and Medicaid coverage provides access to medical and support services, Joe still has difficulty affording his numerous prescription medications.**

Joe was born and raised in Texas, but moved to Oklahoma at age 53 to be closer to his adult children. He suffered a major heart attack about 20 years ago, after which he became eligible for SSDI benefits based on his work history and disability status. After receiving SSDI for 24 months, he was able to enroll in Medicare; he enrolled in Medicaid in 2005. Joe has traditional Medicare, and he is also covered under a Medicare Part D prescription drug plan. Joe's Medicaid coverage includes state plan and home and community-based waiver services.

*"I monitor all of the [Medicaid] services that we put in place ... making sure that all services are being implemented and he has the help that he needs at home to stay at home safely and independently."*

*~ Linda, Joe's Case Manager*

Joe is having a difficult time making ends meet. His food stamp benefits have been cut, and he often resorts to food banks for groceries. Joe says he would like to be able to eat fresh foods, but canned food is all that he can afford.

In addition to financial difficulties, Joe has several major health issues to manage. Joe was on kidney dialysis until he received a transplant last year. Due to his kidney transplant, diabetes, and other health conditions, Joe takes over 20 prescription medications every day, most of which are covered under his Medicare Part D plan. Medicaid covers transportation services to his medical appointments. He has a visiting nurse come to his home twice a week to check his blood pressure and administer medications and a personal care aide who comes three times a week to help with household chores. Joe's home and community-based services waiver case manager monitors his Medicaid services to ensure that he can live safely and independently at home. Joe feels that it would be beneficial to have someone to help coordinate all of his care. In the past, he has missed doctor appointments because he could not keep track of them all.

Joe has experienced other challenges with his health care coverage. For example, at times he has gone without medication that his doctor prescribed because the drug was not covered by his Medicare Part D plan and he could not afford to pay for it out-of-pocket. At other times, he has set up payment plans to be able to afford drugs that are not covered by Medicare. In addition, neither Medicare nor Medicaid covers routine dental care or dentures. Although Medicaid did cover the surgery Joe needed to have all of his teeth pulled, he had to pay for dentures himself.

Despite the difficulties Joe has faced with his health care, dual coverage under Medicare and Medicaid has been a real safety net for him. Without this coverage, Joe would not be able to afford to see his specialists or get his prescription medications. With his health conditions, and especially given his status as a transplant recipient, this access to care is vital to his survival.

# ROBERT, AGE 41

## THREE RIVERS, MICHIGAN

**Without Medicare and Medicaid, Robert would not be able to afford his doctor visits. Robert believes a care coordinator would help him better understand his coverage and access a specialist.**

Robert lives with his fiancée and children. He is currently taking classes on self-advocacy for people with mental and physical disabilities. It takes him about an hour to get to these classes, but he feels it is important to make the effort, especially since there are no such classes closer to home. Once these classes end, Robert plans to continue with more classes to become a peer-support specialist.

Robert deals with a number of health conditions, including Crohn's disease, depression, bipolar disorder, and blindness in one eye. Robert is enrolled in a Medicare Advantage plan and a Medicare Part D prescription drug plan. He also has coverage through Medicaid FFS. Robert greatly values the services and supports he receives as a dually eligible beneficiary.

New to the area, Robert does not have many ties to his community and does not feel there is anyone nearby – apart from his family – who he can turn to for information or assistance when he needs help.

> *"When I go in the hospital, they ask me 'What kind of insurance do you have?' and I tell them Medicaid and Medicare. If you don't have any insurance ... and you try to get care, it is hard."*
>
> *~ Robert, age 41*

His fiancée is studying to be a nurse and she manages a lot of Robert's care. She helps him stay on track with his appointments and drives him various places if he is not well enough to drive on his own. When seeking information on treatments or new resources, Robert first turns to family members for advice. Although he sometimes feels unsure about how to navigate the programs, Robert feels that Medicare and Medicaid "have his back." He says he would not be able to afford to see a doctor without this coverage. He is also appreciative that Medicaid helps pay for the psychologist he visits twice a month for counseling.

Accessing care and program resources can be challenging for Robert. Prior to moving to Three Rivers, Robert had been receiving treatment for Crohn's disease, but he has not been able to find a new gastroenterologist nearby who will accept Medicare and Medicaid. As a result, Robert has gone without this much needed care and treatment.

Robert would like help from a care coordinator who could help connect him to resources, schedule appointments, and communicate with doctors. He explains, "If there was someone who had more insight or more information ... that could help us ... or different avenues that we could take, yes. That would be of help."

# BONNIE, AGE 65
## TULSA, OKLAHOMA

**The personal care services Bonnie receives at an adult day center allow her to live in the community, but she has not been able to access dental services despite coverage under both Medicare and Medicaid.**

*"I don't always notice if I have rashes and stuff ... this last one I didn't know and of course [the aide] found it because she was in [the shower] with me. She could see."*

*~ Bonnie, age 65*

Bonnie lives at home with her adult son. She is a fairly independent woman and very proud of it. She worked as long as her health would permit, providing transportation and appointment scheduling assistance for clients at a mental health services agency. In December 2010, she had to stop working because of her many health problems. It was then that she became eligible for SSDI benefits based on her work history and medical impairments and became a Medicare beneficiary after the required 24-month waiting period. Even before she stopped working, Bonnie was eligible for Medicaid through a buy-in program, and her Medicaid coverage continued after she became eligible for SSDI.

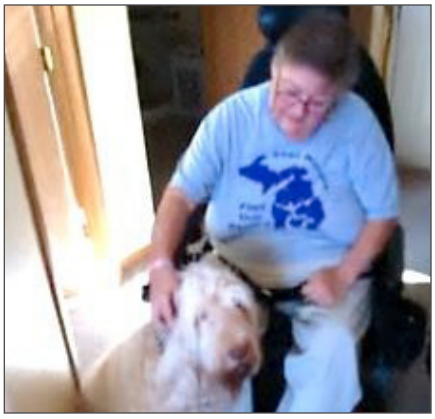
Bonnie lives with a number of health conditions, including arthritis, neuropathy, atrial fibrillation, chronic obstructive pulmonary disease, gout, and high blood pressure. She sees six different doctors and has been hospitalized four times in the last five years for conditions including pneumonia, atrial fibrillation, and a bleeding ulcer. Her most recent inpatient stays resulted from breaking her left femur. After the initial surgery to repair her leg, she transitioned to a nursing home where she lived for four months. She was very pleased with the physical therapy she received in the nursing home, but unhappy with most other aspects of living in an institution. Because she had such a bad experience in the nursing home, Bonnie insisted on returning to her own home after her second leg surgery in June 2011.

While Bonnie values her independence, she is also thankful to have assistance with her care. During the week she spends three to five days at an adult day center, a Medicaid covered benefit that provides essential services that help her to remain in the community. At the center, she receives some of her meals and assistance with bathing, which is important since she broke her ribs in 2007 after falling in the bathtub. The aide who helps Bonnie shower discovered a rash that turned out to be an adverse reaction to a medication, which was serious enough to require an inpatient hospital stay. Bonnie also gets help from someone who answers her questions about insurance, such as the most suitable Medicare Part D prescription drug plan. She considers her social worker at the adult day center to be a friend and someone who is always there when needed.

Bonnie wears dentures that she was able to purchase herself when she was still working, but she has not been able to afford to see a dentist and sometimes gets painful sores in her mouth. For now, Bonnie is able to manage her health and household on her own, with the necessary services and supports that Medicare and Medicaid cover, but she hopes there are services available to help her stay in her home, if there ever comes a day when she feels like she needs more help.

# RHON, AGE OVER 65
## EAST LANSING, MICHIGAN

**Navigating both the Medicare and Medicaid programs is a challenge at times, but, despite her health issues, Rhon continues to remain in the community supported by Medicare and Medicaid services.**



Rhon retired in 1998. Her only source of income is Social Security. She currently lives in an apartment in a senior housing community with her dog and two parrots. Previously, she lived in her own house in a rural area, but she moved out because she lost her house due to foreclosure.

Born with cerebral palsy, Rhon has developed a number of serious health issues over the years including diabetes, arthritis, liver failure, and end-stage renal disease. In 2000, she was diagnosed with carcinoid cancer. Before her cancer diagnosis, Rhon was able to walk with the help of service dogs, but since then, she has relied on a motorized wheelchair. On a daily basis, Rhon receives multiple injections to treat her diabetes and cancer, and she also takes numerous medications to manage her other health conditions.

*[Nurses] would intercede and get through to doctors for me. I felt like I had someone watching my back. And it just took a lot of stress out."*

*~ Rhon, over age 65*

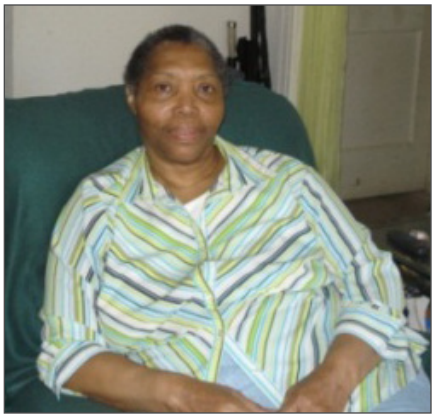
Before gaining Medicare coverage, Rhon had employer-sponsored health insurance. A year after her retirement, she began receiving SSDI benefits, and two years later qualified for Medicare. Even with Medicare, Rhon had to spend her entire retirement savings to pay for services not covered by Medicare. Once her savings were depleted, Rhon became eligible for Medicaid. Rhon is currently enrolled in traditional Medicare and a Medicare Part D prescription drug plan and she is self-directing her Medicaid home and community-based waiver services.

Rhon visits many health care providers on a regular basis, and all of her doctors communicate directly with her about her care. She says it is a "full-time job" keeping all of her doctors informed and trying to manage her health-related tasks. Rhon receives assistance throughout the week from home health aides, allowing her to continue to live in the community instead of a long-term care facility.

Rhon has faced the most frustration with her Medicare Part D plan and with getting the durable medical equipment that she needs. Although Medicare Part D makes her medications more affordable, Rhon is constantly stressed about seeking prior authorizations, filling out paperwork, and diligently monitoring her prescription drugs. Rhon believes that people with severe disabilities can easily be isolated in the health care system. Despite the challenges brought on by her long-term disability and chronic conditions, she is a self-advocate in managing her health needs. She says she does not know how she would be able to survive without the coverage she receives from Medicare and Medicaid.

# VIRGINIA, AGE 72
## OKLAHOMA CITY, OKLAHOMA

**Tailored Medicare and Medicaid in-home care and supportive services allow Virginia to better manage daily care and household tasks and connect with her care providers.**



Virginia lives alone in a single-family home and finds it challenging to maintain her daily routine. Virginia's multiple surgeries for a hernia make it difficult for her to go up and down stairs, do laundry, and clean her house. In April 2011, Virginia was diagnosed with uterine cancer; she began treatment and had a full hysterectomy. At a recent check up, Virginia's doctors told her there were no signs of cancer. At the beginning of her treatment, Virginia had Medicare, for which she became eligible at age 65. Unable to keep up with the bills for the Medicare cost-sharing portion of her cancer treatment, Virginia had to spend the small retirement fund she saved while working as a school secretary. Eventually, her health care expenses depleted her savings, and she enrolled in Medicaid. Virginia is covered under traditional Medicare, a Medicare Part D prescription drug plan, and Medicaid. In Oklahoma, Medicaid covers state plan and home and community-based waiver services.

*"The nurse that comes is under Medicare. The person that comes out to help me [with household chores and health care-related tasks] is under Medicaid. [It was] only after I had cancer treatment that I started getting help."*

*~ Virginia, age 72*

In-home health services continue to be very important for Virginia's care and daily life. Prior to her cancer diagnosis, Virginia received some home health services covered by Medicare. When she needed more assistance after her cancer treatments, Virginia was able to increase the amount of help she received, including visits from a nurse who came to her home every day to administer post-surgery shots for one month. Now that Virginia is doing better, the nurse visits her less often – usually once a week. Medicaid supplements Medicare in providing her with personal care aides who go to her home three times a week.

Virginia is happy that programs like Medicare and Medicaid exist and that she is able to get assistance. Virginia has recently had a few bumps in her care. For example, her personal care aide was recently changed, and she is not satisfied the new aide. Virginia says her current personal care aide has different ideas about the type of assistance she is supposed to provide around the house. Thanks to Medicaid, Virginia has a case manager who is helping her sort through the situation. The case manager is working with Virginia and the new aide to get them on the same page and make sure they share an understanding around expectations and responsibilities. Despite these miscommunications, Virginia expresses that she could not continue to live independently without Medicaid home and community-based services.

# CONCLUSION

The profiles of people eligible for both Medicare and Medicaid illustrate the diverse needs of the dually eligible population and their wide array of medical conditions, personal circumstances, and health care needs. Yet the 14 personal stories presented here suggest that dually eligible beneficiaries' experiences have some common themes. These beneficiaries rely on Medicare and Medicaid coverage for access to necessary medical and non-medical acute and long-term care services and supports without which care would be unaffordable. Without Medicaid coverage as a supplement to Medicare, low-income Medicare beneficiaries with limited assets could face unaffordable out-of-pocket medical and long-term care costs. Navigating these two separate, yet complementary, programs on a day-to-day basis to obtain care, access providers, and achieve wellness poses several challenges for some, particularly those with the need for intensive services under both programs. Coordinating care, locating service providers, deciphering program materials, and managing the cost and administration of medications as a Medicare Part D prescription drug plan enrollee are among the challenges described by several beneficiaries included in this report.

While these profiles do not include an analysis of beneficiaries' cost and access to care, those featured and other beneficiaries with significant health care-related costs could benefit from efforts to integrate primary care, acute care, behavioral health, and long-term care services and align financing across the Medicare and Medicaid programs. Federal and state governments are engaged in an effort to address these concerns. Based on new authority in the Affordable Care Act, Centers for Medicare & Medicaid Services (CMS) is testing capitated and managed FFS financial alignment demonstration models, which seek to improve care and control costs for dually eligible beneficiaries. As of June 2013, of the 26 states that submitted financial alignment demonstration proposals to CMS, proposals from six states (California, Illinois, Massachusetts, Ohio, Virginia, and Washington) were approved by CMS, and proposals from 16 states remain pending.[13]

Looking forward, it will be important to monitor the progress of states participating in the financial alignment demonstrations and the extent to which adequate protections are in place to assure that dually eligible beneficiaries have access to high quality, coordinated services and supports. As more states move toward managed care delivery systems, assessing efforts to educate dually eligible beneficiaries and providers about plans, provider networks, and transition supports (e.g. enrollment brokers, options counseling), evaluating access to medical and long-term services and supports, and assuring adequate oversight will be essential. While the demonstrations offer the potential opportunity to improve care coordination, lower program costs, and achieve outcomes, such as the increased use of HCBS instead of institutional care and reduced hospital admissions, the high care needs of many dually eligible beneficiaries increases their vulnerability when care delivery systems are changed at the same time. Beyond these demonstration projects, policymakers will want to explore additional policy options that could provide improvements in care coordination as well as assess how other changes in Medicare and Medicaid policy would affect dually eligible beneficiaries.

**This brief was prepared by Michael Perry and Naomi Mulligan with PerryUndem Research and Communication as well as Erica Reaves, Loren Saulsberry, Gretchen Jacobson, and MaryBeth Musumeci with the Kaiser Family Foundation. The authors extend their deep appreciation to the individuals who helped coordinate the interviews and to the dually eligible beneficiaries who so generously shared their time, effort, and personal stories.**

# Endnotes

[1] Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FFY 2009 MSIS and CMS-64 reports, 2012. 2008 MSIS was used for Pennsylvania, Utah, and Wisconsin, because 2009 data was unavailable.

[2] *See* Kaiser Commission on Medicaid and the Uninsured, "Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending," July 2010, available at: http://www.kff.org/health-reform/report/chronic-disease-and-co-morbidity-among-dual/.

[3] *See* Kaiser Family Foundation, "Medicare's Role for Dual-Eligible Beneficiaries," April 2012, available at: http://www.kff.org/medicare/issue-brief/medicares-role-for-dual-eligible-beneficiaries/ and Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Role for Dual Eligible Beneficiaries," April 2012, available at: http://www.kff.org/medicaid/issue-brief/medicaids-role-for-dual-eligible-beneficiaries/.

[4] People with end-stage renal disease must have worked long enough to qualify for Medicare Part A (or be the spouse or dependent child of someone who qualifies for Part A) and be on regular dialysis or require a transplant in order to be eligible for Medicare before the age of 65. See Kaiser Family Foundation, "Medicare At A Glance," November 2012, available at: http://www.kff.org/medicare/fact-sheet/medicare-at-a-glance-fact-sheet/.

[5] *See* Kaiser Commission on Medicaid and the Uninsured, "Federal Core Requirements and State Options in Medicaid: Current Policies and Key Issues," April 2011, available at: http://www.kff.org/health-reform/fact-sheet/federal-core-requirements-and-state-options-in/; and Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program At A Glance," March 2013, available at: http://www.kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/.

[6] Ibid.

[7] *See* Kaiser Family Foundation's Program on Medicare Policy, "Medicare Advantage Fact Sheet," November 2012, available at: http://www.kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/.

[8] *See* Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FFY 2008 MSIS and Form CMS-64 reports, 2012.

[9] *See* Kaiser Family Foundation's Program on Medicare Policy, "Medicare's Role for Dual-Eligible Beneficiaries," April 2012, available at: http://www.kff.org/medicare/issue-brief/medicares-role-for-dual-eligible-beneficiaries/.

[10] As shown in Figure 1, the 2008 Medicare Current Beneficiary Survey (MCBS) Cost and Use File estimates that dually eligible beneficiaries account for 20 percent of the Medicare population. In Appendix B, we look at the number of dually eligible beneficiaries as a share of the total Medicare population at the state level. Because the MCBS data do not allow for state-level approximations, we compared the total number of dually eligible beneficiaries in July 2008 in the FY 2008 MSIS data file to the CMS State/County Market Penetration files. Using the latter methodology, we approximate that dually eligible beneficiaries account for 18 percent of the total Medicare population.

[11] Ibid.

[12] *See* Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Role for Dual Eligible Beneficiaries," April 2012, available at: http://www.kff.org/medicaid/issue-brief/medicaids-role-for-dual-eligible-beneficiaries/.

[13] Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FFY 2008 MSIS and Form CMS-64 reports, 2012.

# Appendices

## Appendix A: Glossary

**Coinsurance:** A beneficiary's share of the cost of a covered service, calculated as a percent of the allowed amount for the service. The remaining share of the allowed amount is paid by the health insurance company or plan. This is an example of cost-sharing.

**Co-Payment/Co-Pay:** A fixed amount a beneficiary pays for a covered service. The amount can vary by the type of covered service, and for Medicaid purposes generally must be "nominal." Certain groups of Medicaid beneficiaries are exempt from co-pays. This is an example of cost-sharing.

**Fee-for-Service (FFS):** A service delivery and payment model where health care providers are reimbursed for each service. The FFS model is utilized in both the Medicare and Medicaid programs.

**Health Maintenance Organization (HMO):** A type of managed care health insurance plan where enrollees receive most or all of their services from health care providers (often referred to as the "network") who are contracted to serve the plan's members. HMOs require that enrollees select a primary care physician (PCP) who is responsible for managing and coordinating services and supports. Enrollees are required to obtain a referral from their PCP to receive services from a specialist. Under Medicaid, such a plan is referred to as a "Managed Care Organization (MCO)."

**Managed Care:** A service delivery and financing model that utilizes provider network management and/or service utilization management with the goals of controlling costs and ensuring or improving care quality for beneficiaries. In the Medicaid program, there are two main permutations of managed care: risk-based capitated Managed Care Organizations (MCOs) and Primary Care Case Management (PCCM)/managed fee-for-service (FFS) models.

**Medicaid:** A public health insurance program for eligible low-income persons, including pregnant women, children and families, individuals with disabilities, and Medicare beneficiaries with limited resources. The Medicaid program is administered by states within broad federal rules and is financed jointly by states and the federal government. The federal government matches state Medicaid expenditures according to a match rate, known as the Federal Medical Assistance Percentage, or FMAP. Medicaid beneficiaries receive their care mostly from private providers, with two-thirds receiving all or most of their care in managed care arrangements.

**Medicaid Buy-In Program:** A type of optional Medicaid coverage group that allows certain beneficiaries, such as working-age adults with disabilities, to access or retain Medicaid coverage despite having an income that would otherwise exceed the Medicaid financial eligibility threshold. Beneficiaries pay income-based premiums to "buy into" the Medicaid program.

**Medicaid Home and Community-Based Services (HCBS) Waiver:** An option available to states under § 1915(c) of the Social Security Act to provide Medicaid long-term services and supports in home and community-based settings. Beneficiaries can receive a combination of medical services and non-medical services, including, but not limited to, adult day health services, homemaker/home health aide and personal care services, respite care, and case management services. Waiver programs also allow states to offer other approved medical and social services, such as those that may assist in diverting individuals from institutional settings (e.g. nursing homes) to community-based settings (e.g. private homes) or maintaining beneficiaries in the community.

## Appendix A: Glossary, continued

**Medicaid Spend-Down:** An optional state Medicaid coverage group in which an individual whose income exceeds the state Medicaid eligibility guidelines reduces his or her income to qualify for Medicaid assistance by deducting incurred medical expenses.

**Medicaid State Plan Benefits:** Benefits included in a State Plan ("Plan"), the official document describing the nature and scope of a state's Medicaid program without which a state would be ineligible to receive federal funding for providing Medicaid services under § 1902 of the Social Security Act. Included in the Plan are "mandatory" and "optional" services. Mandatory services include early and periodic screening, diagnosis, and treatment for children under age 21; family planning services and supplies; inpatient and outpatient hospital services; laboratory and x-ray services; nursing facility and home health care for individuals age 21 and over; physician, nurse midwife, and nurse practitioner services; rural health clinic/federally qualified health center services; tobacco cessation counseling; and transportation to medical care. Many states offer "optional" services, e.g. case management, dental services, home and community-based services, hospice, physical therapy and related services, personal care, prescription drugs (all states), private duty nursing services.

**Medicare:** A federal health insurance program created for individuals age 65 and older and individuals under age 65 with permanent disabilities, regardless of income or medical history. Nonelderly people who receive Social Security Disability Insurance (SSDI) generally become eligible for Medicare after a two-year waiting period, while those diagnosed with end-stage renal disease or amyotrophic lateral sclerosis become eligible for Medicare with no waiting period. Medicare is organized into four parts: A, B, C, and D (please see below for more information). Medicare is financed by general revenues, payroll tax contributions, and beneficiary premiums, as well as other sources.

**Medicare Part A:** Covers inpatient hospital stays, skilled nursing facility stays, home health visits (also covered under Part B), and hospice care. Part A benefits are subject to a deductible and coinsurance. Most people age 65 and older are entitled to Part A if they or their spouse are eligible for Social Security payments and have made payroll tax contributions for 10 or more years.

**Medicare Part B:** Covers physician visits, outpatient services, preventive services, and home health visits. Part B benefits are subject to a deductible, and cost-sharing generally applies for most Part B benefits. Part B is funded by general revenues and beneficiary premiums.

**Medicare Part C (Medicare Advantage):** A type of Medicare health plan offered by a private company that contracts with CMS to provide Medicare Part A and Part B benefits and often Part D prescription drug coverage (the services are not separately financed). For individuals enrolled in Medicare Advantage plans, which include Health Maintenance Organizations (HMOs), Medicare Medical Savings Account Plans, Preferred Provider Organizations (PPOs), Private Fee-for-Service Plans, and Special Needs Plans (SNPs), Medicare services are covered through the plan, not traditional Medicare.

**Medicare Part D:** A program that provides prescription drug and medication coverage for Medicare beneficiaries who are enrolled in a Medicare-approved plan that includes drug coverage, i.e. a Medicare Prescription Drug Plan or a Medicare Advantage Plan. Part D is funded by general revenues, beneficiary premiums, and state payments.

## Appendix A: Glossary, continued

**Medicare Medical Savings Account (MSA) Plan:** A Medicare Advantage plan that combines a high-deductible Medicare Advantage plan with a medical savings account. Under a Medicare MSA plan, beneficiaries have the flexibility to self-direct their care. The high-deductible portion of the plan covers health costs only after a beneficiary meets their plan's high annual deductible. A beneficiary can use funds in the medical savings account to cover health care expenses incurred before the annual deductible is met. Medicare MSA plans do not provide Medicare Part D prescription drug coverage.

**Self-Directed Services:** An alternative service delivery model for community-dwelling Medicaid beneficiaries who desire to self-manage the home and community-based services and supports they receive under a Medicaid State Plan or waiver. Beneficiaries choosing to direct their own care may be given an individual budget that they use to allocate among and pay for approved services and/or also may be given authority to select and dismiss their care providers.

**Social Security Disability Insurance (SSDI):** Administered by the federal Social Security Administration, the SSDI program pays monthly benefits to eligible individuals. An individual qualifies for SSDI benefits if she has a severe physical or mental disability that is expected to last at least 12 months or result in death; is under the age of 65; and has the required work history (40 qualifying quarters of work). A qualifying disability must result in medical and functional limitations that meet or equal a list of criteria established by the Social Security Administration or must prevent a beneficiary from engaging in her past relevant work and in any other substantial gainful activity that exists in the national economy. This benefit does not depend on the current income or resources of beneficiary; instead the amount varies based upon the beneficiary's earning history.

**Special Needs Plan (SNP):** Authorized in the Medicare Prescription Drug Improvement and Modernization Act of 2003, a SNP is a type of Medicare Advantage plan that is approved by CMS and run by a private company. Membership is limited to eligible individuals with specific characteristics or diagnoses who live in the plan's defined geographical service area and who are covered under Medicare Part A and Medicare Part B. The plan is permitted to limit enrollment to subgroups of Medicare beneficiaries of three types: (1) individuals who have one or more severe or disabling chronic conditions; or (2) individuals who reside in a nursing home or require a nursing home level of care in the community; or (3) individuals who are dually eligible for Medicare and Medicaid. There are separate types of SNPs for each of these subgroups of Medicare beneficiaries. Plan enrollees receive all of their medical health care services covered under Medicare Parts A, B, and D through a single SNP and are required to see in-network providers.

**Supplemental Security Income (SSI):** A federal income supplement program which provides cash assistance to individuals with low incomes and limited assets who are age 65 or under, blind, or living with a disability (as defined by the criteria used for SSDI) to meet basic needs for food, clothing, and shelter. The maximum SSI monthly federal benefit rate in 2013 is $710 per month for an individual, which is approximately 74 percent of the federal poverty level.

# Appendix B: Dually Eligible Beneficiaries, Enrollment, 2008

| State | Dually Eligible Beneficiaries, Total Enrollment | Dually Eligible Beneficiaries as a Share of | | "Full" Dually Eligible Beneficiaries, Enrollment | "Full" Dually Eligible Beneficiary Enrollment as a Share of Total Enrollment |
|---|---|---|---|---|---|
| | | All Medicare Beneficiaries | All Medicaid Beneficiaries | | |
| Alabama | 208,250 | 23% | 23% | 99,997 | 48% |
| Alaska | 13,006 | 20% | 11% | 12,710 | 98% |
| Arizona | 147,966 | 15% | 10% | 114,499 | 77% |
| Arkansas | 118,405 | 21% | 17% | 68,793 | 58% |
| California | 1,201,009 | 24% | 11% | 1,174,336 | 98% |
| Colorado | 69,872 | 11% | 12% | 64,521 | 92% |
| Connecticut | 103,162 | 17% | 19% | 78,226 | 76% |
| Delaware | 23,796 | 15% | 12% | 11,095 | 47% |
| District of Columbia | 22,192 | 26% | 13% | 18,806 | 85% |
| Florida | 601,276 | 17% | 20% | 348,735 | 58% |
| Georgia | 264,172 | 20% | 16% | 145,673 | 55% |
| Hawaii | 32,688 | 15% | 15% | 29,734 | 91% |
| Idaho | 30,889 | 13% | 15% | 21,719 | 70% |
| Illinois | 313,365 | 16% | 13% | 274,655 | 88% |
| Indiana | 155,826 | 14% | 14% | 100,567 | 65% |
| Iowa | 81,382 | 14% | 17% | 68,310 | 84% |
| Kansas | 63,077 | 13% | 18% | 46,963 | 74% |
| Kentucky | 178,381 | 21% | 21% | 110,464 | 62% |
| Louisiana | 180,354 | 25% | 16% | 107,123 | 59% |
| Maine | 91,976 | 33% | 26% | 53,332 | 58% |
| Maryland | 109,905 | 13% | 14% | 74,493 | 68% |
| Massachusetts | 254,979 | 22% | 17% | 247,751 | 97% |
| Michigan | 263,859 | 14% | 13% | 233,786 | 89% |
| Minnesota | 132,224 | 15% | 16% | 119,950 | 91% |
| Mississippi | 150,850 | 28% | 20% | 81,354 | 54% |
| Missouri | 171,506 | 15% | 17% | 155,892 | 91% |
| Montana | 18,446 | 9% | 17% | 15,835 | 86% |
| Nebraska | 41,643 | 13% | 17% | 37,674 | 90% |
| Nevada | 40,009 | 10% | 15% | 21,718 | 54% |
| New Hampshire | 28,783 | 12% | 19% | 20,543 | 71% |
| New Jersey | 203,908 | 14% | 21% | 170,771 | 84% |
| New Mexico | 55,971 | 17% | 11% | 39,533 | 71% |
| New York | 737,161 | 22% | 15% | 658,601 | 89% |
| North Carolina | 310,496 | 20% | 18% | 250,178 | 81% |
| North Dakota | 15,353 | 12% | 22% | 11,319 | 74% |
| Ohio | 303,761 | 14% | 15% | 205,501 | 68% |
| Oklahoma | 113,553 | 17% | 15% | 95,020 | 84% |
| Oregon | 90,355 | 14% | 17% | 62,159 | 69% |
| Pennsylvania | 391,855 | 15% | 18% | 333,096 | 85% |
| Rhode Island | 39,388 | 20% | 20% | 33,851 | 86% |
| South Carolina | 150,973 | 19% | 18% | 131,959 | 87% |
| South Dakota | 20,520 | 14% | 17% | 13,760 | 67% |
| Tennessee | 284,368 | 26% | 19% | 216,329 | 76% |
| Texas | 626,375 | 20% | 15% | 384,677 | 61% |
| Utah | 30,952 | 10% | 10% | 28,198 | 91% |
| Vermont | 31,828 | 26% | 19% | 19,951 | 63% |
| Virginia | 171,256 | 14% | 19% | 118,961 | 69% |
| Washington | 149,782 | 14% | 13% | 113,851 | 76% |
| West Virginia | 79,682 | 19% | 20% | 49,523 | 62% |
| Wisconsin | 211,378 | 21% | 21% | 128,311 | 61% |
| Wyoming | 10,065 | 11% | 13% | 6,838 | 68% |
| **United States** | **9,142,228** | **18%** | **15%** | **7,031,641** | **77%** |

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

# Appendix C: Dually Eligible Beneficiaries, Medicaid Expenditures, 2008

| State | Dually Eligible Beneficiaries, Total Medicaid Expenditures (in millions) | Expenditures, by Service, as a Share of Total Medicaid Expenditures for Dually Eligible Beneficiaries | | | | | Medicaid Expenditures for Dually Eligible Beneficiaries as a Share of Total Medicaid Expenditures | Annual Per Capita Medicaid Expenditures for Dually Eligible Beneficiaries |
|---|---|---|---|---|---|---|---|---|
| | | Medicare Premiums[1] | Medicare Acute Care Cost-Sharing | Acute Care Not Covered by Medicare | Prescribed Drugs | Long-Term Care | | |
| Alabama | $1,589 | 14% | 12% | 1% | 1% | 72% | 42% | $8,591 |
| Alaska | $249 | 7% | 10% | 7% | 1% | 75% | 28% | $21,117 |
| Arizona[2] | $1,298 | 12% | N/A | N/A | N/A | N/A | 18% | $10,161 |
| Arkansas | $1,517 | 17% | 21% | 11% | 1% | 51% | 45% | $14,612 |
| California | $15,341 | 12% | 24% | 3% | 2% | 59% | 41% | $14,207 |
| Colorado | $1,194 | 6% | 16% | 3% | 0% | 75% | 39% | $19,883 |
| Connecticut | $2,501 | 9% | 6% | 3% | 1% | 80% | 58% | $27,704 |
| Delaware | $360 | 7% | 10% | 3% | 1% | 78% | 31% | $17,098 |
| District of Columbia | $502 | 4% | 7% | 37% | 1% | 50% | 36% | $26,301 |
| Florida | $6,131 | 16% | 19% | 2% | 1% | 62% | 41% | $12,260 |
| Georgia | $2,263 | 11% | 12% | 5% | 1% | 72% | 32% | $9,783 |
| Hawaii | $427 | 13% | 7% | 4% | 1% | 75% | 36% | $15,001 |
| Idaho | $413 | 8% | 14% | 8% | 1% | 71% | 34% | $15,197 |
| Illinois | $3,358 | 9% | 17% | 6% | 1% | 67% | 29% | $12,220 |
| Indiana | $2,190 | 6% | 16% | 4% | 1% | 73% | 38% | $16,933 |
| Iowa | $1,391 | 13% | 9% | 6% | 1% | 72% | 48% | $19,653 |
| Kansas | $948 | 7% | 10% | 2% | 1% | 80% | 42% | $17,580 |
| Kentucky | $1,653 | 12% | 15% | 2% | 2% | 69% | 34% | $10,688 |
| Louisiana | $1,833 | 12% | 10% | 5% | 1% | 72% | 34% | $11,254 |
| Maine | $1,064 | 8% | 6% | 25% | 1% | 60% | 47% | $12,925 |
| Maryland | $1,978 | 7% | 14% | 3% | 1% | 75% | 35% | $20,867 |
| Massachusetts | $4,804 | 6% | 16% | 18% | 1% | 58% | 44% | $21,276 |
| Michigan | $3,268 | 11% | 21% | 3% | 1% | 65% | 34% | $14,469 |
| Minnesota | $3,157 | 4% | 24% | 2% | 0% | 69% | 46% | $27,754 |
| Mississippi | $1,538 | 16% | 14% | 4% | 1% | 66% | 41% | $11,510 |
| Missouri | $2,448 | 11% | 16% | 9% | 2% | 62% | 37% | $16,969 |
| Montana | $364 | 10% | 8% | 4% | 1% | 77% | 46% | $24,444 |
| Nebraska | $732 | 12% | 12% | 3% | 1% | 72% | 45% | $20,329 |
| Nevada | $426 | 19% | 11% | 4% | 1% | 65% | 34% | $12,715 |
| New Hampshire | $518 | 3% | 11% | 2% | 1% | 83% | 49% | $21,629 |
| New Jersey | $3,946 | 6% | 9% | 7% | 1% | 77% | 49% | $21,551 |
| New Mexico | $733 | 8% | 10% | 4% | 0% | 78% | 24% | $15,021 |
| New York | $20,402 | 5% | 14% | 4% | 1% | 77% | 45% | $31,752 |
| North Carolina | $3,407 | 9% | 11% | 9% | 2% | 69% | 34% | $12,269 |
| North Dakota | $323 | 3% | 7% | 1% | 1% | 89% | 59% | $24,822 |
| Ohio | $5,229 | 6% | 11% | 3% | 1% | 79% | 42% | $20,363 |
| Oklahoma | $1,299 | 9% | 15% | 3% | 1% | 73% | 36% | $13,291 |
| Oregon | $1,302 | 7% | 13% | 2% | 1% | 76% | 41% | $16,564 |
| Pennsylvania | $6,789 | 6% | 7% | 1% | 1% | 85% | 43% | $20,138 |
| Rhode Island | $762 | 4% | 15% | 10% | 1% | 70% | 47% | $22,011 |
| South Carolina | $1,578 | 9% | 25% | 2% | 2% | 62% | 38% | $11,737 |
| South Dakota | $255 | 9% | 12% | 1% | 1% | 77% | 38% | $14,264 |
| Tennessee | $2,403 | 13% | 20% | 1% | 1% | 65% | 33% | $9,379 |
| Texas | $6,244 | 13% | 14% | 10% | 1% | 61% | 30% | $11,007 |
| Utah | $392 | 3% | 26% | 3% | 2% | 66% | 26% | $15,037 |
| Vermont | $390 | 1% | 8% | 12% | 3% | 75% | 40% | $14,051 |
| Virginia | $2,109 | 9% | 10% | 2% | 1% | 78% | 40% | $13,996 |
| Washington | $2,056 | 10% | 8% | 5% | 1% | 76% | 34% | $16,123 |
| West Virginia | $867 | 10% | 7% | 2% | 1% | 79% | 37% | $12,580 |
| Wisconsin | $2,578 | 9% | 22% | 4% | 5% | 60% | 52% | $13,836 |
| Wyoming | $214 | 5% | 22% | 1% | 0% | 72% | 43% | $24,964 |
| **United States[3]** | **$128,735** | **9%** | **16%** | **5%** | **1%** | **69%** | **39%** | **$16,087** |

**Notes:** The sum of the expenditures by service may not add up to state total due to rounding. 1 The "Medicare Premiums" service category includes additional cost-sharing, specifically deductibles and coinsurance, required to be paid for some "partial" dually eligible beneficiaries. 2 Expenditures for Arizona are not shown by service because most expenditures for dually eligible beneficiaries in Arizona are covered under the Arizona Long-Term Care System (ALTCS), a capitated program, and cannot be separated out by service type. 3 The national totals include Arizona spending by service.

**Source:** Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on data from FY 2008 MSIS and Form CMS-64 reports.

THE HENRY J. KAISER FAMILY FOUNDATION


**THE HENRY J. KAISER FAMILY FOUNDATION**

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

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

www.kff.org



This publication (#8446) is available on the Kaiser Family Foundation's website at www.kff.org.


The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation, based in Menlo Park, California.