The Roles of Medicare and Medicaid in Financing Health and Long-Term Care for Low-Income Seniors:

A Chart Book on Medicare–Medicaid Enrollees in Four States

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Executive Summary

For Medicare beneficiaries with low incomes, and for many who need extensive long-term care services, Medicaid plays a crucial role by filling gaps in Medicare's benefits. The 7 million Americans who are covered by both Medicare and Medicaid represent nearly one-fifth of each program's enrollment, but account for a much larger share of each program's spending. In 1997, these Medicare-Medicaid enrollees accounted for about 28 percent of Medicare spending and 35 percent of Medicaid spending nationwide, reflecting their relatively greater medical and long-term care needs. The importance of this population to these two programs and the importance of these programs to this population has raised significant interest among federal and state policymakers about the interaction between Medicare and Medicaid, including the potential for substitution of services between the two and the possibility of improved coordination of care for enrollees of both programs.

This chart book examines the way Medicare and Medicaid interact to serve low-income seniors covered by both programs. It is based on combined Medicare and Medicaid data for individuals enrolled in both programs in four states, which vary in the characteristics of their Medicaid programs and populations: Georgia, Maryland, Massachusetts, and Wisconsin. Data combining information from the two programs are not currently available for a national population and have only recently begun to be available for some states. This analysis is one of the first to examine service use and spending across both programs for a large sample of Medicare-Medicaid enrollees in several states. The findings reveal how the experiences of elderly Medicare-Medicaid enrollees differ among different categories of enrollees and in different states, and shed light on how the two programs work together to serve beneficiaries.

Medicare's and Medicaid's Roles in Protecting Low-Income Seniors

Most Medicare-Medicaid enrollees are eligible for full Medicaid benefits under their state's eligibility criteria. For these enrollees, Medicaid supplements Medicare by paying for services Medicare does not cover and, for most, paying Medicare's premium and some cost-sharing amounts. For about 9 percent (in 1995) of Medicare-Medicaid enrollees, Medicaid provides more limited assistance, paying only for Medicare cost-sharing and premiums, or assisting only with premiums.

Although Medicare provides financial protection against the costs of medical care for nearly all elderly Americans and some younger Americans with disabilities, the program's beneficiary cost-sharing requirements and gaps in coverage can lead to high out-of-pocket expenses. Medicare benefits include inpatient and outpatient hospital,

physician, diagnostic laboratory, and other professional medical services. Medicare does not cover most long-term care, but does provide limited coverage of skilled nursing facility care and home health care for enrollees who have skilled care needs and meet certain other criteria. Beneficiaries' expenses can be quite high, particularly for people who need a lot of care. In addition to the Part B premium ($45.50 per month in 2000), Medicare requires beneficiaries to pay deductible or coinsurance amounts for most covered services. Also, Medicare does not have a catastrophic cap on beneficiary expenses, so there is no limit on the total amount a person may have to pay out-of-pocket for cost-sharing during a year.

Medicaid plays a critical role for eligible low-income Medicare beneficiaries. By paying Medicare's premium and cost-sharing requirements, Medicaid enables enrollees to obtain needed care that they otherwise might have been prohibited from getting because they could not afford the premiums, deductibles, or coinsurance costs. In addition to assisting with premiums and cost-sharing, Medicaid pays for services Medicare does not cover, most notably, prescription drugs and nursing home and home- and community-based long-term care services. Medicaid often also pays for other services not covered by Medicare, such as transportation for medical care, eyeglasses, hearing aids, and dental care. Because states have considerable flexibility in designing their Medicaid programs, benefits and eligibility criteria vary among states.

The Four-State Data

Most of the analysis in the chart book is based on Medicare and Medicaid data for Medicare–Medicaid enrollees in Georgia, Maryland, Massachusetts, and Wisconsin. The states were chosen largely on the basis of data availability, but also (from those for which data were potentially available) to represent some variation in population characteristics, geographic location, and Medicaid programs.

The analysis relies on a database containing individual-level information from 1995 for Medicare–Medicaid enrollees in the four states. The database, constructed from enrollment and claims data from the Medicare and Medicaid programs, provides a rich source of information on service use and spending under each program. Constructing this type of database requires the creation of standardized enrollment, payment, and utilization categories based on varied state-specific Medicaid programs and data systems. Because Medicare–Medicaid status is relatively dynamic, enrollment status, service use, and spending were all tracked on a monthly basis. For claims spanning more than one month, spending and service use in each month were approximated by apportioning them across the relevant months. The analysis is based on data for months of dual Medicare and Medicaid enrollment for all people in the four states who were enrolled in both programs during at least one month of 1995. (A small fraction of Medicare–Medicaid enrollees in the four states were enrolled in Medicare or Medicaid

managed care programs; these enrollees were omitted from the analysis of service use and spending because this information is often incomplete or unavailable for managed care enrollees.)

Most of the charts in the book present results based on combined data for the four states. Because most relationships (though not specific details, such as spending amounts) shown in the charts applied in each state separately, the combined data provide a useful way to present the main findings. For topics where differences among states were notable and of interest, charts are given showing comparative information across states. For the charts that show only the four-state combined data, corresponding results for each state are provided in a set of tables in the Appendix. (For convenience, the appendix tables are numbered so that each one's number matches the number of its corresponding chart.)

The populations described in the charts differ somewhat among the sections of the chart book. Specifically, to describe the characteristics of Medicare-Medicaid enrollees (presented in Section II), data were used for the total Medicare-Medicaid population in the four states, including those with more limited Medicaid benefits as well as those with full Medicaid benefits. By contrast, the analysis of spending and service use (presented in Sections III and IV) is based on elderly Medicare-Medicaid enrollees estimated to have full Medicaid benefits. The population was restricted to those with full Medicaid benefits so that observed differences in Medicaid service use patterns among states, and among population groups, would not be influenced by differing proportions of people with access to all Medicaid services in contrast to limited benefits.

Main Findings

Both Medicare and Medicaid are crucial to financing health care for low-income elderly Americans. Elderly Medicare-Medicaid enrollees of whom three-quarters are women use many services of all kinds. In the four states analyzed here, spending across both programs for elderly Medicare-Medicaid enrollees averaged $1,675 per person per month in 1995, or about $20,100 per year (for Medicare-Medicaid enrollees with full Medicaid benefits). This spending reflects relatively high use of acute care services, which are primarily financed by Medicare, as well as the use of long-term care services, which are primarily a Medicaid responsibility.

The elderly Medicare-Medicaid population includes two different groups of about equal size. About half the population uses long-term care services either in nursing facilities or at home and accounts for the majority (82% in the four states) of Medicare and Medicaid spending for elderly Medicare-Medicaid enrollees. Long-term care services were defined to include Medicaid-financed nursing home and home care (that is, home health, personal care, and home- and community-based waiver services), and Medicare-financed skilled nursing facility and home

health services, with one exception. The exception is that people who had no Medicaid long-term care service use and who only used Medicare skilled nursing facility or home health services during a period of 60 or fewer days were not considered "long-term care users" and their service use was not included in long-term care spending. More than three-quarters of elderly long-term care users live in nursing homes, and two-thirds of their Medicare and Medicaid spending is for nursing home care, nearly all of which is paid for by Medicaid. Long-term care users—whether in a nursing home or in the community—also need a substantial amount of acute care.

The other half of elderly Medicare–Medicaid enrollees use no Medicaid- or Medicare-financed long-term care services. They use less acute care on average than long-term care users (but similar to the amount used by the general Medicare population). Medicare finances the majority of their health care, accounting for nearly three-quarters of their spending, but they depend on Medicaid to support their cost-sharing and prescription drug coverage.

Characteristics of Medicare–Medicaid Enrollees

- In the four states, 15 percent of Medicare enrollees in 1995 were covered by Medicaid, similar to the nationwide proportion in that year (16%). More than nine of 10 Medicare–Medicaid enrollees had full Medicaid benefits under their state's program. However, states varied in their proportion of Medicare beneficiaries with Medicaid (ranging from 10% in Maryland to 19% in Georgia) and their proportion of Medicare–Medicaid enrollees with full Medicaid benefits (ranging from 86% in Georgia to 98% in Wisconsin). This variation reflects differences in both population characteristics and eligibility criteria.

- Medicare–Medicaid enrollees are disproportionately very old or under age 65 and disabled—19 percent are age 85 or older, and 31 percent are under age 65, compared with 10 percent and 15 percent, respectively, of all Medicare enrollees in the four states. Among Medicare beneficiaries age 85 and older, 29 percent also have Medicaid; among those under age 65, 31 percent do.

- Just over three-quarters (77%) of elderly Medicare–Medicaid enrollees are women. Among Medicare–Medicaid enrollees age 85 and older, 84 percent are women.

- In the four states, 35 percent of elderly Medicare-Medicaid enrollees live in nursing homes. Nursing home residence varies greatly among states, ranging from 24 percent of elderly Medicare-Medicaid enrollees in Georgia to 46 percent in Wisconsin.

Spending and Service Use of Elderly Medicare-Medicaid Enrollees

- Spending across both programs for elderly Medicare-Medicaid enrollees (with full Medicaid benefits) averaged $1,675 per person per month in 1995. Medicaid financed 59 percent of this spending, reflecting the significant amount of long-term care received by elderly Medicare-Medicaid enrollees.

- More than half of the spending across both programs was for long-term care services (nursing home and home care), the overwhelming majority of which was financed by Medicaid.

- On average, Medicare-Medicaid enrollees use substantially more Medicare services than other Medicare beneficiaries~~in~~ 1995, average Medicare spending per person for elderly Medicare-Medicaid enrollees in the four states was 68 percent greater than the average level for all Medicare beneficiaries.

Elderly Medicare-Medicaid Enrollees Using Long-Term Care Services

- The 48 percent of elderly Medicare-Medicaid enrollees (with full Medicaid benefits) who use long-term care services~~in~~ nursing homes or the community~~ac~~count for the majority of both Medicare and Medicaid spending by elderly Medicare-Medicaid enrollees. These long-term care users as a group accounted for 82 percent of combined Medicare and Medicaid spending on the elderly population enrolled in both programs.

- Compared with other elderly Medicare-Medicaid enrollees, those using long-term care services are considerably older (45% were age 85 or older, compared with 14% of other elderly Medicare-Medicaid enrollees), more likely to have used hospital care during the year (38% compared with 22%), and more likely to have died during the year (12% compared with 3%).

- Among elderly Medicare-Medicaid enrollees who use long-term care services, 78 percent live in nursing homes. Two-thirds of total Medicare and Medicaid spending for these nursing home residents is for nursing

home care, 92 percent of which is paid for by Medicaid. Their nursing facility spending averaged $2,109 per person per month in the four states (or about $25,300 on an annual basis).

- For the 22 percent of elderly Medicare–Medicaid long-term care users who live in the community, Medicare-financed home health care and Medicaid-financed home care account for almost half (46%) of combined program spending, or about $869 per person per month. Medicare and Medicaid each financed about half of this home care spending in the four states as a group, but each program's share varied considerably among states–for example, Medicare's share of home care spending for this population ranged from 24 percent in Maryland to 73 percent in Georgia.

- Whether in the community or in a nursing home, elderly Medicare–Medicaid enrollees using long-term care also use substantial acute care services. In fact, spending for acute care services is quite similar for nursing home and community groups. The most significant difference is that community-based long-term care users in the four states had greater inpatient hospital spending than nursing home residents–averaging $456 per person per month, compared with $357 for nursing home residents.

- For the half of the elderly Medicare–Medicaid population that uses no Medicaid- or Medicare-financed long-term care, Medicare pays for nearly three-quarters of spending across both programs. But this population depends on Medicaid to pay for cost-sharing, prescription drugs, and services not covered by Medicare. This population's Medicare spending averaged $429 per person per month in the four states, roughly similar to the average for Medicare beneficiaries without Medicaid. This population's Medicaid spending averaged $161 per person per month, or more than $1,900 on a yearly basis.

Conclusion

Understanding the use and spending patterns of Medicare–Medicaid enrollees is essential to evaluating various policy proposals under discussion for the future of both programs. Because of their complex care needs, these enrollees require a broad range of services and rely extensively on both programs. To ensure that low-income Medicare–Medicaid enrollees are adequately protected, neither program can afford to ignore the value of the other in developing strategies for the future. As policymakers seek ways to cope with the current and future financial pressures each program faces, it will be important to consider how policy options will affect this important and vulnerable population.

I. Introduction

Medicare–Medicaid enrollees account for a disproportionately large share of each program's spending (Chart I-1).

Although constituting less than one-fifth of the enrollees in each program, Medicare–Medicaid enrollees accounted for more than one-fourth of Medicare spending and more than one-third of Medicaid spending in 1997.

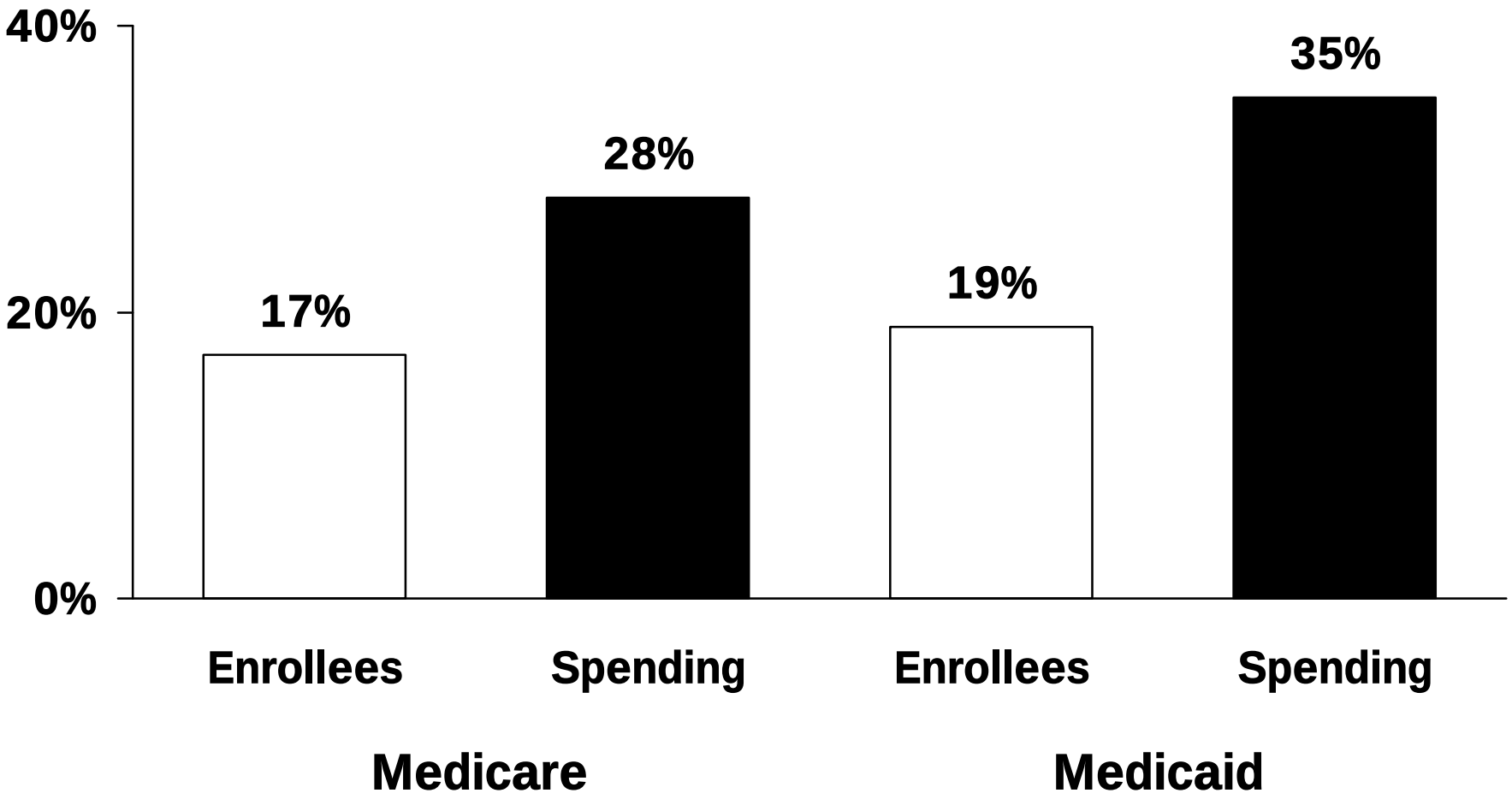
- In 1997, an estimated 6.7 million low-income elderly and disabled Medicare enrollees were also covered by Medicaid at some point during the year, accounting for 17 percent of all Medicare beneficiaries.[1] These Medicare–Medicaid enrollees accounted for 28 percent of Medicare spending, or about $58 billion.

- Medicare–Medicaid enrollees represented 19 percent of Medicaid enrollees in 1997 and accounted for 35 percent of Medicaid spending, or about $56 billion.

[1] William D. Clark and Melissa M. Hulbert, "Research Issues: Dually Eligible Medicare and Medicaid Beneficiaries, Challenges and Opportunities," *Health Care Financing Review* 20 (Winter 1998):1–10.

Chart I-1. Medicare–Medicaid Enrollees as a Percentage of Each Program's Enrollees and Spending

United States, 1997



Source: W. Clark and M. Hulbert, "Research Issues: Dually Eligible Medicare and Medicaid Beneficiaries, Challenges and Opportunities," *Health Care Financing Review* 20 (Winter 1998):1–10.

Eligibility for Medicaid coverage, and the extent of Medicaid's assistance, are determined by a combination of federal and state rules (Table I-1).

The type of assistance Medicaid provides to Medicare–Medicaid enrollees differs among eligibility categories. Most Medicare–Medicaid enrollees have full Medicaid benefits under their state's program. For the minority of Medicare–Medicaid enrollees, Medicaid provides much more limited help by assisting only with Medicare premiums and cost-sharing requirements.[2]

Eligibility for Full Medicaid Benefits. Medicare enrollees with full Medicaid benefits are those who meet the income and other criteria for Medicaid eligibility that would apply in their state regardless of their Medicare status. For these Medicare–Medicaid enrollees, Medicaid pays for health and long-term care services that Medicare does not cover. Most Medicare enrollees with full Medicaid benefits (specifically, those with income at or below the federal poverty level who also meet a resource test) are Qualified Medicare Beneficiaries (QMBs). For QMBs, Medicaid pays Medicare's premiums. States also pay Medicare's cost-sharing requirements for QMBs, but may limit what they pay to an amount based on Medicaid's payment rates (thus, Medicaid's contribution could be small or nothing). QMBs do not have to pay any of Medicare's cost-sharing amounts because providers are not allowed to bill QMBs for any amounts above the combined payments from Medicare and Medicaid.

Unlike Medicare, Medicaid eligibility rules and benefits may vary by categories of individuals (for example, for elderly nursing home residents compared with elderly community residents) as well as by state. The main categories of Medicare enrollees who are eligible for full Medicaid coverage under their state's program are the following:

- ***Supplemental Security Income (SSI) recipients*.** Most states are required to provide Medicaid coverage to SSI recipients. An exception occurs for 11 states, as of 1998, that have chosen the "209(b)" option, which permits states to apply more restrictive income or resource requirements than the SSI rules.[3]

[2] This section draws extensively from Andy Schneider, Kristen Fennel, and Patricia Keenan, "Medicaid Eligibility for the Elderly," Issue Paper, Kaiser Commission on Medicaid and the Uninsured (May 1999). For additional ways people with disabilities may qualify for Medicaid, also see: Andy Schneider, Victoria Strohmeyer, and Risa Ellberger, "Medicaid Eligibility for Individuals with Disabilities," Issue Paper, Kaiser Commission on Medicaid and the Uninsured (July 1999).

[3] Specifically, it allows states to use their 1972 state assistance eligibility rules in determining eligibility for the elderly instead of the federal SSI rules, which annually adjust income standards for inflation. However, a state using its 1972 criteria must also allow people to

- ***"Medically needy" individuals*.** States have the option of providing coverage to people for whom the state sets income and resource standards, where income spent on medical and long-term care is not counted in determining whether the income standard is met. Thus, people who satisfy the resource requirement but have income above the standard may "spend down" their income to a qualifying threshold if they have sufficiently high medical or long-term care expenses during a budget period of not more than six months. Eligibility must be redetermined for each budget period. As of 1998, 35 states (including the District of Columbia) provided coverage to "medically needy" individuals (but in one state, it does not apply to the elderly and disabled). The income limit to qualify varies widely among states. In 1998, the limit ranged from $100 per month (or 15% of the federal poverty level) in Louisiana to $741 per month (or 110% of the federal poverty level) in Vermont. In 1998, the limit for individuals was below 50 percent of the federal poverty level in one-third of states with medically needy coverage, and at or above the poverty level in only two states.

  Federal law allows states to exclude nursing home care and some optional services (such as dental care) from their medically needy programs. However, only five states with medically needy programs do not cover nursing home care in those programs and all five instead cover nursing home residents under the "special income rule" described below. Nursing home residents, after "spending down" to the qualifying income level, must pay the rest of their income toward their care, except for a small personal needs allowance and a certain amount of income for a spouse who continues to live in the community, intended to protect the spouse from impoverishment.

- ***Nursing facility residents under special income rule (300 percent rule).*** Many residents of nursing homes and other institutions are eligible for Medicaid under medically needy rules. However, states have the option of establishing a separate income limit for residents of nursing homes or other institutions, which can be no higher then 300 percent of the SSI standard. Nursing home residents must meet both the income standard and the SSI resource test to qualify. As under medically needy programs, nursing home residents must pay all of their income for their care, except for certain allowances for personal needs and living expenses of a spouse in the community. As of September 1996, 33 states~~19~~ with medically needy coverage and 14 without~~op~~ted to cover individuals residing in institutions under this "special income rule."

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deduct health care expenses from income (that is, "spend down") in determining eligibility (which they generally cannot do to qualify for SSI).

- ***Recipients of State Supplementation Payments (SSP).*** States have the option of providing Medicaid coverage to additional people who receive SSP but not SSI.
- ***Individuals eligible for home- and community-based waiver program services.*** States have the option of covering home- and community-based services for elderly people at high risk of entering a nursing home, under "section 1915(c)" waivers. For these programs, states have the same options for eligibility criteria as for nursing home residents, but in practice states usually apply more restrictive standards. Most states apply an income standard of 300 percent of the SSI standard, but few apply spousal impoverishment protections or medically needy provisions to waiver service eligibility.[4] All states, except Arizona, offer home- and community-based waiver services. (Arizona offers similar services under a different waiver.) Because these services are provided under a waiver program, states can (and do) limit the number of participants, and restrict programs to specific population groups or geographic areas.

- ***Elderly and disabled people with income up to the poverty level.*** States have the option of extending Medicaid to elderly and disabled people, for whom the state sets an income standard up to the poverty level, and a resource standard that must be no more restrictive than the SSI standard. In 1999, 13 states (including the District of Columbia) provided this optional coverage~~the~~ income standard was 100 percent of the poverty level in all but one of these states, where it was 90 percent.

Eligibility for Medicaid Assistance with Medicare Premiums and Cost-Sharing. States are required to provide Medicaid assistance to the following groups of Medicare beneficiaries:

- ***Qualified Medicare Beneficiaries (QMBs).*** These are Medicare beneficiaries with income not greater than 100 percent of the federal poverty threshold and resources that do not exceed twice the limit for SSI eligibility. Some QMBs qualify for full Medicaid benefits under their state's Medicaid eligibility standards; others, often referred to as **QMBs-only,** do not. For QMBs, states are required to pay the Medicare Part B premium and the Medicare Part A premium (if any), and may pay Medicare's cost-sharing requirements. QMBs do not have to pay any cost-sharing because providers are not allowed to bill them. However, if the

[4] Rosalie A. Kane, Robert L. Kane, and Richard C. Ladd, *The Heart of Long-Term Care* (New York and Oxford: Oxford University Press, 1998).

state does not pay the full Medicare cost-sharing amount, QMBs may have difficulty finding a provider willing to treat them at the lower rate.[5]

- ***Specified Low-Income Medicare Beneficiaries (SLMBs).*** These are Medicare beneficiaries with income above 100 percent and not more than 120 percent of the poverty threshold, and with assets that do not exceed twice the limit for SSI eligibility. States must pay the Medicare Part B premium for SLMBs. **SLMBs-only** refers to those who do not qualify for full Medicaid.

- ***Qualifying Individuals-1 (QI-1s) and Qualifying Individuals-2 (QI-2s).*** The Balanced Budget Act of 1997 (BBA) created a five-year block grant for states, beginning in 1998, to pay Medicare's Part B premium for QI-1s and to pay a portion of the Part B premium for QI-2s. **QI-1s** are people entitled to Medicare Part A who have income above 120 percent and below 135 percent of the federal poverty level and assets not exceeding twice the SSI limit, and who are not otherwise entitled to Medicaid. **QI-2s** must meet the same criteria as QI-1s, except that their income must be less than 175 percent of the poverty level. For QI-2s, Medicaid pays only the portion of the Part B premium estimated to be attributable to the home health benefit ($1.14 per month in 1999). States, however, are not required to pay these benefits after the allocated funds run out, so the number of QI-1s and QI-2s in each state may be constrained by the amount of funds.[6]

- ***Qualified Disabled Working Individuals (QDWIs).*** Certain disabled people who lose their Medicare coverage because of returning to work are entitled to purchase Medicare. Under QDWI rules, states have the option of paying the Medicare Part A premium for such individuals if their income does not exceed 200 percent of the poverty level.

[5] Patricia B. Nemore, *Variations in State Medicaid Buy-In Practices for Low-Income Medicare Beneficiaries: A 1999 Update* (Washington, DC and Menlo Park, CA: The Henry J. Kaiser Family Foundation, December 1999).

[6] States are not required to contribute matching funds for QI-1 and QI-2 benefits.

Table I-1
Medicaid Eligibility for Medicare Beneficiaries, 2000

Beneficiaries Receiving Full Medicaid Benefits		
Category	**Income Test[b]**	**Resource Test**
Mandatory Coverage		
Supplemental Security Income (SSI) Recipients[a]	Income below $512 per month for an individual.[c] Income below $769 per month for a couple.[c]	Up to $2,000 for an individual. Up to $3,000 for a couple.
Optional Coverage		
Medically Needy	State sets income standard; individual may "spend down" to qualify by deducting incurred medical expenses from income.	State sets standard (must be no more restrictive than SSI standard).
Residents of Nursing Facilities Under Special Income Rule (300% rule)	Income standard no higher than 300% of SSI standard ($1,536 per month in 2000).	Same as SSI.
People Eligible for Home- and Community-Based Waiver Program Services	State sets standard (in most states, 300% of SSI standard). (Person must have level of need equivalent those eligible for nursing home care.)	State sets standard (in most, same as SSI).
Individuals Receiving State Supplementation Payments (SSP)	State income standard for SSP eligibility.	State standard for SSP eligibility.
Elderly and Disabled People with Income Up to the Federal Poverty Level	State sets standard up to 100% of federal poverty level.	State sets standard (must be no more restrictive than SSI standard).

Table I-1 (continued)

Beneficiaries Receiving Medicaid Assistance with Medicare Premiums and Cost-Sharing			
Category	**Income Test[b]**	**Resource Test**	**Medicaid Pays**
Mandatory Coverage			
Qualified Medicare Beneficiaries (QMBs)	Up to 100% FPL (in 2000, $696 per month for individual, $935 per month for couple).	Up to 200% of SSI limit ($4,000 for individual, $6,000 for couple).	All Medicare premiums and cost-sharing.[d]
Specified Low-Income Medicare Beneficiaries (SLMBs)	100% to 120% of FPL (in 2000, $835 per month for individual, $1,125 per month for couple).	Up to 200% of SSI limit.	Medicare Part B monthly premium ($45.50 per month in 2000).
Qualified Individuals 1 (QI-1s)[e]	120% to 135% of FPL (in 2000, $940 per month for individual, $1,266 for couple).	Up to 200% of SSI limit.	Medicare Part B monthly premium.
Qualified Individuals 2 (QI-2s)[e]	135% to 175% of FPL (in 2000, $1,218 per month for individual, $1,641 for couple).	Up to 200% of SSI limit.	A portion of the Medicare Part B monthly premium ($1.14 per month in 1999).
Optional Coverage			
Qualified Disabled Working Individuals (QDWIs)	Up to 200% of FPL (must be eligible for Medicare Part A on the basis of disability).	Up to 200% of SSI limit.	Medicare Part A premium only ($301 per month in 2000).[f]

[a] In some states, known as 209(b) states, individuals with SSI are not automatically eligible for Medicaid; they are usually subject to more restrictive income and/or resource tests.
[b] Income figures do not include a $20 monthly income disregard.
[c] Countable income excludes $65 per month in wages plus one-half of wages over $65.
[d] States are not required to pay Medicare cost-sharing if Medicaid payment rates are sufficiently lower than Medicare payment rates.
[e] Benefit is subject to an annual federal funding cap.
[f] States may pay a portion of premium on a sliding scale for people with income between 150% and 200% of FPL.

Note: FPL = federal poverty level.

Sources: A. Schneider, K. Fennel, and P. Keenan, "Medicaid Eligibility for the Elderly," Issue Paper, Kaiser Commission on Medicaid and the Uninsured, May 1999; Brian K. Bruen et al., "State Usage of Medicaid Coverage Options for Aged, Blind, and Disabled People," Discussion Papers, Assessing the New Federalism (Washington, DC: Urban Institute, August 1999); Health Care Financing Administration, "2000 Income Limits for Dual Eligibles," www.hcfa.gov/medicaid/4732rate.htm (accessed 3/16/00); and Social Security Administration, "A Desktop Guide to SSI Eligibility Requirements," SSA Publication No. 05-11001 (January 2000).

Most Medicare benefits require beneficiary cost-sharing (Table I-2).

Part A of Medicare, also known as the Hospital Insurance program, covers inpatient hospital services, short-term care in skilled nursing facilities, hospice care, and some home health care. Part B, also called the Supplementary Medical Insurance program, covers physician services, outpatient hospital services, diagnostic laboratory services, ambulatory surgical services, some home health care, and some preventive health services, such as mammography screening and flu shots. Medicare managed care plans~~an~~ option in some areas of the country~~are~~ required to provide all Part A and Part B benefits and may provide additional benefits.

- Most Medicare beneficiaries pay no Part A premium.[7] The Part B premium is $45.50 per month in 2000.

- Cost-sharing is required for most of Medicare's covered services. Furthermore, unlike many employment-based health insurance plans, Medicare does not have a catastrophic cap limiting the amount a person may have to pay out-of-pocket during a year.

- Medicare does not cover most long-term care services. Nursing home care is covered only for beneficiaries needing daily skilled nursing or rehabilitation services who have recently had a hospital stay of at least three days, and are covered only for up to 100 days. Home health is covered only for homebound beneficiaries who need part-time skilled nursing care or therapy services.

- Elderly Medicare beneficiaries living in the community (that is, not in nursing homes) are estimated to have spent an average of $2,149 in 1997 out-of-pocket for medical care~~th~~is amount includes insurance premiums and prescription drugs, but excludes long-term care. Among elderly beneficiaries with incomes below the poverty threshold, those without Medicaid coverage spent an average of $2,203 out-of-pocket, or about half of their income.[8]

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[7] Rather, they are entitled to Part A in one of the following three ways: they are age 65 or older and they or their spouse have contributed payroll taxes to Social Security for at least 40 quarters; they are disabled and have received Social Security disability payments for at least 24 months; or they have end-stage renal disease (ESRD) and have contributed to Social Security (or are the spouse or dependent of a contributor). However, elderly and certain younger disabled people who are not entitled to Part A may purchase it by paying a premium of $301 per month in 2000 (they must also enroll in, and pay the premium for, Part B).

[8] David J. Gross et al., "Out-of-Pocket Health Spending by Poor and Near-Poor Elderly Medicare Beneficiaries," *Health Services Research* 34 (April 1999, Part II):241–254.

Table I-2
Medicare Cost-Sharing Requirements, 2000

Part A[a]	
Services	**Beneficiary Cost-Sharing**
Hospital Stays	Deductible: $776 per benefit period. Coinsurance: $194/day for days 61–90; $388/day for days 91–150 (available once per person); All costs for additional days.
Skilled Nursing Facility Care (following a hospital stay of at least 3 days)	Coinsurance: $97/day for days 21–100; All costs for additional days.
Home Health Care (for homebound beneficiaries needing skilled care)	None for home health services; coinsurance of 20% for durable medical equipment.

Part B	
Services	**Beneficiary Cost-Sharing**
Premium	$45.50 per month.
Deductible	$100 per year.
Physician and Other Medical Services	Coinsurance: 20% of approved amount.
Outpatient Hospital Care	Coinsurance: 20% of hospital's charges.
Outpatient Mental Health	Coinsurance: 50% of approved amount.
Home Health Care (for homebound beneficiaries needing skilled care)	None for home health services; coinsurance of 20% for durable medical equipment.

[a] For most Medicare beneficiaries, there is no Part A premium. However, elderly and certain younger disabled people who are not entitled to Part A may purchase it by paying a premium of $301 per month in 2000 (they must also enroll in, and pay the premium for, Part B).

Note: Home health care is now included in Parts A and B.

Source: Health Care Financing Administration, *Medicare and You 2000,* Publication No. HCFA-10050 (Baltimore, MD: U.S. Department of Health and Human Services, revised January 2000).

The overwhelming majority of Medicare–Medicaid enrollees have full Medicaid benefits under their state's program (Chart I-2).

In 1995, approximately 91 percent of Medicare–Medicaid enrollees were eligible for full Medicaid benefits, while the remaining 9 percent received more limited benefits.

- For Medicare–Medicaid enrollees with full Medicaid benefits, Medicaid supplements Medicare by paying for services Medicare does not cover, primarily nursing home and other long-term care services and prescription drugs. For most of these enrollees, Medicaid also pays Medicare's premiums and some cost-sharing amounts. For those who are also Qualified Medicare Beneficiaries (QMBs), states are required to pay premiums and may pay for cost-sharing. For those who are also Specified Low-Income Medicare Beneficiaries (SLMBs), states pay Part B premiums. For those who are not enrolled in one of these programs, states have the option of paying Medicare's cost-sharing and premium requirement.[9]

- About 6 percent of Medicare–Medicaid enrollees in 1995 were QMBs who were not eligible for full Medicaid benefits (often referred to as QMBs-only); therefore, they received Medicaid coverage only for their Medicare premiums and cost-sharing. For another 3 percent of Medicare–Medicaid enrollees who were SLMBs-only, Medicaid was responsible only for their Part B premiums.

- A number of low-income Medicare beneficiaries who are eligible for QMB or SLMB benefits are not enrolled in these programs, with especially low participation for the SLMB program. A recent study estimated that 78 percent of eligible Medicare beneficiaries are enrolled as QMBs, and only 16 percent of eligible beneficiaries are enrolled as SLMBs.[10] Some barriers to enrollment include complicated state processes for determining eligibility and limited outreach activities.[11]

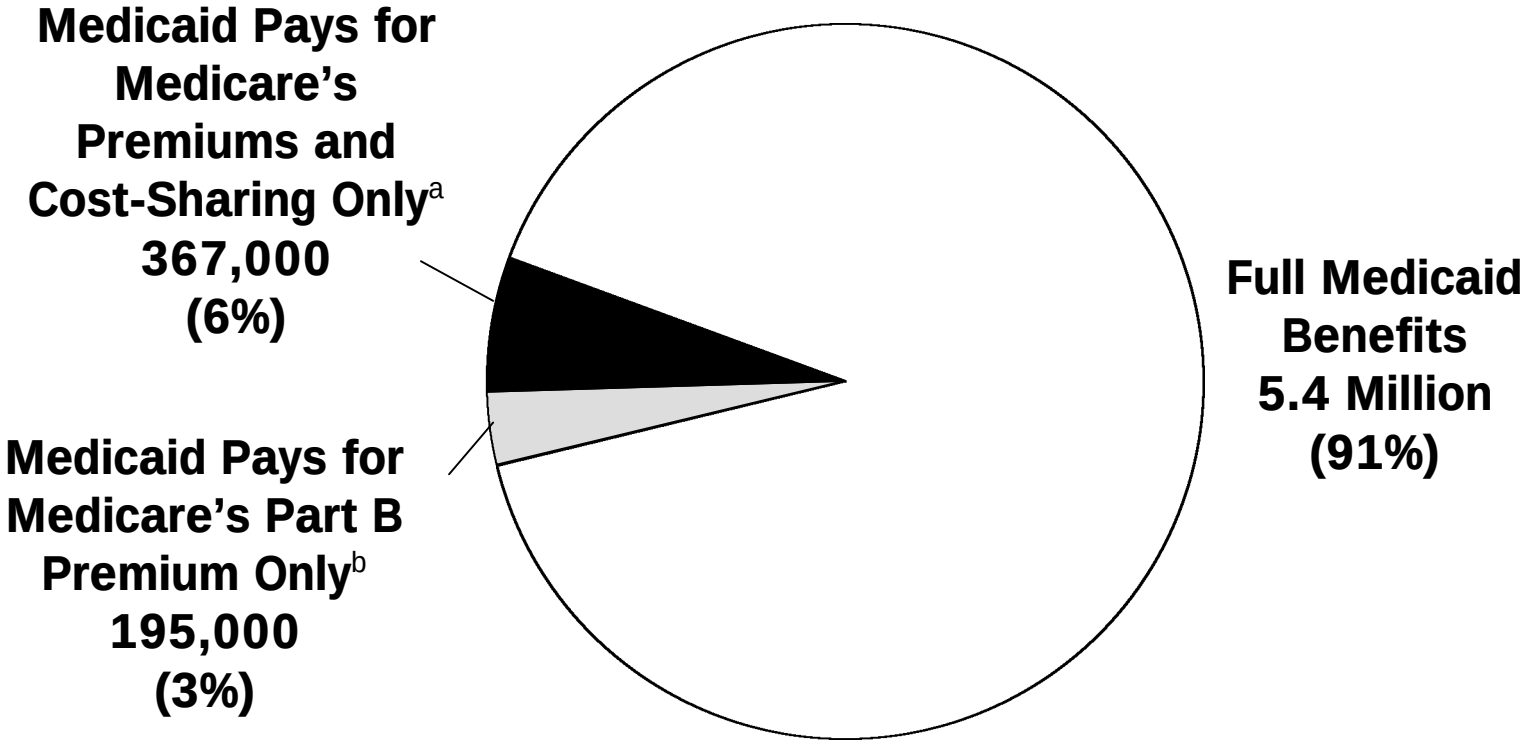
[9] Some people with full Medicaid benefits may have income or assets that are above the cutoffs for QMB or SLMB eligibility—for example, people may have income that exceeds the thresholds for QMB or SLMB eligibility, but qualify for Medicaid under their state's "medically needy" rules because of sufficiently high medical expenses.

[10] Marilyn Moon, Niall Brennan, and Misha Segal, "Options for Aiding Low-Income Medicare Beneficiaries," *Inquiry* 35 (1998):346–356.

[11] Nemore (December 1999).

Chart I-2. Distribution of Medicare–Medicaid Enrollees, by Extent of Medicaid Coverage

United States, 1995



Total Medicare–Medicaid Enrollees = 6 Million

[a] Qualified Medicare Beneficiaries (QMBs) who are not full Medicaid enrollees.
[b] Specified Low-Income Medicare Beneficiaries (SLMBs) who are not full Medicaid enrollees.

Source: Alliance for Health Reform, *Managed Care and Vulnerable Americans: Medicare and Medicaid Dual Eligibles*, March 1997.

The four states in this study vary in population characteristics and Medicaid programs (Table I-3).

The most populous state among the four is Georgia, followed by Massachusetts, Wisconsin, and Maryland. Together, the four states represent 8.9 percent of the total U.S. population, and 8.4 percent of elderly people.

- Compared with the nation as a whole, the proportion of the population that is elderly is lower in Georgia and Maryland, and higher in Massachusetts and Wisconsin. A similar pattern occurs for people age 85 and over, the group most likely to need long-term care~~in~~ 1995, the proportion of people in this age group was lower than the national average of 1.4 percent in Georgia (1.0%) and Maryland (1.1%), and higher in Massachusetts and Wisconsin (1.7% in each).

- Among the four states, Georgia had the highest poverty rate in 1994~~9~~5 among both nonelderly and elderly populations. In Georgia, 15.9 percent of the elderly and 19.4 percent of people under age 65 had family income below the federal poverty level, compared with national rates for these age groups of 12.1 percent and 18.9 percent, respectively. The poverty rate for the elderly was less than the national average in Massachusetts (11.2%) and Wisconsin (7.9%), and slightly above it in Maryland (12.3%). The poverty rate for the nonelderly was less than the national average in all three of the other states.

- The proportion of people with Medicaid in a state reflects the interplay of demographic factors and eligibility rules. Among the four states, Georgia's Medicaid program covers the largest proportion of people (15.7% in 1995), consistent with the state's higher poverty rate. Coverage is lowest in Maryland (8.1%). In Massachusetts, Medicaid covers 12 percent of the population, reflecting the relatively greater share of people age 85 and older as well as the state's relatively generous eligibility standards. Wisconsin's Medicaid program covers 8.9 percent of the state's residents, reflecting not only its lower poverty rate but also its relatively older population and its investment in long-term care.

- Medicaid programs in the four states vary considerably in level of spending for long-term care services for the elderly and in the proportion of that spending devoted to home-based (in contrast to institutional) care. In 1995, Massachusetts and Wisconsin spent considerably more on nursing home care per elderly person using Medicaid services than the national average, but somewhat less on home-based care. Georgia's 1995 spending was less than the national average in both areas, and Maryland's was more.

Table I-3
Selected Characteristics of the United States and Four States, 1995

	United States	Georgia	Maryland	Massachusetts	Wisconsin
Population (in thousands) [1]	262,761	7,192	5,027	6,061	5,113
Percent Age 65 and over	12.8%	10.0%	11.3%	14.1%	13.3%
Percent Age 85 and over	1.4%	1.0%	1.1%	1.7%	1.7%
Percent Nonmetropolitan [2]	21.8%	34.6%	10.5%	23.8%	31.8%
Percent Below Poverty (1994–1995)[a]					
Age under 65 [3]	18.9%	19.4%	15.9%	14.9%	12.3%
Age 65 and over [4]	12.1%	15.9%	12.3%	11.2%	7.9%
Percent Covered by Medicaid					
All Ages [5]	13.4%	15.7%	8.1%	12.0%	8.9%
Under Age 65 (1994–1995) [2]	12.2%	13.0%	9.3%	8.9%	7.9%
Age 65 and over [5]	12.4%	13.7%	7.7%	13.7%	12.1%
Medicaid Spending per Elderly Beneficiary[b] [6]					
Nursing Facility	$6,577	$3,556	$8,183	$11,932	$10,789
Home Care	$806	$338	$1,129	$515	$514
Nursing Home Beds per 10,000 People Age 75 and Over [7]	120	129	120	143	152

[a] Based on noninstitutional population.
[b] Spending per person receiving Medicaid services during the year.

Sources:
[1] U.S. Bureau of the Census, "ST-97-4, Estimates of the Population of the U.S., Regions, Divisions, and States by 5-Year Age Groups and Sex: Annual Time Series, July 1, 1990 to July 1, 1997," www.census.gov/population/estimates/state/97ageby5.txt (accessed 7/29/99).
[2] Urban Institute, "New Federalism Highlights of State Policies," reports on Health Policy for Low-Income People in Georgia (December 1998), Maryland (April 1999), Massachusetts (March 1998), and Wisconsin (December 1998).
[3] D. Liska, N. Brennan, and B. Bruen, *State-Level Databook on Health Care Access and Financing,* Third Edition (Washington, DC, Urban Institute: 1998).
[4] Urban Institute, unpublished TRIM adjusted estimate based on merged March 1995 and March 1996 Current Population Surveys (December 1999).
[5] D. Liska et al., *Medicaid Expenditures & Beneficiaries: National and State Profiles and Trends: 1990–1995*, Kaiser Commission on the Future of Medicaid (November 1997).
[6] J. Wiener and D. Stevenson, "Long-Term Care for the Elderly and State Health Policy," Urban Institute New Federalism Issues and Options for States, Series A, No. A-17 (November 1997).
[7] B. Bedney et al., *1995 State Data Book on Long-Term Care Program and Market Characteristics* (San Francisco: The University of California, San Francisco, November 1996).

Medicaid eligibility rules differ among the four states (Table I-4).

In general, Massachusetts and Wisconsin have relatively broader income criteria than the other two states. Georgia appears to have the most restrictive income tests.

- In addition to covering SSI recipients, Massachusetts and Wisconsin cover people who received state supplementation payments (SSP) but not SSI. Massachusetts further covers elderly residents with incomes up to the federal poverty level who meet certain resource tests (and disabled residents with incomes up to 133% of the poverty level under a demonstration program).[12]

- All four states offer coverage for the "medically needy" in the community and in nursing facilities. However, the income thresholds for this coverage vary widely. In Wisconsin, which has the most generous income test for this group, income (after "spending down" for health care) must be no greater than $578 for an individual (or 86% of the federal poverty level). At the other end of the range, the income threshold in Georgia is $208 (or 31% of the federal poverty level). For nursing home residents, Georgia also applies the 300 percent rule, so people with income above a maximum (which is not greater than 300% of the poverty level) cannot qualify for Medicaid regardless of how large their health care expenses may be.

- Currently, all four states offer home- and community-based services under a federal waiver, although they vary in the characteristics and size of the populations served by these programs. The extent of home- and community-based services waiver spending was notably lower in 1995 (the year analyzed in this chart book) in these states~~an~~d nationwide~~th~~an currently.[13]

- While Table I-4 provides some general comparative information about Medicaid eligibility in the four states, Medicaid eligibility is complex and depends not only on income limits but also on resource tests and what types of income and resources are used in applying the tests.

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[12] Brian K. Bruen et al., "State Usage of Medicaid Coverage Options for Aged, Blind, and Disabled People," Discussion Papers, Assessing the New Federalism (Washington, DC: Urban Institute, August 1999).
[13] Brian Burwell, "Medicaid Long-Term Care Expenditures in FY98," Memorandum (Cambridge, MA: The MEDSTAT Group, April 1, 1999).

Table I-4
Overview of Medicaid Eligibility Criteria for Elderly and Disabled People in Four States, 1998

Eligibility Category	Georgia	Maryland	Massachusetts	Wisconsin
	Maximum Income for Individuals Monthly Amount (and as a percentage of the Federal Poverty Level)			
Supplemental Security Income (SSI) Recipients	$494 (74%)	$494 (74%)	$494 (74%)	$494 (74%)
State Supplementation Payments (SSP) Recipients[a]	—	—	$623 (93%)	$578 (86%)
"Medically Needy"	$208 (31%)	$350 (52%)	$522 (78%)	$578 (86%)
Elderly People with Income up to the Federal Poverty Level	—	—	$671 (100%)	—
Is Nursing Facility Care Covered for the "Medically Needy?"	Yes	Yes	Yes	Yes
Is the Special Income Rule (300% Rule) for Nursing Home Residents in Effect (as of 1996)?	Yes	No	No	No
Are Home- and Community-Based Services Waiver Programs Available?	Yes	Yes	Yes	Yes

[a] Income threshold for individuals living independently in their own homes; threshold may differ for other groups.

Note: "—" indicates that the state does not offer this coverage.

Sources: Brian K. Bruen et al., "State Usage of Medicaid Coverage Options for Aged, Blind, and Disabled People," Discussion Papers, Assessing the New Federalism (Washington, DC: Urban Institute, August 1999); and Health Care Financing Administration, "Home- and Community-Based Services 1915(c) Waivers," www.hcfa.gov/medicaid/hpg4.htm (accessed 12/6/99).

II. Characteristics of Medicare–Medicaid Enrollees in Four States

The proportion of Medicare enrollees who are covered by Medicaid varies among states (Chart II-1).

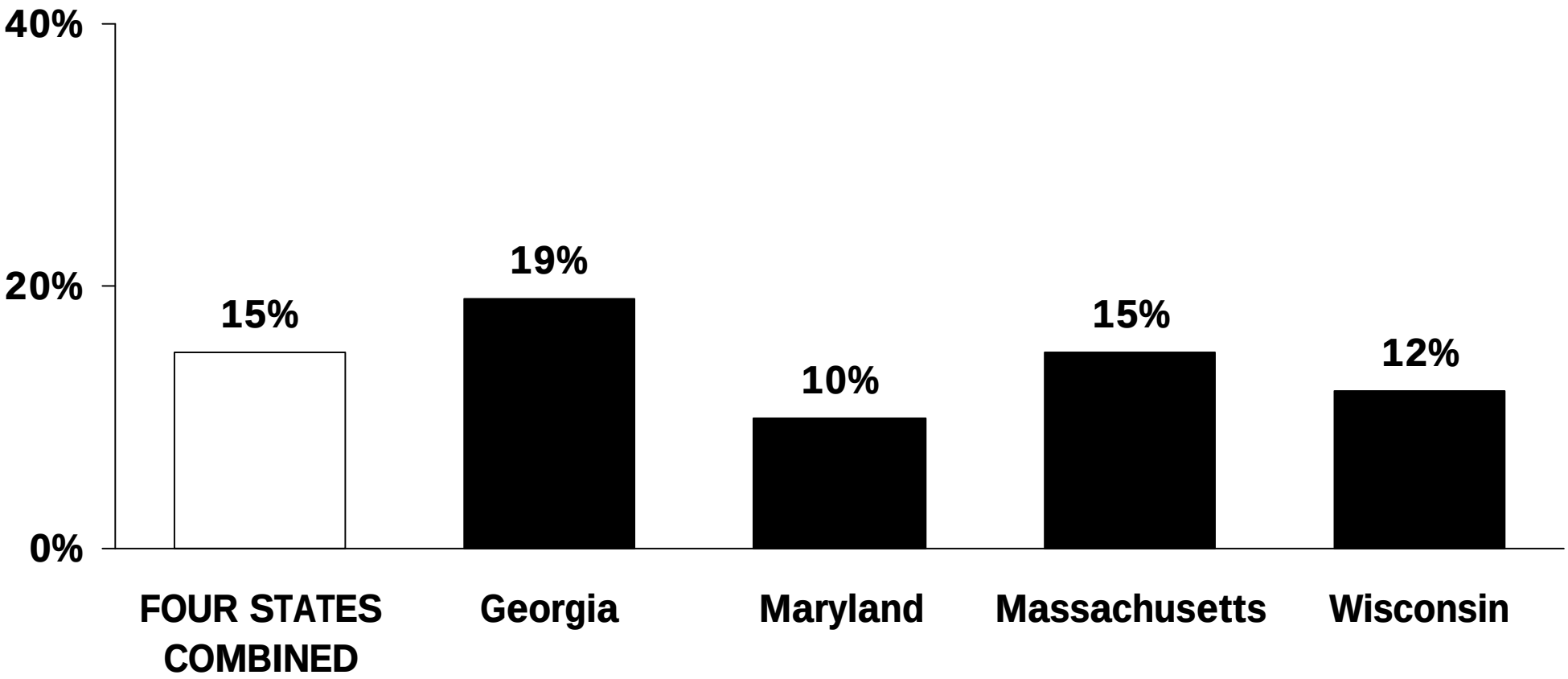
- Among the four states combined, Medicare-Medicaid represented about 15 percent of Medicare enrollees in 1995, similar to the national share, 16 percent, in that year.[14]

- The proportion of Medicare beneficiaries with Medicaid ranged from 10 percent in Maryland to 19 percent in Georgia.

- The variation in rates reflects a number of factors, including income and resource levels of the state population, state eligibility rules, and the extent and success of state efforts to enroll eligible Medicare beneficiaries in Medicaid. In Massachusetts, the relatively higher rate is consistent with the state's relatively broader eligibility criteria.

[14] Health Care Financing Administration, *A Profile of Dually Eligible Beneficiaries* (Baltimore, MD: Health Care Financing Administration, March 1997), based on 1995 data from the Medicare *Current Beneficiary Survey.*

Chart II-1. Medicare–Medicaid Enrollees as a Percentage of Medicare Enrollees, 1995



Note: Medicare–Medicaid enrollees and Medicare enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status and Medicare status, respectively.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin; data for all enrollees from the Medicare 5 Percent Denominator File.

The proportion of Medicare–Medicaid enrollees with full benefits varies somewhat among states (Chart II-2).

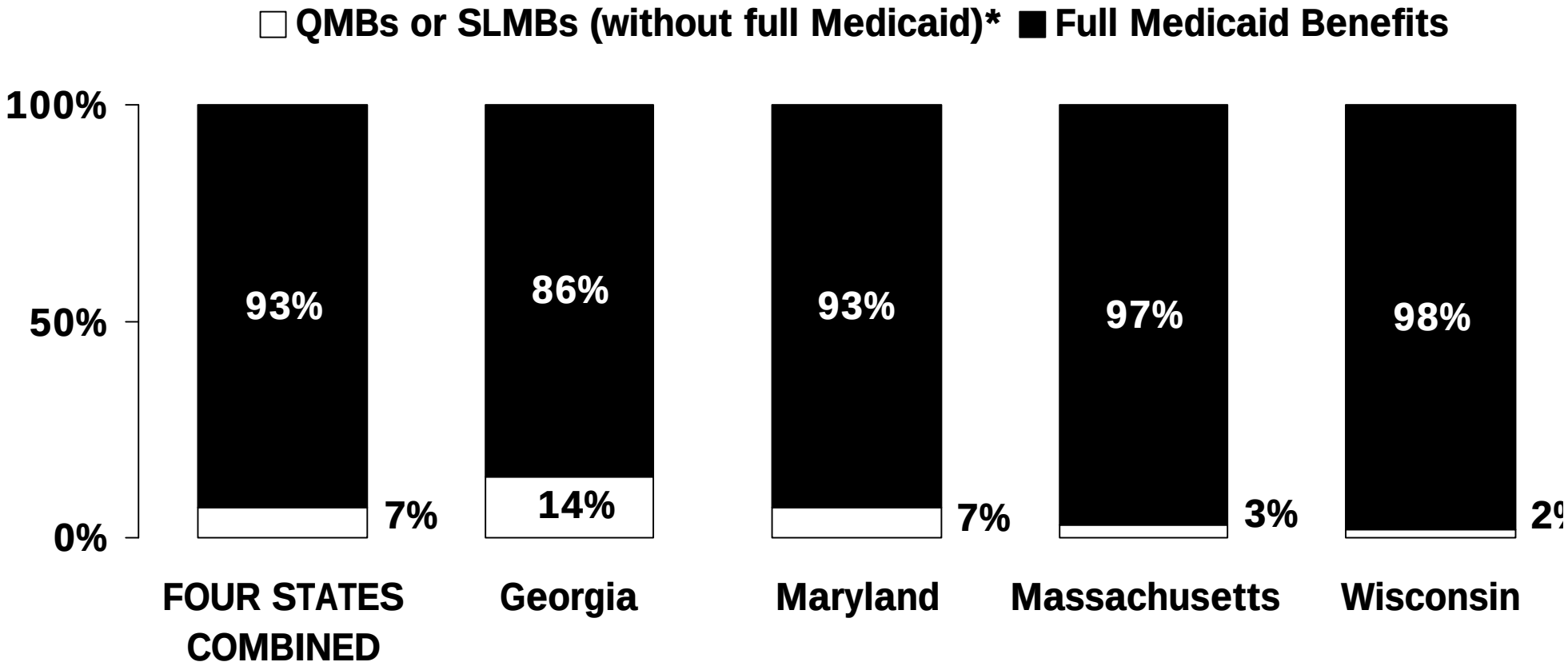
- Among the four states combined, the proportion of Medicare–Medicaid enrollees with full benefits in 1995 was an estimated 93 percent (slightly higher than the estimated national rate of 91% for that year). The other 7 percent of Medicare–Medicaid enrollees in the four states were QMBs-only or SLMBs-only, so they received limited Medicaid assistance.

- The proportion of Medicare–Medicaid enrollees with full benefits in 1995 ranged from an estimated 86 percent in Georgia to 98 percent in Wisconsin. The other Medicare enrollees in each state—that is, those who were QMBs-only or SLMBs-only—ranged from 14 percent in Georgia to 2 percent in Wisconsin. A proportion with full benefits in a state is related to eligibility criteria. For example, a state with relatively broader eligibility criteria will have a greater proportion with full benefits, all else being equal, because a greater share of people meeting the federal income and resource tests for QMB and SLMB benefits will also meet the tests for full benefits. The proportion with full benefits also reflects the extent to which the state enrolls people eligible as QMBs-only and SLMBs-only in those programs, such as Georgia's outreach efforts to enroll QMBs.

- Since 1995, the proportion of Medicare–Medicaid enrollees with limited benefits has probably increased somewhat because of increased enrollment of QMBs and SLMBs, and the creation of the new QI-1 and QI-2 categories, which first became effective in 1998.

Chart II-2. Estimated Distribution of Medicare–Medicaid Enrollees, by Eligibility Category

Percentage of Medicare–Medicaid Enrollees, 1995



* QMBs = Qualified Medicare Beneficiaries; SLMBs = Specified Low-Income Medicare Beneficiaries.

Note: Medicare–Medicaid enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

The type of insurance (Medicare or Medicaid) people had before obtaining dual Medicare–Medicaid status differs between nonelderly and elderly groups (Chart II-3).

Among Medicare-Medicaid enrollees under age 65, most had Medicaid coverage before becoming dually enrolled in both programs. In contrast, most elderly Medicare-Medicaid enrollees were covered by Medicare first.

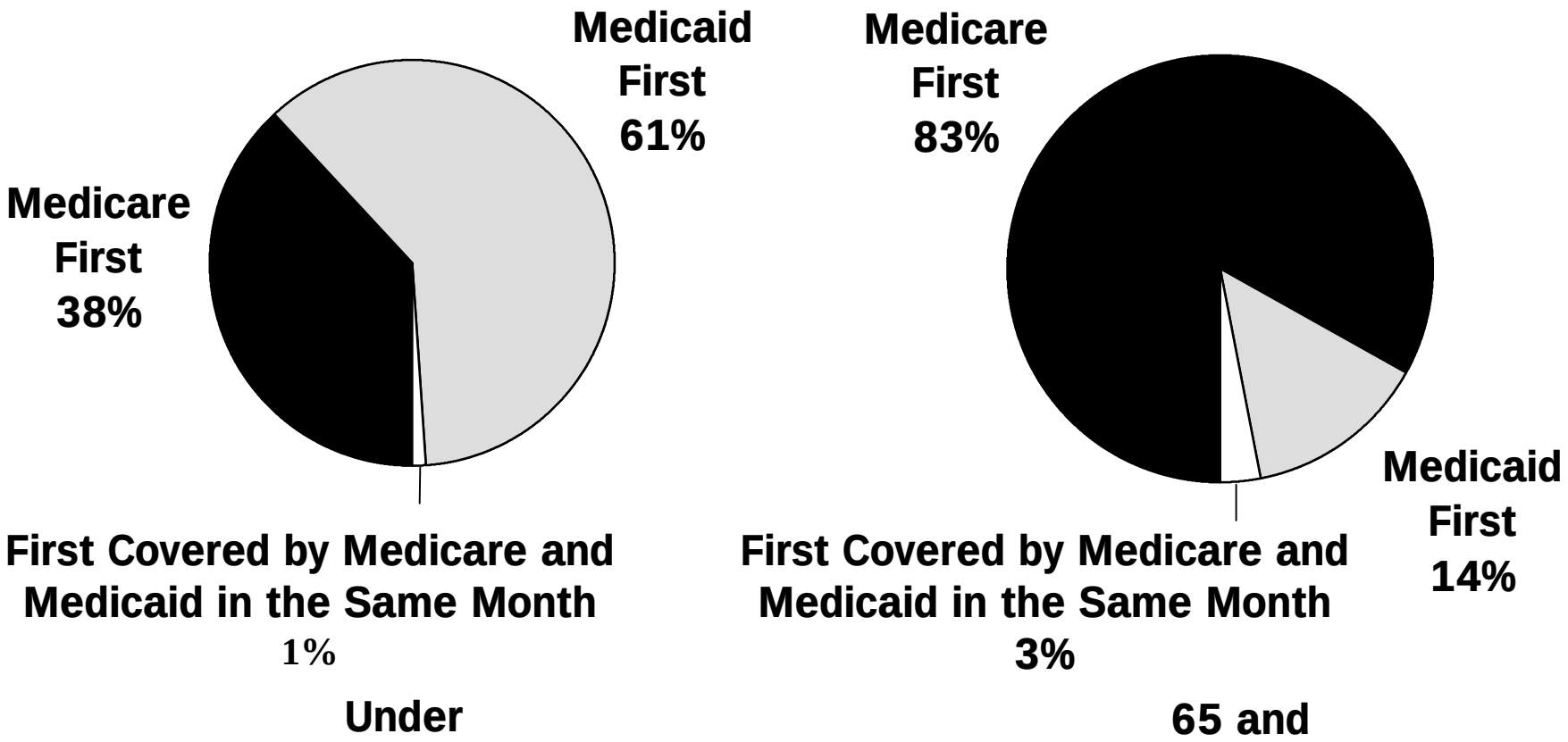
- Among Medicare-Medicaid enrollees who were under age 65 when they first became dually enrolled, 61 percent had Medicaid coverage first. This pattern reflects Medicare's rules for covering disabled nonelderly, which require a disabled person to have received Social Security disability payments for at least 24 months to qualify for Medicare. Thus, many low-income people with disabilities first meet Medicaid eligibility criteria, and then, after the two-year waiting period, become eligible for Medicare.

- Among the 38 percent of nonelderly disabled Medicare-Medicaid enrollees who were covered by Medicare first, many probably qualified for Medicaid under medically needy rules-that is, they had sufficiently high medical and long-term care expenses to enable them to "spend down" their resources to an eligible level-or under the "special income rule" for institutionalized individuals (see Table I-1 and accompanying discussion). A small fraction (1%) of Medicare-Medicaid enrollee under age 65 appear to have enrolled in both programs during the same month.

- For Medicare-Medicaid enrollees who were age 65 or older at the time dual status was obtained, 83 percent were covered by Medicare first. As with younger enrollees who had Medicare first, many of these beneficiaries probably qualified for Medicaid after they had high health care costs-for example, after becoming a nursing home resident. Some may have learned later that they were eligible for Medicaid benefits, such as help with their Medicare premiums, or have experienced a drop in income to a qualifying level (for example, due to retirement or the death of a spouse).

- About 14 percent of elderly Medicare-Medicaid enrollees were covered by Medicaid first, and then Medicare—probably when they turned 65. Another 3 percent enrolled in both programs at the same time, probably when they turned 65.

Chart II-3. Which Program Were Medicare–Medicaid Enrollees Covered by First?



* Age in first month of dual Medicare–Medicaid enrollment.

Note: Chart is based on 1994–1995 data for Medicare–Medicaid enrollees in 1995 who first became covered by both programs after January 1994 (32% of Medicare–Medicaid enrollees under age 65 at the end of 1995, and 24% of those age 65 and older).

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

The Medicare–Medicaid population is relatively dynamic (Chart II-4).

A sizable proportion of people who have Medicare–Medicaid status at some point during the year do not have that status for the full year.

- In the four states, among people who were Medicare–Medicaid enrollees at some point during 1995, about one-quarter had this status for only part of the year.

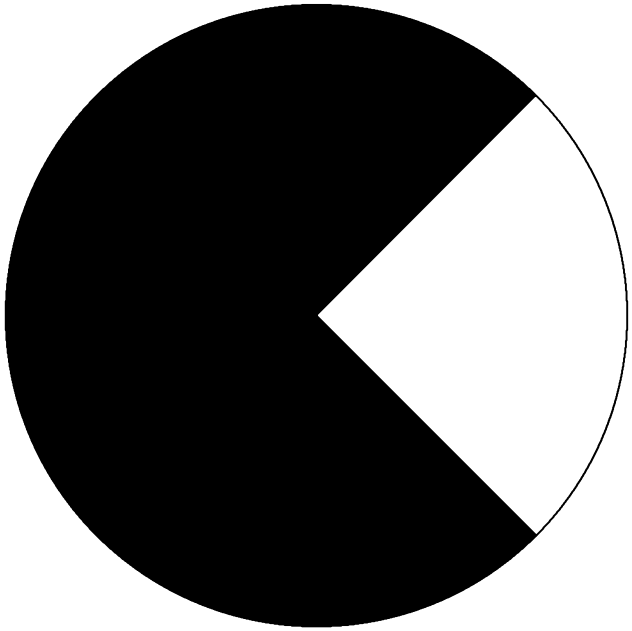
- The figure of one-quarter who had Medicare–Medicaid status for only part of the year reflects new enrollment (14%), deaths (7%), and lapses in enrollment (4%). The proportions for new enrollment and lapses include people who moved into the state or out of the state, respectively~~the~~ number of such people is unknown.

- In the four states combined, 527,000 people were Medicare–Medicaid enrollees during some part or all of 1995. However, the average number of enrollees per month was 459,000 in the four states.

- The size of the Medicare–Medicaid populations varied among the states. Georgia had the largest, with 184,000 total enrollees during the year and a monthly average of 161,000. Maryland had the fewest: 73,000 in total during the year, averaging 62,000 per month (see Appendix Table II-4).

Note: Because of the dynamic nature of the population, this chart book uses monthly status to define the Medicare–Medicaid population and subpopulations of interest. For example, in looking at the age distribution of Medicare–Medicaid enrollees, each Medicare–Medicaid enrollee is weighted according to the fraction of the year that he or she had Medicare–Medicaid status. Thus, a person who had Medicare–Medicaid status for half the year is effectively treated as one-half of a person with that status for the entire year.

Chart II-4. Distribution of Medicare–Medicaid Enrollees, by Months of Medicare–Medicaid Status During the Year, 1995



Reasons for Part-Year Status

Became newly enrolled[b]	**14%**
Died	**7%**
Enrollment ended or lapsed[c]	**4%**

Total Medicare–Medicaid Enrollees During the Year (527,000 in the four states)

[a] Includes about 1% who died during the last month of the year.
[b] Includes about 1% who also died during the year and 1% who also had enrollment end or lapse.
[c] Includes people who moved to other states.

Note: Average number of Medicare–Medicaid enrollees per month = 459,000.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Among Medicare beneficiaries, the youngest and oldest groups are most likely to also have Medicaid coverage (Chart II-5).

Disabled Medicare beneficiaries under age 65 are much more likely to be covered by Medicaid than elderly beneficiaries as a group, but among the elderly, the rate of Medicaid coverage increases notably with age.

- In the four states, 31 percent of disabled Medicare beneficiaries under age 65 are covered by Medicaid, compared with 12 percent of the elderly. This is consistent with the relatively lower level of income and greater need for long-term care among the disabled Medicare population than among elderly enrollees.

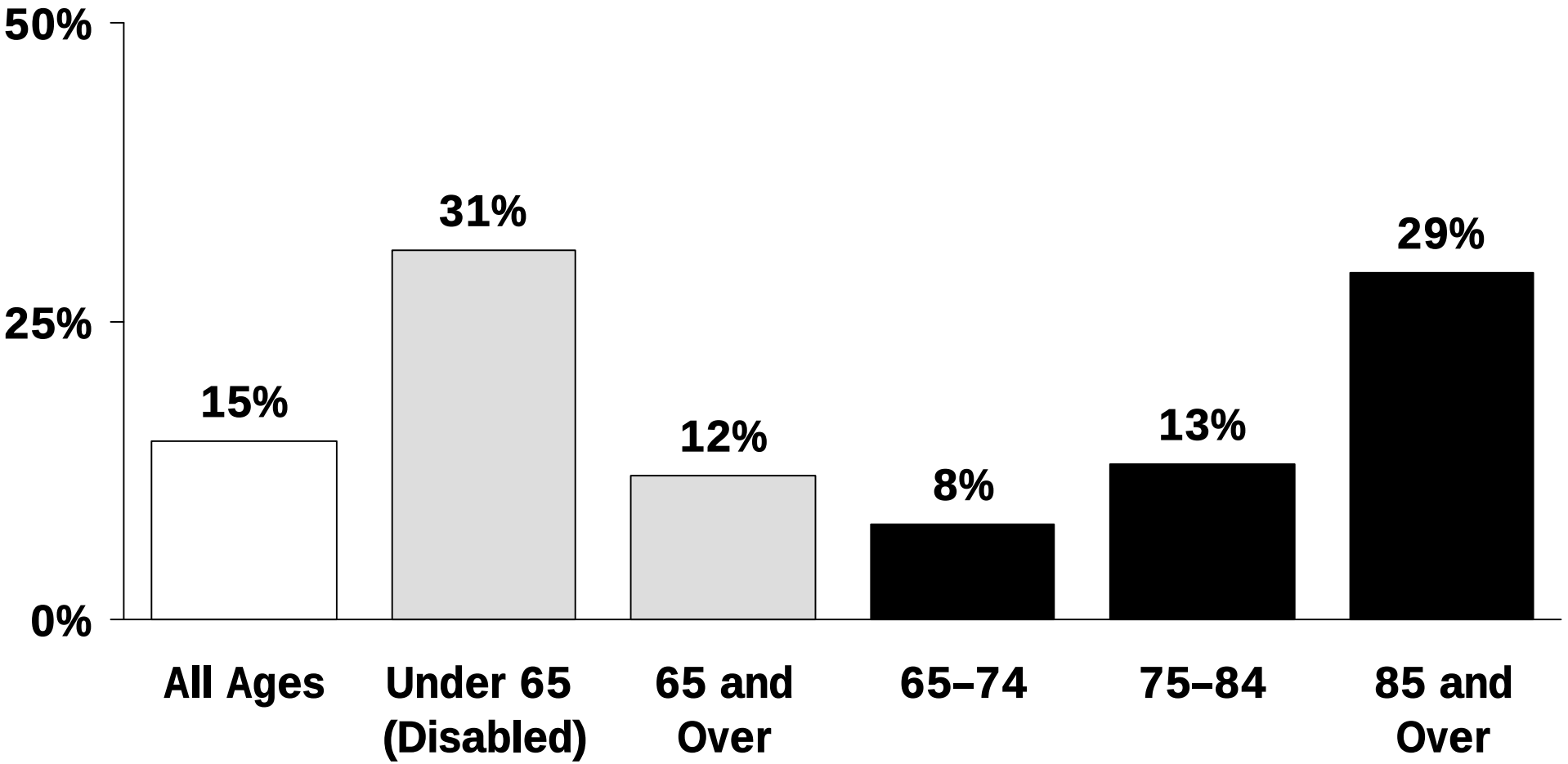
- Among elderly Medicare enrollees, the proportion with Medicaid coverage increases steeply with age, rising from 8 percent of those age 65~~7~~4 in 1995, to 13 percent of those age 74~~8~~5, and then to 29 percent of those age 85 or older. This steep rise is consistent with the greater long-term care expenses, especially for nursing home care, of people age 85 and older (and thus, an increased likelihood that they qualify for Medicaid based on medically needy criteria or criteria for institutional residents), as well as their relatively lower income levels, compared with beneficiaries age 65~~7~~4.

The pattern is similar in each state~~th~~at is, the youngest and oldest groups of Medicare enrollees have the highest rates of Medicaid coverage~~b~~ut the percentage of each age group covered by Medicaid varies among the four states (see Appendix Table II-5).

- Among elderly Medicare beneficiaries, the proportion that also have Medicaid ranged from 8 percent in Maryland to 17 percent in Georgia. Among Medicare beneficiaries age 85 and older, the proportion covered by Medicaid ranged from 20 percent in Maryland to 39 percent in Georgia.

- Medicaid's coverage of Medicare enrollees under age 65 ranged from 24 percent in Maryland to 36 percent in Massachusetts. Although Georgia had the highest coverage among the four states for elderly Medicare beneficiaries, it ranked third in coverage of the nonelderly disabled Medicare beneficiaries (28%), perhaps reflecting more restrictive Medicaid eligibility criteria for this population than in the other states.

Chart II-5. Medicare–Medicaid Enrollees as a Percentage of Medicare Enrollees, by Age, 1995



Note: Medicare–Medicaid enrollees and Medicare enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status and Medicare status, respectively.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin; data for all enrollees from Medicare 5 Percent Denominator File.

Medicare–Medicaid enrollees are more likely than other Medicare beneficiaries to be under age 65 or age 85 and over (Chart II-6).

- In the four states, 31 percent of Medicare–Medicaid beneficiaries were under age 65, compared with 15 percent of all Medicare beneficiaries.

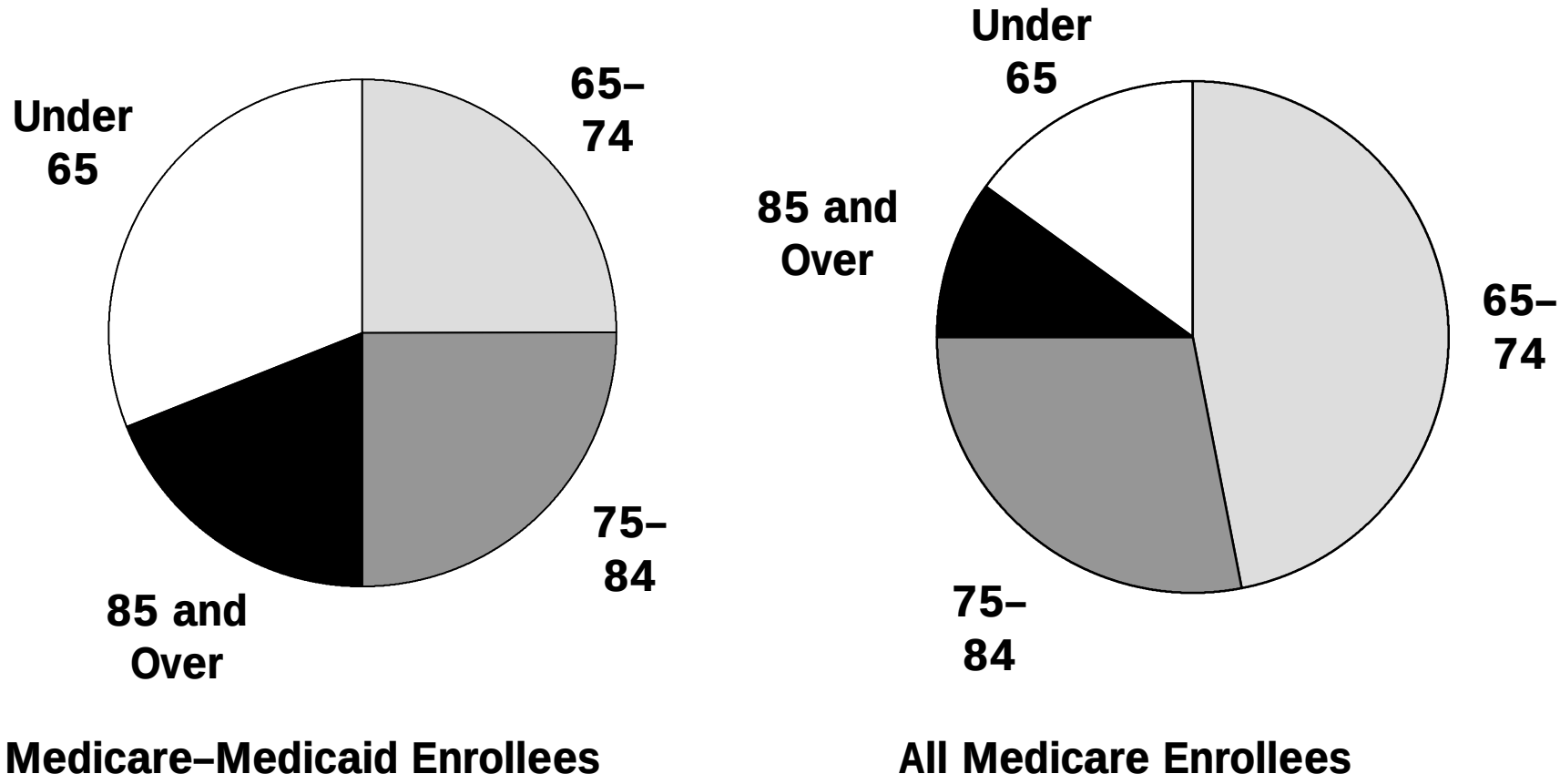
- Among elderly Medicare enrollees, the likelihood of Medicaid coverage increases significantly with age. Thus, 19 percent of Medicare–Medicaid enrollees were age 85 and over, compared with 10 percent of all Medicare enrollees in these states.

States are relatively similar in their age distributions of Medicare–Medicaid enrollees and other enrollees, respectively, although there are some differences (see Appendix Table II-6).

- The pattern of Medicare–Medicaid enrollees being disproportionately in the youngest and oldest age groups is especially pronounced for Wisconsin, where 34 percent of Medicare–Medicaid enrollees are under age 65, and 22 percent are at least 85 years old.

- In Georgia, disabled Medicare beneficiaries under age 65 constitute a larger share of all Medicare enrollees, but a slightly smaller share of Medicare–Medicaid enrollees than in other states.

Chart II-6. Age Distribution of Medicare–Medicaid Enrollees Compared with All Medicare Enrollees, 1995



Note: Medicare–Medicaid enrollees and all Medicare enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status and Medicare status, respectively.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin; data for all enrollees from Medicare 5 Percent Denominator File.

More than two-thirds of Medicare–Medicaid enrollees are women (Chart II-7).

Within each age group elderly and nonelderly Medicare–Medicaid enrollees are more likely to be female than Medicare enrollees in general.

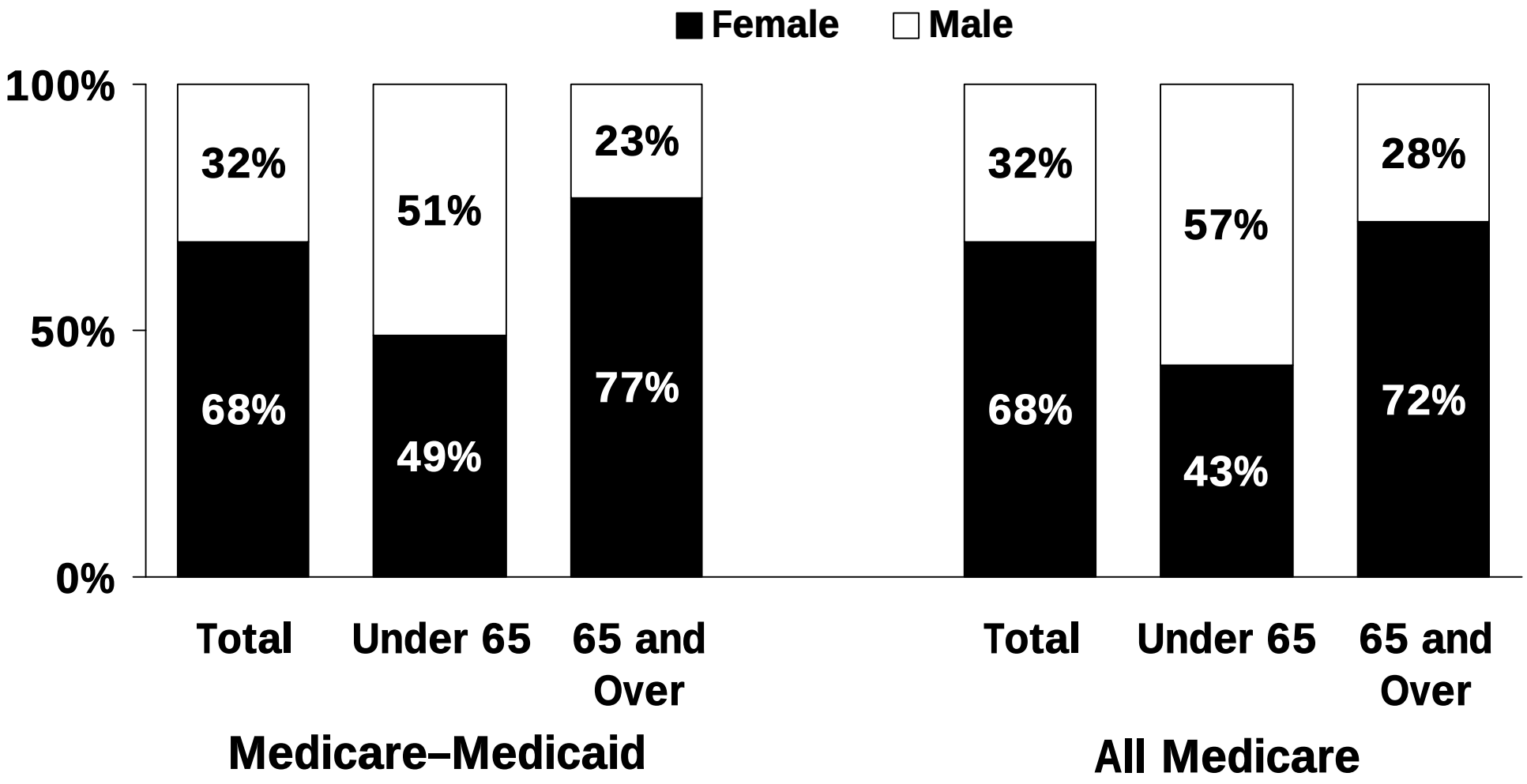
- Among elderly Medicare enrollees, 77 percent of Medicare–Medicaid enrollee are women, compared with 72 percent of all Medicare enrollees in the four states.

- Among disabled Medicare enrollees under age 65, women constitute 49 percent of Medicare–Medicaid enrollees, compared with 43 percent of all Medicare enrollees in the four states.

- For both age groups combined, however, the proportion of Medicare–Medicaid enrollees who are women is similar to that for the general Medicare population (68 percent) reflecting the greater proportion of nonelderly (who are relatively less likely to be female) in the Medicare–Medicaid population than in the general Medicare population.

- The proportion of women among Medicare–Medicaid enrollees increases with age (as it does for the general Medicare population), rising from 71 percent of those age 65–74, to 78 percent of those age 75–84, to 84 percent of those age 85 and older.

Chart II-7. Gender Distribution of Medicare–Medicaid Enrollees Compared with All Medicare Enrollees, by Age, 1995



Note: Medicare–Medicaid enrollees and all Medicare enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status and Medicare status, respectively.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin; data for all enrollees from Medicare 5 Percent Denominator File.

Nursing home residence among Medicare–Medicaid enrollees rises steeply with age (Chart II-8).

Nursing home residence among Medicare-Medicaid enrollees is much greater than for other Medicare enrollees, and increases notably with age.

- Using combined data from the four states, 26 percent of Medicare-Medicaid enrollees lived in nursing homes or similar institutions. Similarly, one study of Medicare-Medicaid enrollees nationwide found that 24 percent of this population lived in nursing homes in 1995, compared with 2 percent of other Medicare enrollees.[15]

- A much greater proportion of elderly than nonelderly Medicare-Medicaid enrollees live in nursing homes-35 percent of the elderly compared with 8 percent of the nonelderly. In contrast, less than 5 percent of elderly people nationwide lived in nursing homes in 1995.[16]

- Among Medicare-Medicaid enrollees age 85 and over in the four states, 62 percent live in nursing facilities or similar institutions.

There are considerable differences among states in the residential status of Medicare-Medicaid enrollees, especially among elderly enrollees (see Appendix Table II-8).

- Among the four states, Georgia has the lowest rate of nursing home residence: 24 percent among elderly and 6 percent among nonelderly Medicare-Medicaid enrollees.

- In contrast, in Wisconsin-the state with the highest rate of nursing home residence among the four-46 percent of elderly and 11 percent of nonelderly Medicare-Medicaid enrollees live in nursing facilities.

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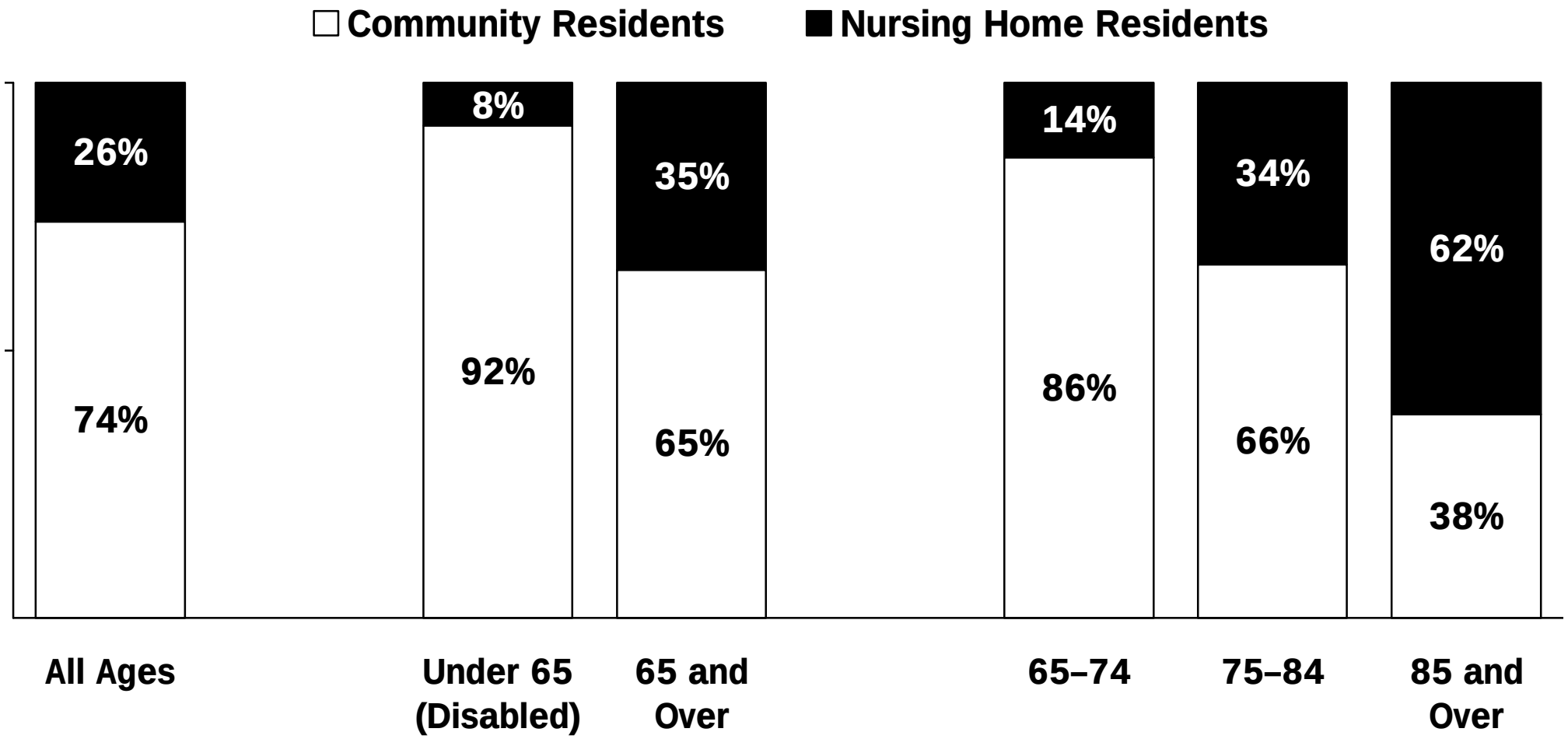
[15] Health Care Financing Administration (March 1997).

[16] Christine E. Bishop, "Where Are the Missing Elders? The Decline in Nursing Home Use, 1985 and 1995," *Health Affairs* 18 (July/August 1999):146–155.

Chart II-8. Distribution of Medicare–Medicaid Enrollees by Nursing Home or Community Residence, by Age, 1995



Note: Enrollees were weighted by the proportion of months of designated status during the year.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

III. Elderly Medicare–Medicaid Enrollees: Spending and Service Use Across Both Programs

For elderly Medicare–Medicaid enrollees, Medicaid contributes more than half of combined Medicare and Medicaid spending (Chart III-1).

Sections III and IV of this chart book analyze spending and service use for elderly Medicare–Medicaid beneficiaries with full Medicaid benefits. An advantage of this approach is that all enrollees analyzed within a state had access to all Medicaid services in the state, so differences in spending among states are not influenced by their differing proportions of enrollees with full benefits in contrast to more limited benefits. The elderly made up 69 percent of the Medicare–Medicaid population with full Medicaid benefits and accounted for 72 percent of their total Medicare and Medicaid spending in the four states.

- For the four states combined, Medicare and Medicaid spending together averaged $1,675 per month per person for elderly Medicare–Medicaid enrollees (or $20,100 on an annualized basis).[17] Medicaid paid for the majority of spending for this group: 59 percent, compared with Medicare's share of 41 percent.

- While Medicare and Medicaid together finance the bulk of health care for Medicare–Medicaid enrollees, some costs are financed out-of-pocket by enrollees or by other insurance. This is especially true of Medicare–Medicaid enrollees who are not eligible for full Medicaid benefits, but also of those with full benefits. For example, people eligible under "medically needy" criteria will have spent down their income on health care to qualify. Similarly, institutional residents are required to pay all of their income for their care except a small allowance for personal needs (and protected income for a community-dwelling spouse). One analysis of 1997 data for all Medicare–Medicaid enrollees found that Medicare and Medicaid together paid for about 80 percent of Medicare–Medicaid enrollees' health care expenditures.[18]

Note: Medicaid spending reported in this chart book includes Medicaid's payments for Medicare deductibles and other cost-sharing, but does not include the amounts paid by Medicaid for Medicare premiums.

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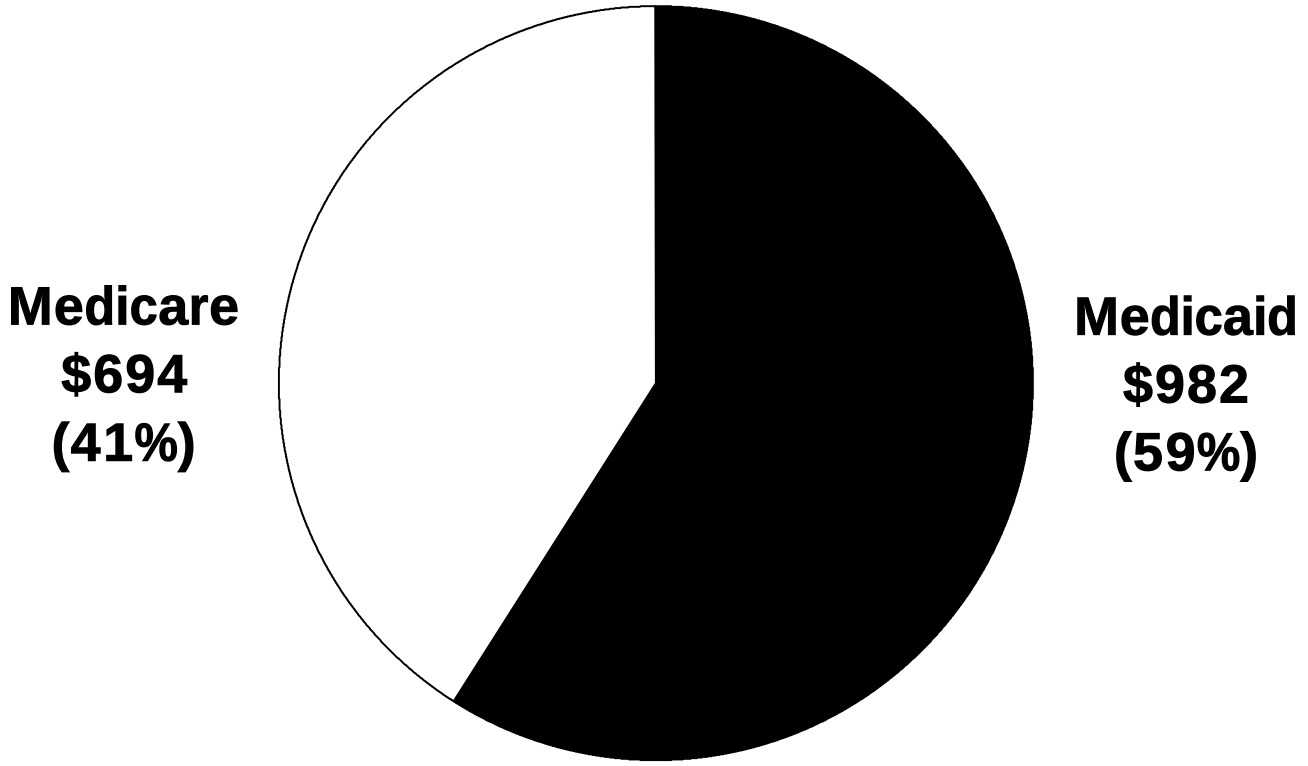
[17] Although annual equivalents to monthly amounts (that is, the monthly amount multiplied by 12) are occasionally presented in the chart book, it should be kept in mind that a significant fraction of Medicare–Medicaid enrollees analyzed did not have that status for all of 1995. Thus, the annualized amount could be considered the spending for a "full-year-equivalent" enrollee.

[18] Lauren A. Murray and Andrew E. Shatto, "MCBS Highlights: Dually Eligible Medicare Beneficiaries," *Health Care Financing Review* 20 (Winter 1998):131–140.

Chart III-1. Average Monthly Medicare and Medicaid Spending for Elderly Medicare–Medicaid Enrollees, 1995



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

States differ in their level of total Medicare and Medicaid spending per person, and each program's share of the total (Chart III-2).

- Average monthly Medicare and Medicaid spending per elderly Medicare–Medicaid enrollee in 1995 ranged from $1,377 in Georgia to $1,991 in Massachusetts (or about one and a half times the Georgia level).

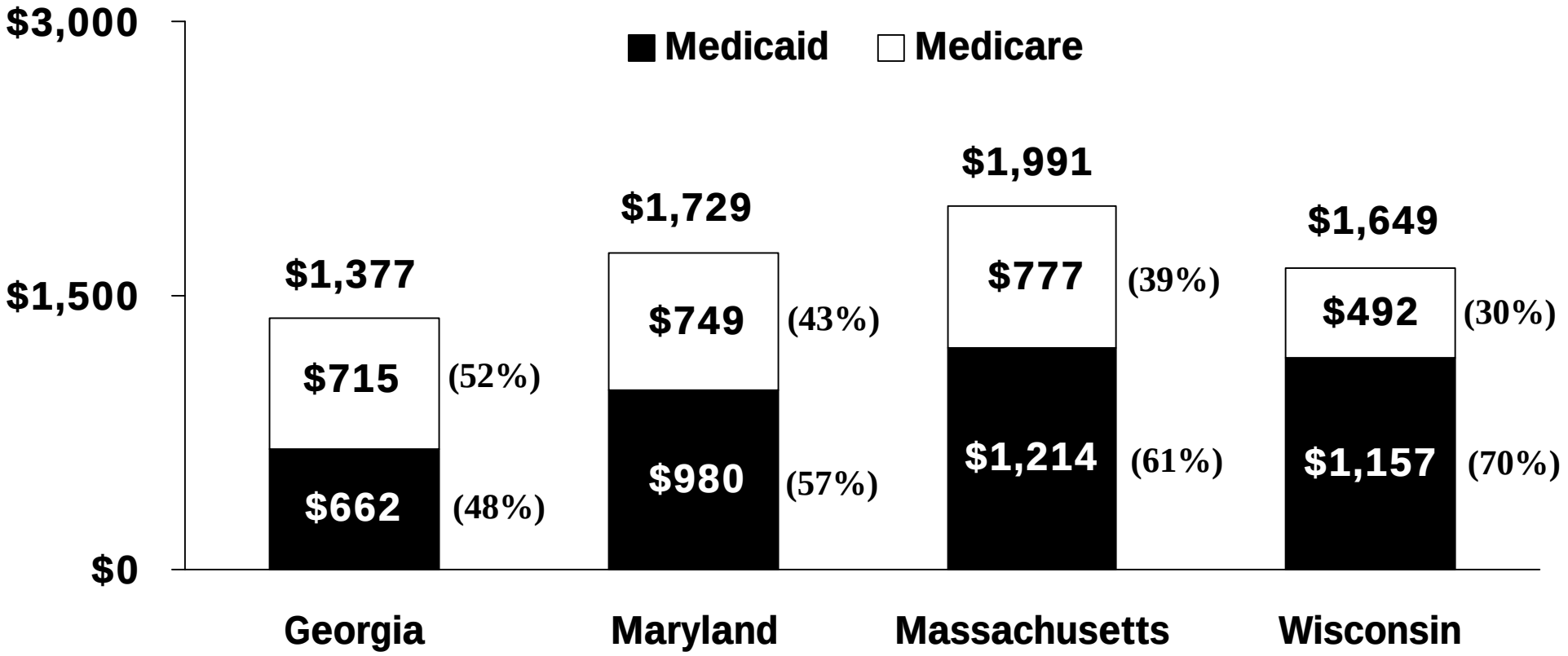
- Most of the difference in average spending per person among the four states is driven by differences in Medicaid spending per person, which ranged from a monthly average of $662 in Georgia to almost double that amount in Massachusetts ($1,214).

- Consistent with this pattern, Medicaid's share of spending is generally greater in the states with higher Medicaid levels. Medicaid's share of spending ranged from 48 percent in Georgia to 70 percent in Wisconsin.

- With the exception of Wisconsin, average Medicare spending per elderly Medicare–Medicaid enrollee is quite similar across states, ranging from a monthly average of $715 in Georgia to $777 in Massachusetts. Wisconsin stands out with a much lower amount—$492, or about two-thirds the average in the other three states.

- Based on Medicare payments per enrollee in 1995 for the general Medicare population, the states ranked in the same order as for elderly Medicare–Medicaid enrollees, with Wisconsin having the lowest average of the four ($298 per month), followed by Georgia ($399), Maryland ($446), and Massachusetts ($506) (Appendix Table III-3).

Chart III-2. Average Monthly Medicare and Medicaid Spending for Elderly Medicare–Medicaid Enrollees, by State



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

On average, Medicare spending for elderly Medicare–Medicaid enrollees is much greater than for Medicare enrollees in general (Chart III-3).

- Average Medicare spending per person for elderly Medicare-Medicaid enrollees is 68 percent greater than all Medicare enrollees in the four states—$694 per month, compared with $413. While Chart III-3 compares elderly Medicare-Medicaid enrollees to Medicare enrollees of all ages in the four states, national data suggest that the level and distribution by service type of Medicare spending for the elderly is nearly identical to that for all enrollees.[19]

- Elderly Medicare-Medicaid enrollees have greater spending, on average, than all Medicare enrollees for each category of Medicare service. Inpatient hospital care—the largest component of spending for both groups—was 51 percent greater for elderly Medicare-Medicaid enrollees than for all enrollees, averaging $284 per month, compared with $188 per month. Use of physician and supplier (such as other professional) services was 32 percent greater for elderly Medicare-Medicaid enrollees ($133 per month) than for the general Medicare population ($101 per month).

- Medicare-Medicaid enrollees use considerably more skilled nursing facility and home health care, on average, than the general Medicare population. In the four states, skilled nursing facility spending per enrollee was more than three times greater for elderly Medicare-Medicaid enrollees than for all enrollees ($66 per month, compared with $19 per month). Home health use was more than twice as great for elderly Medicare-Medicaid enrollees ($82 per month, compared with $38 per month).

- These spending patterns are consistent with other evidence that Medicare-Medicaid enrollees have poorer health status and greater care needs. For example, they are more likely to have many chronic or serious conditions, including stroke, heart disease, diabetes, and hip fractures, than other Medicare enrollees.[20]

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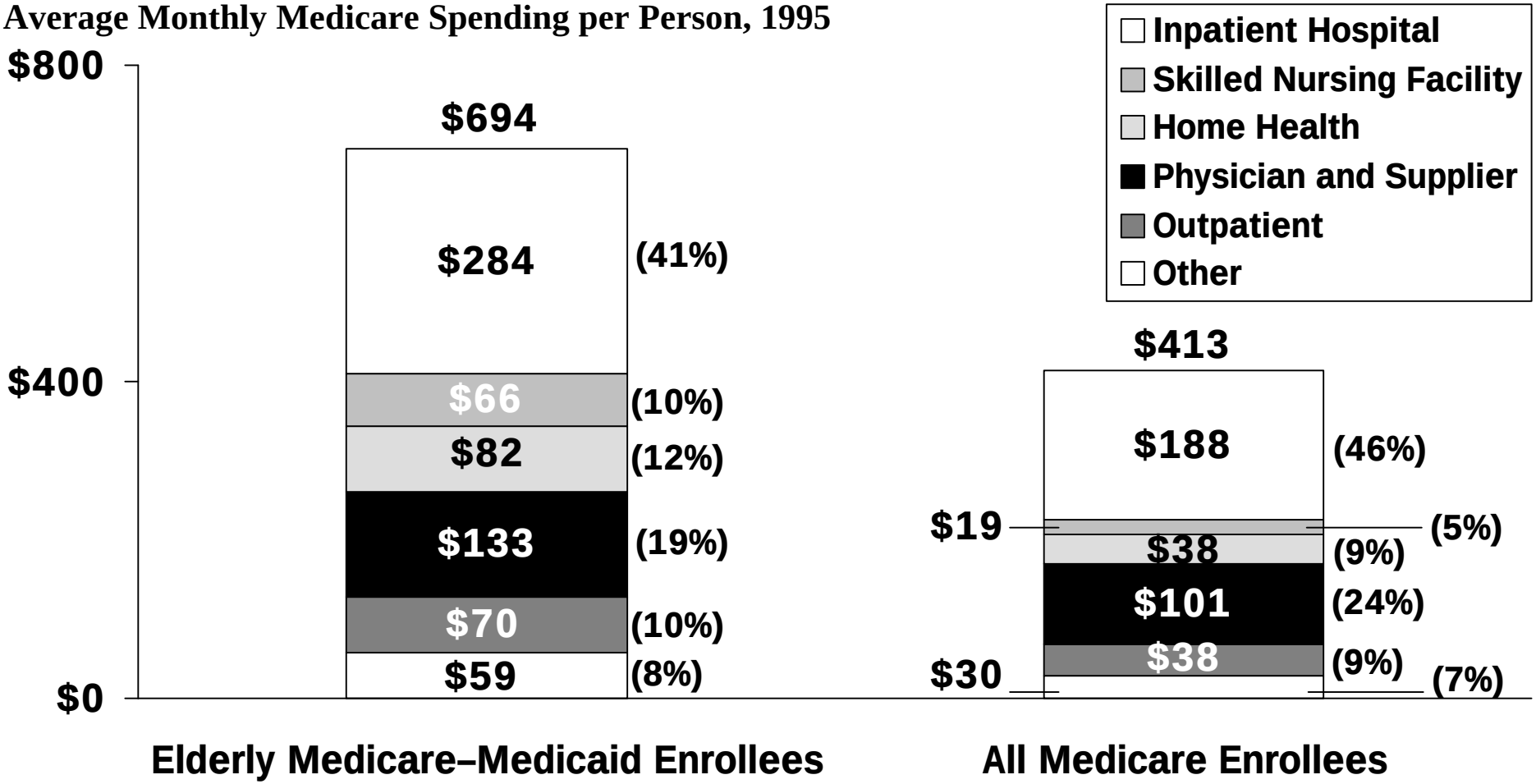
[19] At the national level, Medicare spending per enrollee in 1995 was $4,625 (or $385 per month) for elderly enrollees, compared with $4,667 (or $389 per month) for enrollees of all ages. *Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1997* (Baltimore, MD: U.S. Department of Health and Human Services, Health Care Financing Administration, October 1997).

[20] Health Care Financing Administration (March 1997).

Chart III-3. Medicare Spending for Elderly Medicare–Medicaid Enrollees Compared with All Medicare Enrollees, by Type of Service



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin; and tabulation of data for all enrollees from *Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1997.*

Nursing home care is the single largest component of spending across both programs (Chart III-4).

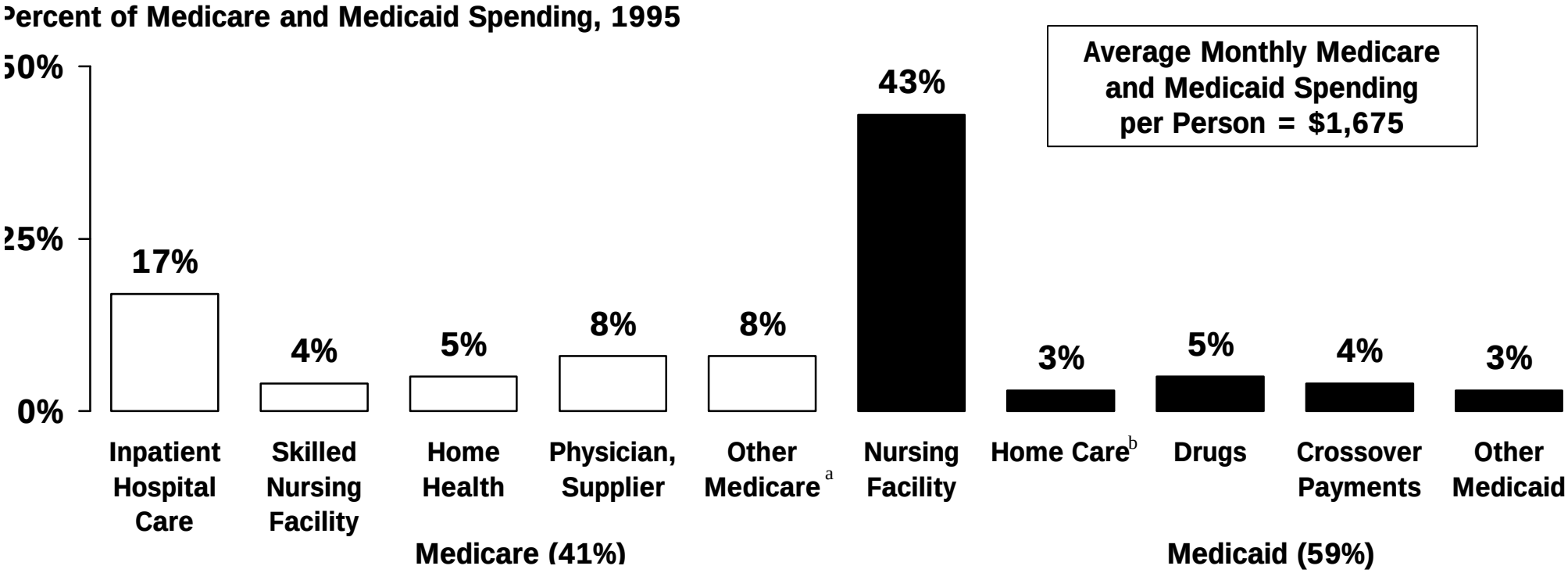
- Looking at the four states combined, the largest component of spending for elderly Medicare–Medicaid enrollees is Medicaid nursing home spending, accounting for 43 percent of overall spending.

- While Medicaid nursing home spending is the largest expenditure category in each of the four states, its share of spending varies significantly, ranging from 32 percent in Georgia to 52 percent in Wisconsin (Appendix Table III-4).

- Medicare inpatient hospital care is the next largest spending category, accounting for 17 percent of total Medicare and Medicaid spending. As a share of spending, Medicare inpatient hospital care among the four states ranged from 12 percent in Wisconsin to 21 percent in Georgia and Maryland (Appendix Table III-4).

- Since Medicaid is a secondary payer after Medicare for services covered by both programs, Medicaid pays for relatively little acute health care for the Medicare–Medicaid population. Noteworthy exceptions are Medicaid payments for prescription drugs and for Medicare's deductibles and copayments ("crossover payments"), which account for 5 percent and 4 percent, respectively, of total Medicare and Medicaid spending.

Chart III-4. Distribution of Medicare and Medicaid Spending for Elderly Medicare–Medicaid Enrollees, by Type of Service



[a] Consists of outpatient (4%), durable medical equipment (1%), chronic care and rehabilitation facilities (2%), and hospice (less than 0.5%).
[b] Consists of home health, personal care, and home- and community-based waiver services.
[c] Medicaid payments for third-party (primarily Medicare) deductibles and copayments.
[d] Consists of professional services, supplies, and transportation (2%); inpatient hospital (1%); and outpatient (less than 0.5%).

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

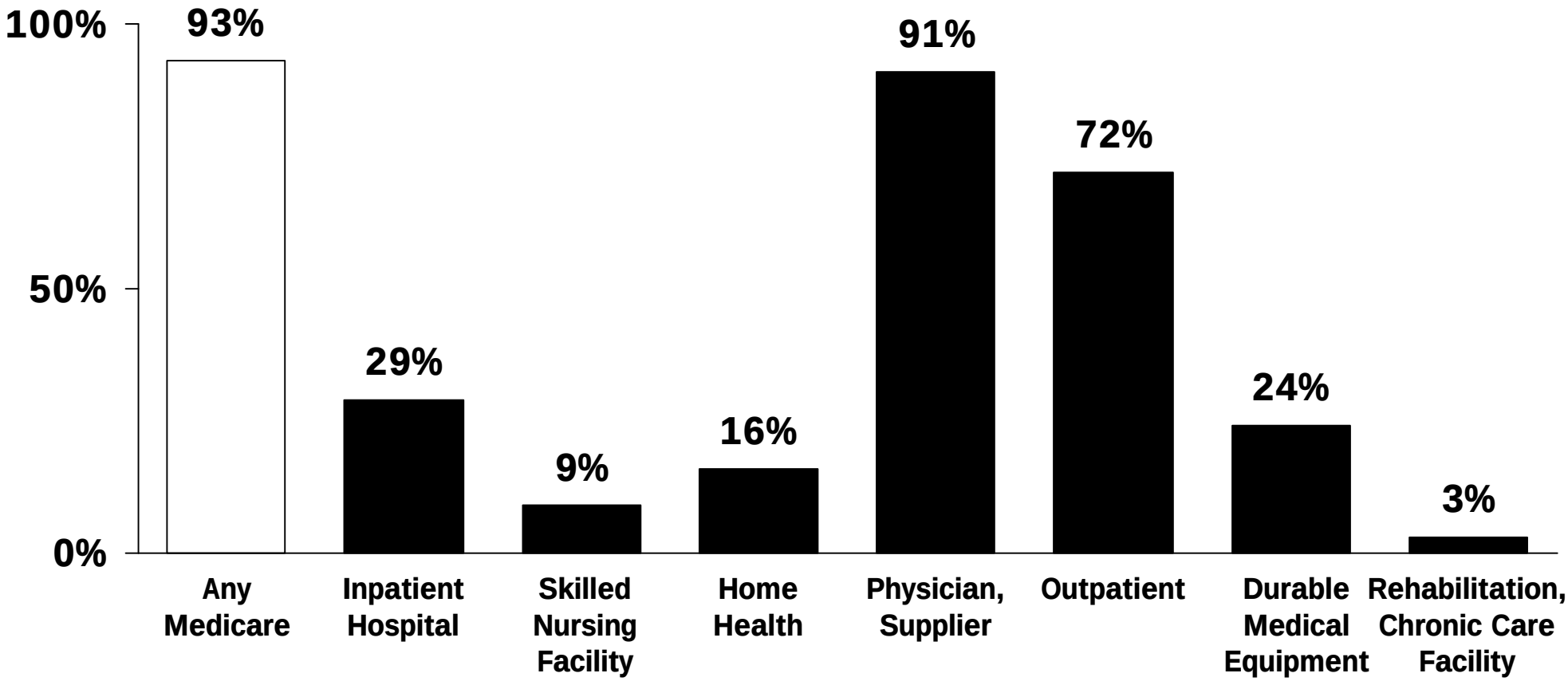
More than nine of 10 elderly Medicare–Medicaid enrollees used Medicare services during the year (Chart III-5).

- Among elderly Medicare–Medicaid enrollees in the four states, 93 percent used Medicare services, and nearly all of these used physician or supplier (such as other professional and laboratory) services.

- Among elderly Medicare–Medicaid enrollees, 29 percent used hospital inpatient care in 1995.

- A significant proportion of elderly Medicare–Medicaid enrollees used home health (16%) or skilled nursing facility services (9%) covered by Medicare. (Additional Medicare–Medicaid enrollees used these services under Medicaid benefits.)

Chart III-5. Percentage of Elderly Medicare–Medicaid Enrollees Using Each Selected Type of Medicare Service, 1995



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Nearly all elderly Medicare–Medicaid enrollees had Medicaid spending during the year (Chart III-6).

- In the four states, 95 percent of elderly Medicare–Medicaid enrollees (with full Medicaid benefits) used Medicaid services or received Medicaid's assistance with Medicare cost-sharing.[21]

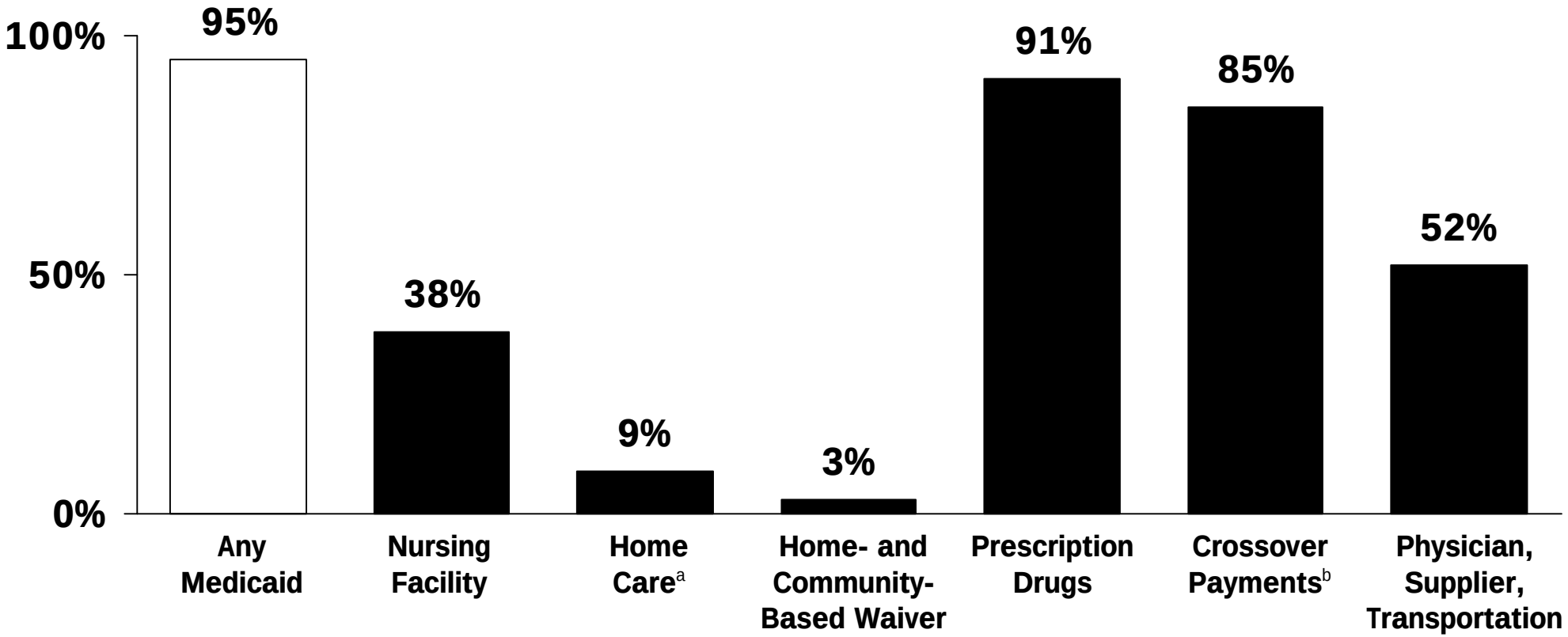
- Ninety-one percent of elderly Medicare–Medicaid enrollees in the four states used Medicaid-covered prescription drugs. The proportion was relatively similar among the states, ranging from about 89 percent in Massachusetts to 93 percent in Georgia (Appendix Table III-6).

- Eighty-five percent had "crossover payments," mainly for Medicare cost-sharing for medical services such as physician visits and inpatient hospital stays.

- Medicaid paid for nursing home care for 38 percent of elderly Medicare–Medicaid enrollees in the four states. The proportion ranged from 29 percent in Georgia to 48 percent in Wisconsin (Appendix Table III-6).

[21] The proportion of Medicare–Medicaid enrollees (with full benefits) who had any Medicaid service use reflects the model used to classify enrollees as eligible for full benefits versus QMB-only or SLMB-only benefits. In general, a person was identified as having full Medicaid benefits if he or she had Medicaid service use (that is, claims other than "crossover" claims, which are mainly payments for Medicare cost-sharing). However, people for whom the eligibility category was indeterminate (typically, people with little service use of any type) were classified as having full Medicaid benefits, resulting in a small percentage of "full benefits" enrollees who used no Medicaid services.

Chart III-6. Percentage of Elderly Medicare–Medicaid Enrollees Using Each Selected Type of Medicaid Service, 1995



[a] Does not include home- and community-based waiver services.
[b] Medicaid payments for third-party (primarily Medicare) deductibles and copayments.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

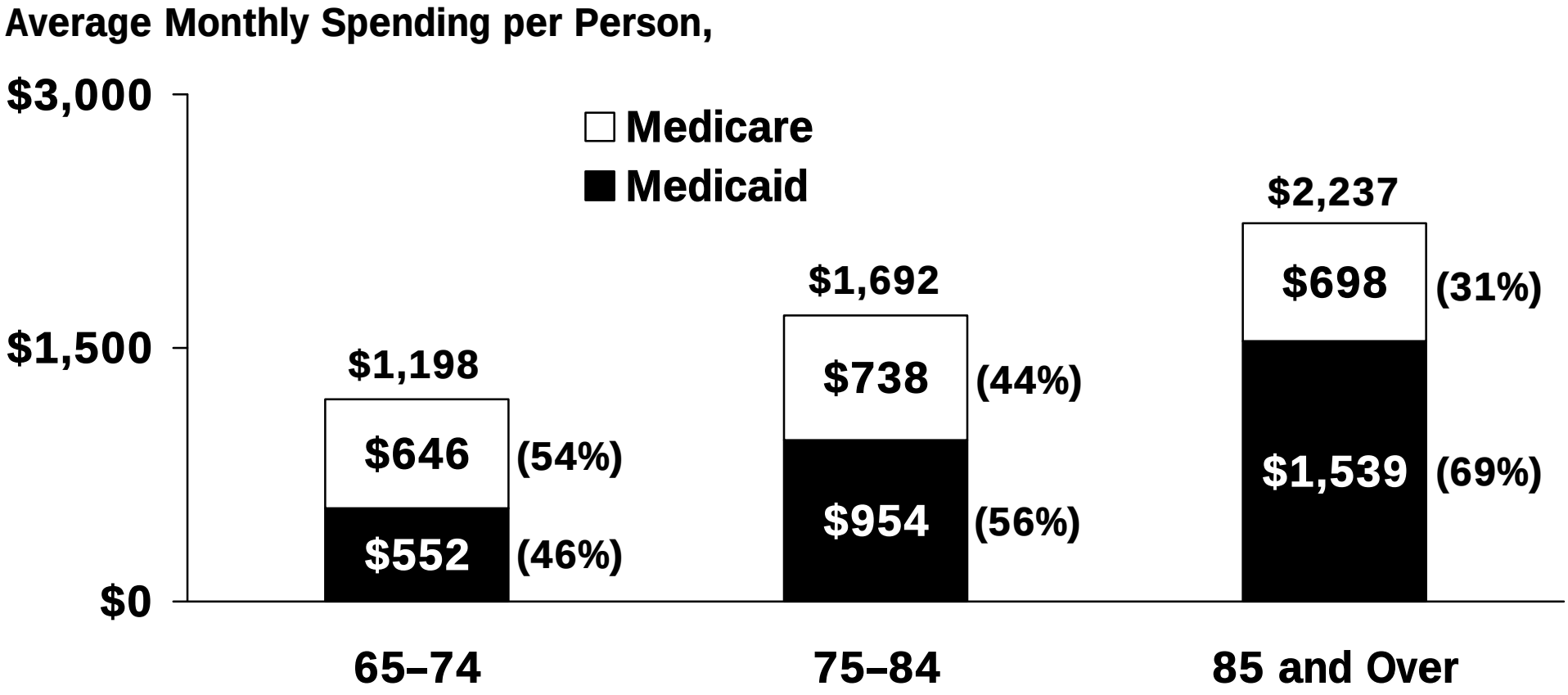
Average spending for elderly Medicare–Medicaid enrollees increases significantly with age (Chart III-7).

- Average monthly spending for elderly Medicare–Medicaid enrollees age 85 and older is nearly twice as great as for those age 65–74 in the four states—$2,237, compared with $1,198.

- Medicaid's role grows with age, accounting for 46 percent of spending for enrollees age 65–74 and rising to 69 percent for enrollees age 85 and over. In fact, nearly all of the difference in spending between these two age groups is from higher Medicaid spending. This pattern is consistent with the significantly greater reliance on nursing home care in the older age group.

- In the four states as a group, average Medicare spending is lower among Medicare–Medicaid enrollees age 85 or older than among those age 75–84 ($698 per person per month, compared with $738). However, this relationship occurs in only two of the states—Maryland and Massachusetts (see Appendix Table III-7).

Chart III-7. Average Monthly Medicare and Medicaid Spending for Elderly Medicare–Medicaid Enrollees, by Age



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. The distribution of elderly Medicare–Medicaid enrollees among the three age groups is: 35% age 65–74, 36% age 75–84, and 29% age 85 and over.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

IV. Elderly Medicare–Medicaid Enrollees Using Long-Term Care Services

Nearly half of elderly Medicare–Medicaid enrollees used long-term care services (Chart IV-1).

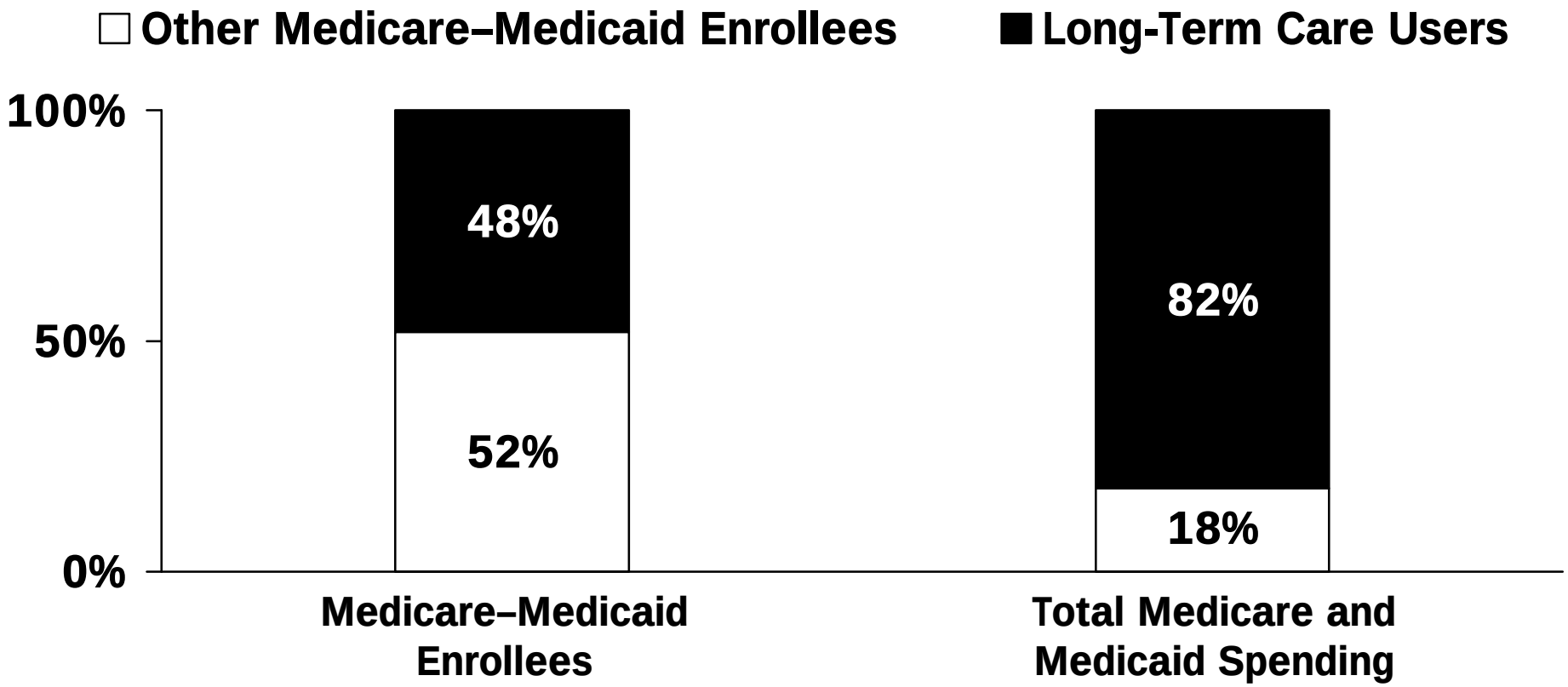
- Across the four states, 48 percent of elderly Medicare–Medicaid enrollees used long-term care services financed by Medicaid or Medicare in 1995. These enrollees, referred to here as "long-term care users," do not include additional people who may have received unpaid help with long-term care needs at home from family members or friends, or who paid for such services privately.

- Long-term care users account for a disproportionately high share of spending. In the four states, they accounted for 82 percent of all Medicare and Medicaid spending for elderly Medicare–Medicaid enrollees in 1995.

- Among individual states, long-term care users vary as a share of elderly Medicare–Medicaid enrollees, ranging from 39 percent in Georgia to 58 percent in Wisconsin (see Appendix Table IV-1). Similarly, their share of total Medicaid and Medicare spending ranged from a low of 73 percent in Georgia to a high of 88 percent in Wisconsin.

Note: Long-term care users were defined on the basis of their observed pattern of service use. A person was designated as a long-term care user if he or she used Medicaid nursing facility services, home care, or home- and community-based waiver services, or used Medicare skilled nursing facility or home health services that were part of a longer episode of long-term care service use. Specifically, enrollees who had no Medicaid long-term care use and only used Medicare long-term-care-type services during a period of fewer than 60 days were not considered to be "long-term care users" since their pattern of care suggested that the services were more likely to have been "post-acute" in nature. There is considerable overlap in these service categories, however, so this approach is clearly an approximation. For each person, status as a long-term care user was defined on a monthly basis, with all months including, and subsequent to, the first month identified as a long-term care month, designated long-term care months. (Analysis of the data suggested that this was a reasonable assumption because most people continued to use long-term care services in subsequent months.)

Chart IV-1. Elderly Medicare–Medicaid Enrollees: Distributions of Enrollees and Spending, by Use of Long-Term Care Services, 1995



Note: Long-term care users are defined as Medicare–Medicaid enrollees using Medicaid nursing facility or home care services in 1995, or using Medicare skilled nursing facility or home health services for 60 or more days during three or more consecutive months (of which at least one was in 1995). Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Enrollees were weighted by months of designated status during the year.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Compared with other elderly Medicare–Medicaid enrollees, those using long-term care are older and less healthy (Chart IV-2).

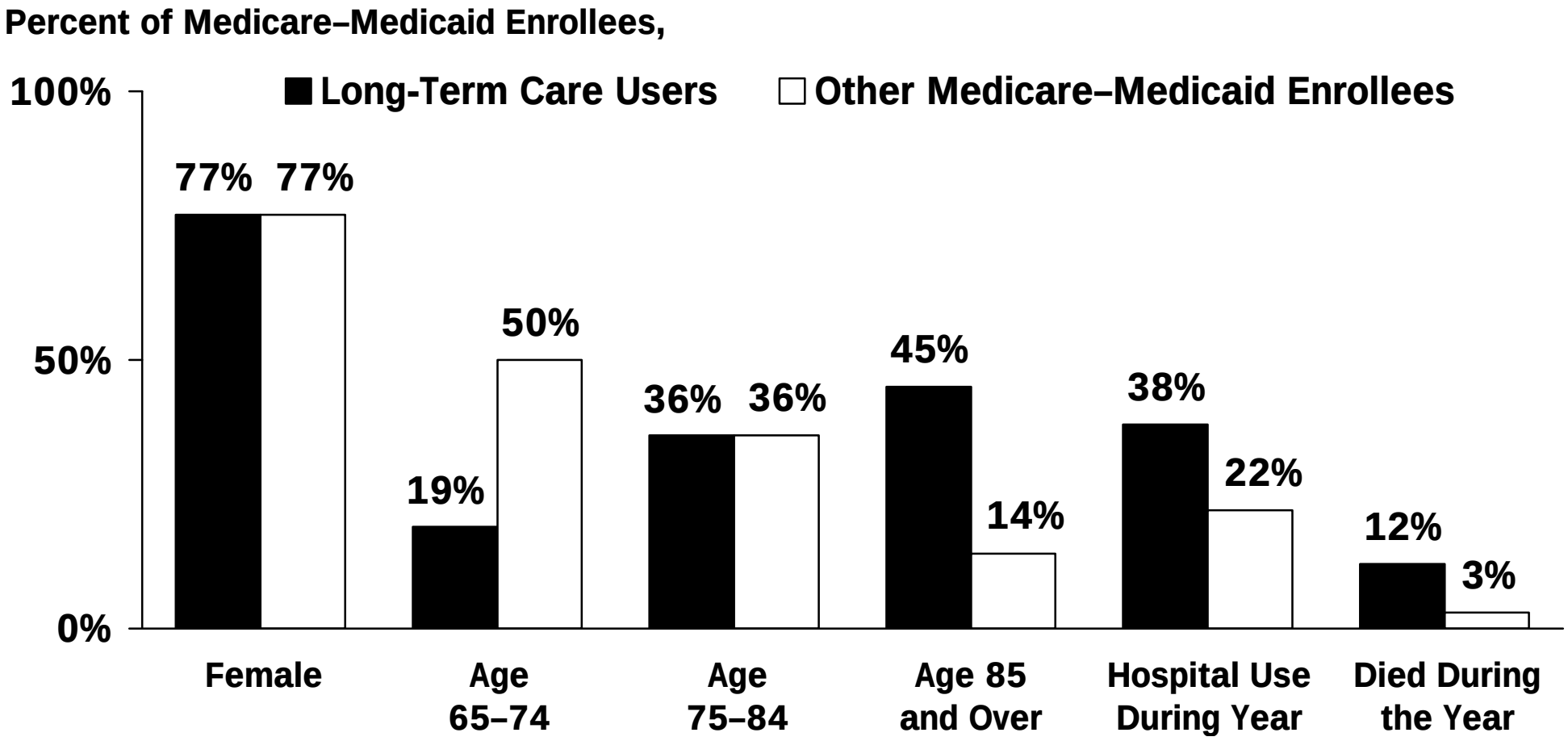
- Among elderly Medicare–Medicaid enrollees in 1995, 45 percent of long-term care users in the four states were age 85 or older, compared with 14 percent of those who do not use long-term care.

- Despite the difference in age distribution, women constituted the same proportion of long-term care users as non-long-term care users: 77 percent.

- Long-term care users were more likely than nonusers to use hospital care—38 percent of long-term care users had hospital care use during the year, compared with 22 percent of other elderly Medicare–Medicaid enrollees (this includes hospital use prior to the beginning of long-term care use and during the long-term care period).

- Reflecting the older age and poorer health status of long-term care users, mortality was much higher for this population—12 percent of long-term care users died during the year, compared with 3 percent of other elderly Medicare–Medicaid enrollees.

Chart IV-2. Characteristics of Elderly Medicare–Medicaid Enrollees, by Use of Long-Term Care Services



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

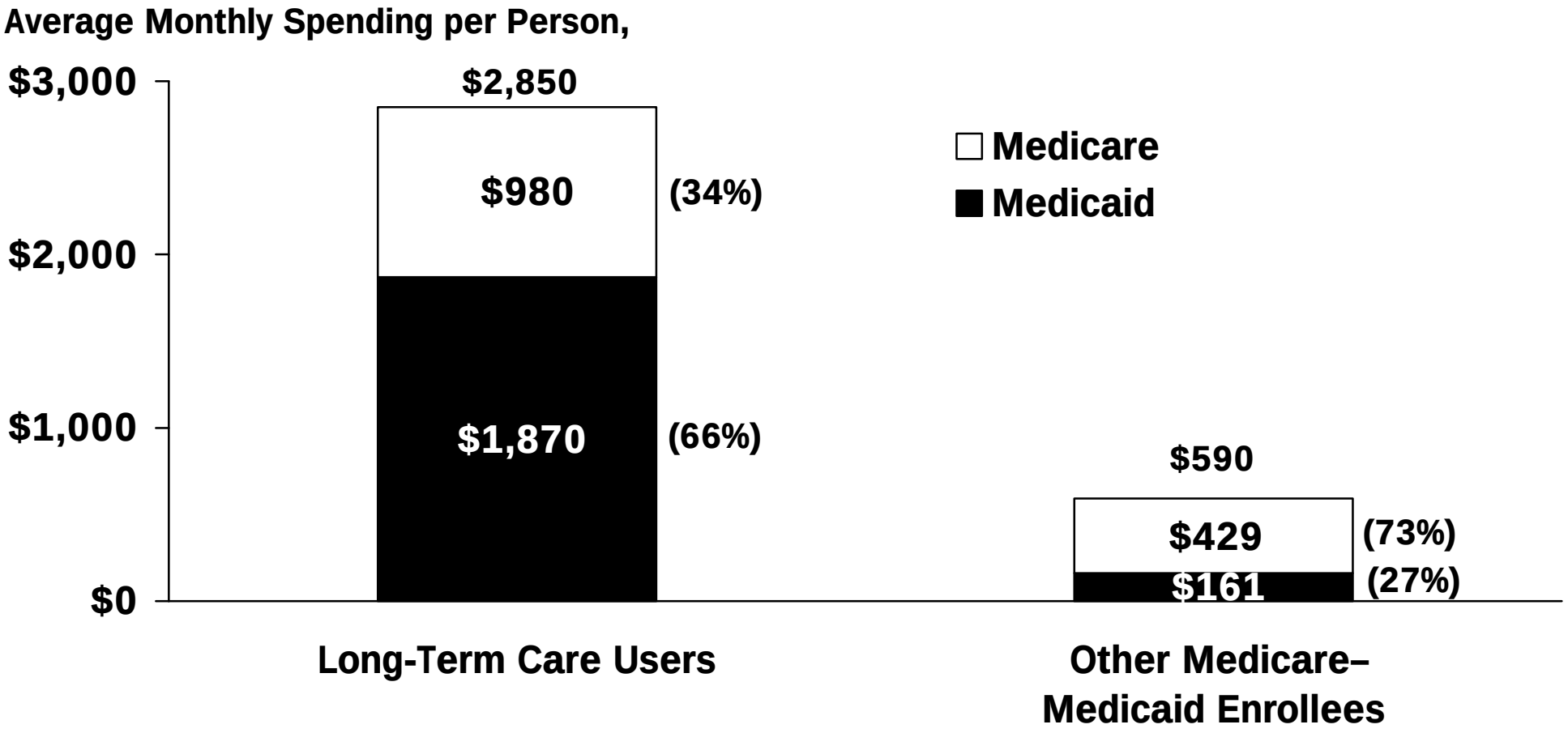
Average Medicare and Medicaid spending is nearly five times greater for long-term care users than for other Medicare–Medicaid enrollees (Chart IV-3).

Both Medicare and Medicaid spending are much higher for long-term care users than for other elderly Medicare–Medicaid enrollees, reflecting their greater need for acute as well as long-term care services.

- Combined Medicare and Medicaid spending for elderly enrollees who used long-term care services averaged $2,850 per month (or $34,200 on an annual basis), compared with $590 per month (or $7,080 per year) for those who were not long-term care users.

- Medicaid financed two-thirds of spending for long-term care users, compared with 27 percent for elderly Medicare–Medicaid enrollees who did not use long-term care. This is consistent with Medicaid's major role in long-term care services and relatively smaller role for Medicare–Medicaid enrollees with respect to acute medical care.

Chart IV-3. Average Monthly Spending for Elderly Medicare–Medicaid Enrollees, by Use of Long-Term Care Services



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Medicare–Medicaid enrollees who use long-term care services use much more acute care than those who are not long-term care users (Chart IV-4).

- In the four states combined, average monthly spending per person by Medicare was more than twice as large for long-term care users as for elderly Medicare–Medicaid enrollees not using long-term care—$980, compared with $429 in 1995.

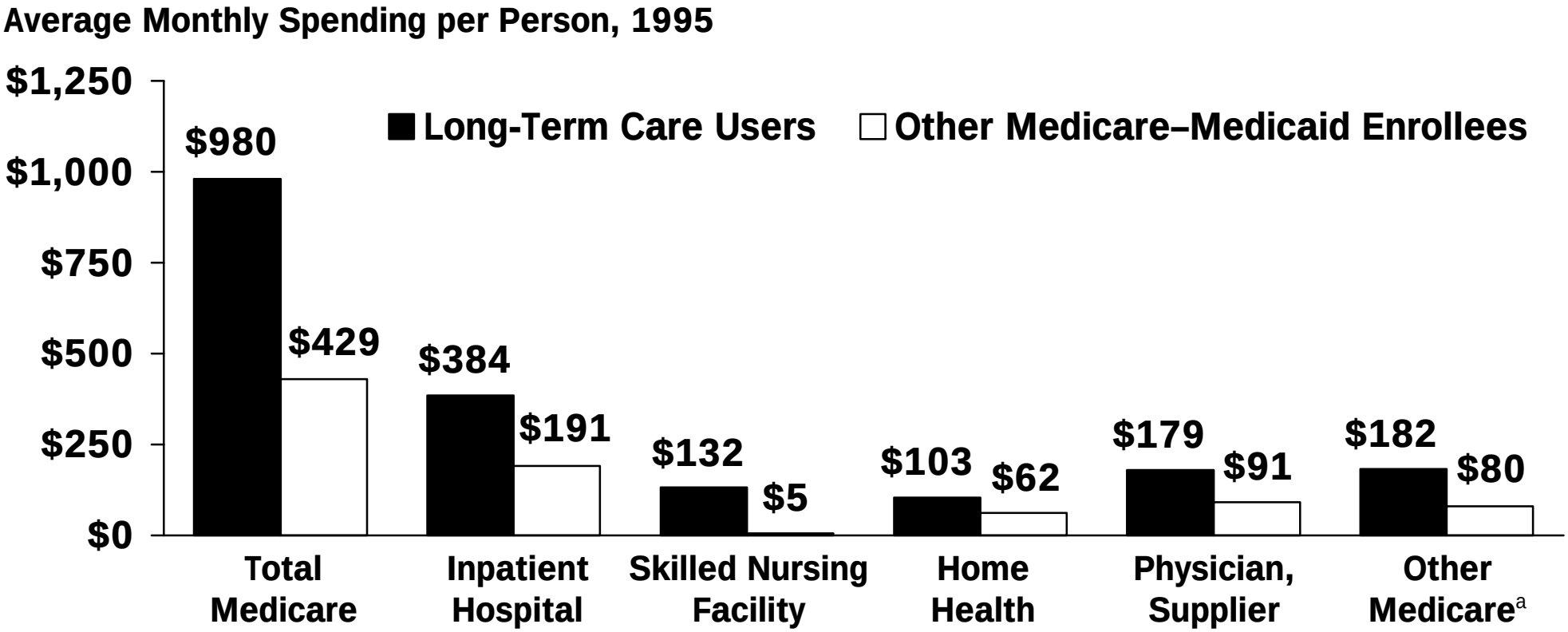
- Long-term care users had higher spending, on average, for each of Medicare's services than other Medicare–Medicaid enrollees.

- Differences between the two groups' use of hospital care was the single largest factor in determining the overall difference in Medicare spending between the two groups, and accounted for just over one-third of that difference. Long-term care users averaged $384 per month for hospital stays, compared with $191 for enrollees who were not long-term care users. Similarly, Medicare spending for physician and other professional services was about half as much for the group not using long-term care services, as was Medicaid spending for prescription drugs (shown in Chart IV-5).

- Long-term care users' greater use of Medicare skilled nursing facility and home heath care accounted for about 30 percent of the overall difference in Medicare spending between long-term care users and other Medicare–Medicaid enrollees.

- Skilled nursing facility and home health care accounted for about one-quarter of Medicare spending for long-term care users, averaging $235 per month per person. In comparison, for other Medicare–Medicaid enrollees, spending on these services (for short-term periods) averaged $67 per month per person.

Chart IV-4. Average Monthly Spending for Medicare Services for Elderly Medicare–Medicaid Enrollees, by Use of Long-Term Care Services



[a] Consists of outpatient, durable medical equipment, chronic care and rehabilitation facilities, and hospice.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Nursing home care accounts for 80 percent of Medicaid spending for long-term care users (Chart IV-5).

- Average monthly Medicaid spending per person was more than 11 times greater for long-term care users than nonusers~~$1~~,870, compared with $161. This is consistent with Medicaid's major role in long-term care services and relatively smaller role, for Medicare~~-~~Medicaid enrollees, with respect to acute medical care.

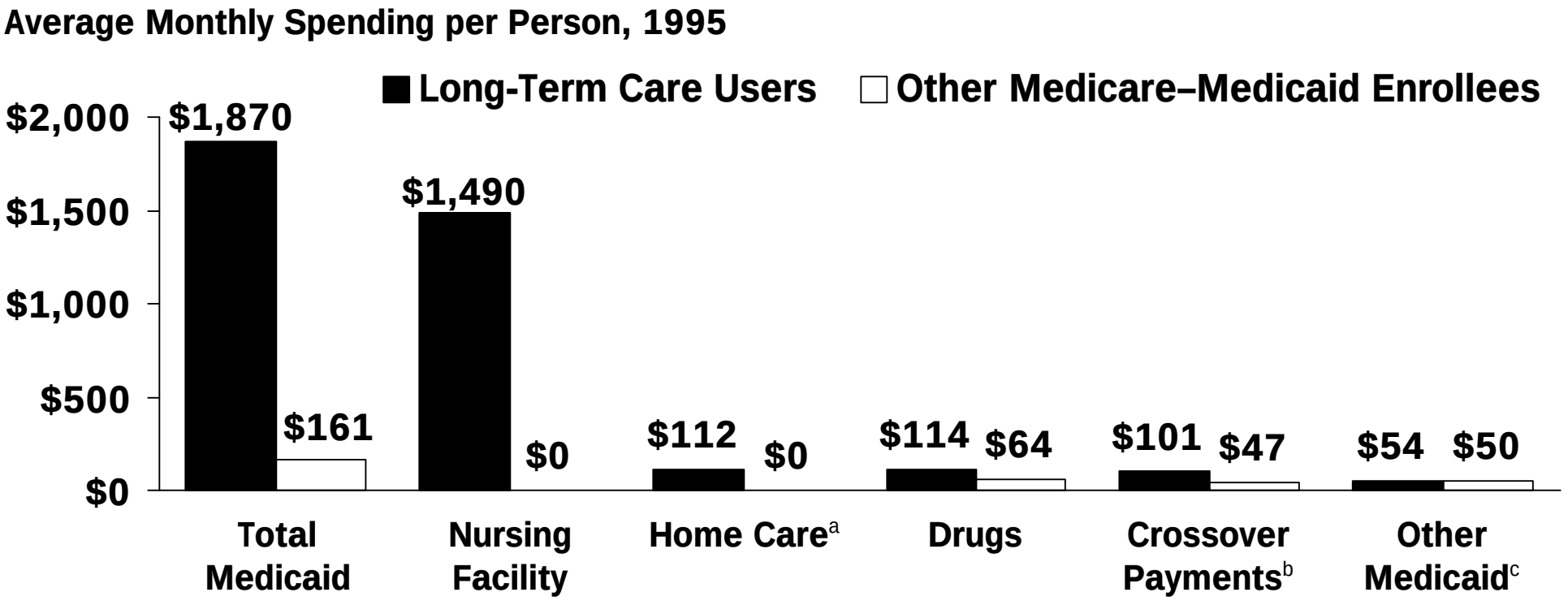
- Medicaid spending for nursing facilities accounted for 80 percent of Medicaid spending for long-term care users, and accounted for over half of their total Medicare and Medicaid spending~~$1~~,490 per person per month out of a total of $2,850. Combined with Medicare spending for skilled nursing facilities for long-term care users (Chart IV-4), total nursing facility spending averaged $1,622 per person per month, or 57 percent of total Medicare and Medicaid spending for long-term care users.

- Medicaid home care accounted for only 6 percent of Medicaid spending for elderly Medicare~~-~~Medicaid long-term care users, averaging $112 per person per month. Combined with Medicare spending (Chart IV-4), total Medicare and Medicaid spending for home health and home care for elderly Medicare~~-~~Medicaid long-term care users averaged $215 per person per month, or about 8 percent of total Medicare and Medicaid spending for this group.

- Nearly two-thirds of total Medicare and Medicaid spending for elderly Medicare~~-~~Medicaid long-term care users was for Medicare- or Medicaid-financed long-term care services (nursing home and home care).

- Although elderly Medicare~~-~~Medicaid enrollees not using long-term care rely mainly on Medicare, Medicaid nonetheless fills important gaps. Prescription drugs were the largest single component of elderly enrollees' Medicaid spending, averaging $64 per month, accounting for 40 percent of their $161 average total Medicaid spending per month. "Crossover payments," mainly for Medicare cost-sharing requirements, averaged $47 per month.

Chart IV-5. Average Monthly Spending for Medicaid Services for Elderly Medicare–Medicaid Enrollees, by Use of Long-Term Care Services



[a] Consists of home health, personal care, and home- and community-based waiver services.
[b] Medicaid payments for third-party (primarily Medicare) deductibles and copayments.
[c] Consists of professional services, supplies, and transportation; inpatient hospital; and outpatient.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

More than three-fourths of Medicare–Medicaid long-term care users live in nursing homes (Chart IV-6).

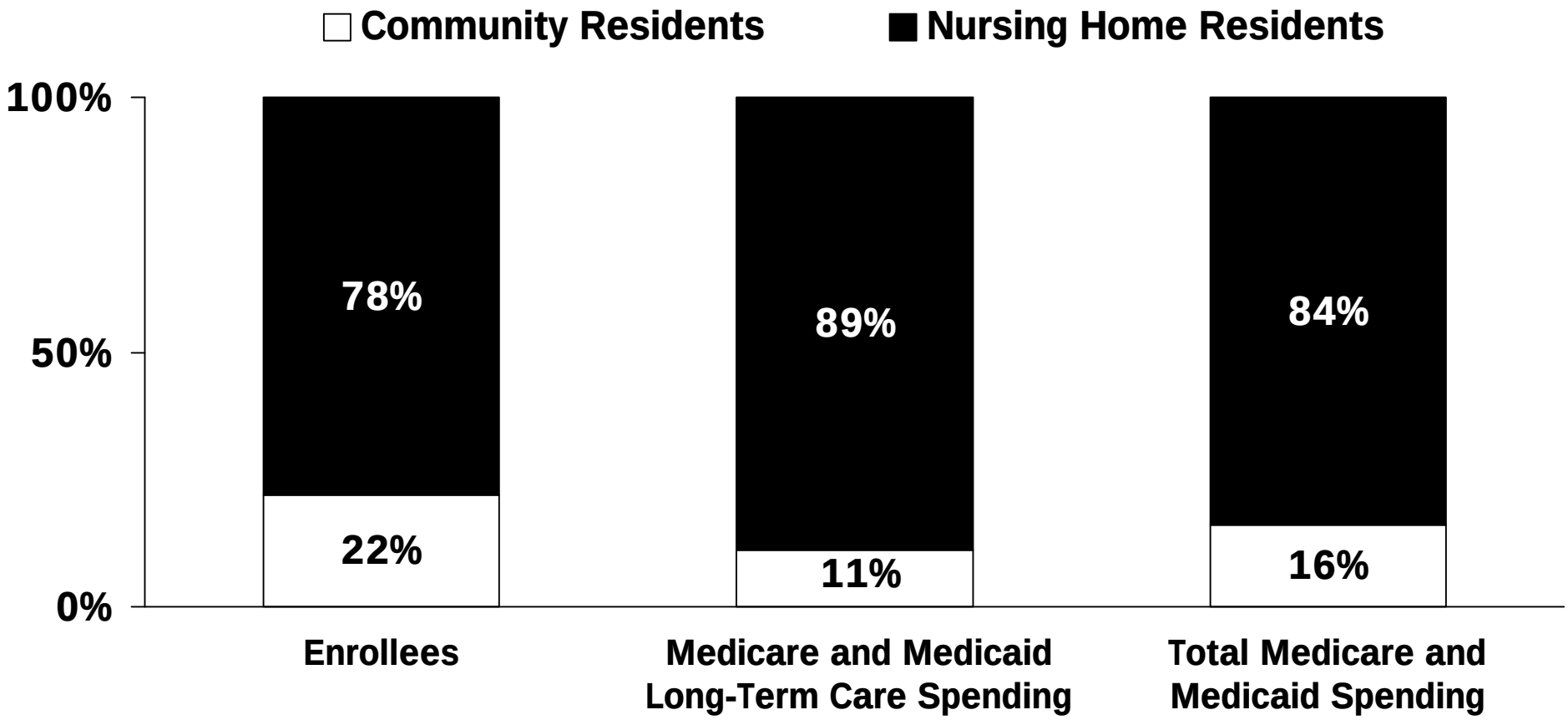
Institutional residents account for the majority of elderly Medicare–Medicaid enrollees using long-term care and for most of the spending for the Medicare–Medicaid long-term care population.

- Seventy-eight percent of long-term care users reside in nursing homes; the other 22 percent live in the community and use home health or home care services.

- Nursing home residents account for the overwhelming majority of spending on long-term care services, 89 percent. (These services include Medicaid-financed nursing home, home care, and home- and community-based waiver services, and Medicare-financed skilled nursing facility and home health services used by people defined as long-term care users).

Note: For the analysis of nursing home- and community-based long-term care populations, all long-term care use months were assigned to one of these categories. Any month in which a person used nursing facility services was designated as a nursing home month; all other long-term care use months were designated as community long-term care months. The use of nursing facility services in a month was defined by observed nursing facility expenditures (Medicare or Medicaid). Patterns of care were also considered, so people who had nursing home stays interrupted by a transfer to another type of facility (such as an acute or rehabilitation hospital) continued to be designated as nursing home residents during any months affected by the interruption.

Chart IV-6. Elderly Medicare–Medicaid Long-Term Care Users: Shares of Enrollees and Spending, by Nursing Home and Community Residence, 1995



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid status. Enrollees were weighted by months of designated status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Among long-term care users, the proportion of nursing home and community residents varies by somewhat by state (Chart IV-7).

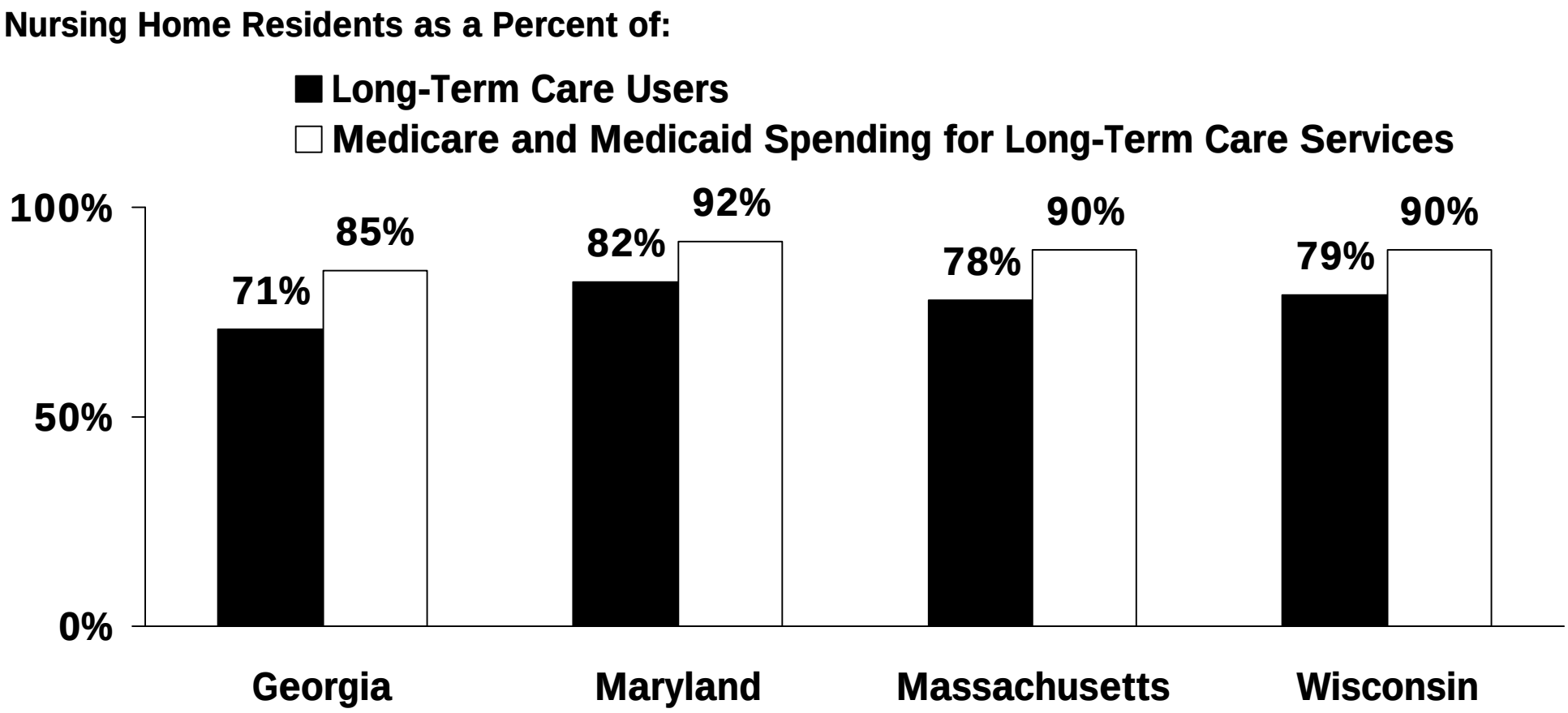
In each of the four states, nursing home residents constituted the majority of elderly Medicare-Medicaid long-term care users and accounted for a disproportionately large share of spending for long-term care services.

- Nursing home residents made up the largest share of long-term care users in Maryland-82 percent-and the smallest in Georgia-71 percent.

- In Massachusetts and Wisconsin, 78 percent and 79 percent, respectively, of elderly Medicare-Medicaid long-term care users were nursing home residents.

- Consistent with the pattern for enrollees, the proportion of long-term care spending accounted for by nursing home residents ranged from 85 percent in Georgia to 92 percent in Maryland.

Chart IV-7. Elderly Medicare–Medicaid Nursing Home Residents as a Percentage of Long-Term Care Users and Long-Term Care Spending, 1995



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid status. Enrollees were weighted by months of designated status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Nursing home residents and community-based long-term care users differ significantly in age and other characteristics (Chart IV-8).

- As a group, nursing home residents are considerably older than community residents~~ha~~lf of nursing home residents are at least 85 years old, compared with 27 percent of community residents.

- Women constitute more than three-quarters of both groups: 77 percent of nursing home residents and 80 percent of community long-term care users.

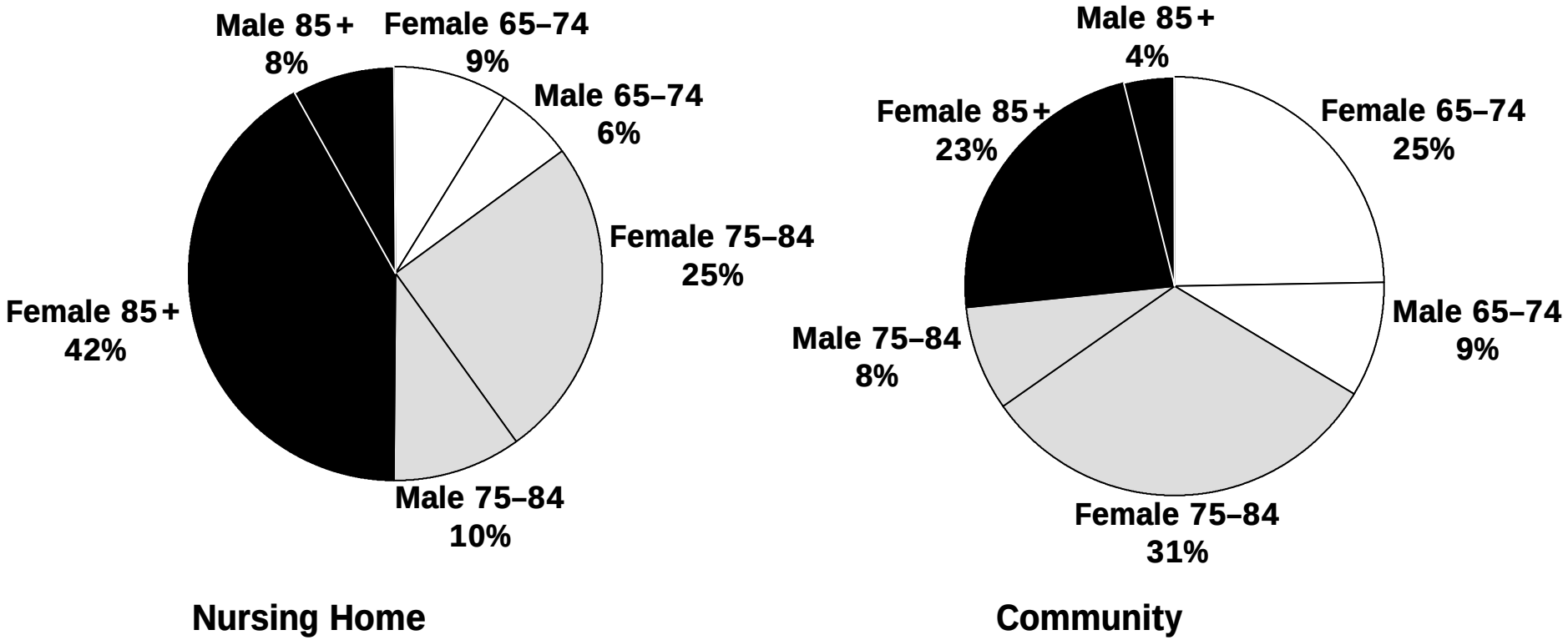
- Both in nursing homes and in the community, the share of women grows with age. Among nursing home residents, women rise from 60 percent among for those age 65~~7~~4, to 84 percent among those age 85 and over. Similarly, women increase from 74 percent of community residents age 65~~7~~4 to 85 percent of community residents age 85 and over.

- The older age and more serious health status of nursing home residents are reflected in their higher death rate: in the four states, 14 percent of elderly Medicare~~M~~edicaid nursing home residents died during the year, compared with 7 percent of elderly long-term-care users in the community (Appendix Table IV-8).

- Medicare~~M~~edicaid nursing home residents are less likely, however, to have hospital use during the year than their community counterparts. In the four states, 35 percent of nursing home residents had hospital use during the year, compared with 47 percent of community-based long-term care users (Appendix Table IV-8).[22]

[22] Hospital use may have occurred before the person became a nursing home resident or community-based long-term care user.

Chart IV-8. Age and Gender Distribution of Elderly Medicare–Medicaid Long-Term Care Users, by Nursing Home and Community Residence, 1995



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid status. Enrollees were weighted by months of designated status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Spending across both programs is considerably greater for long-term care users living in nursing homes than for those in the community (Chart IV-9).

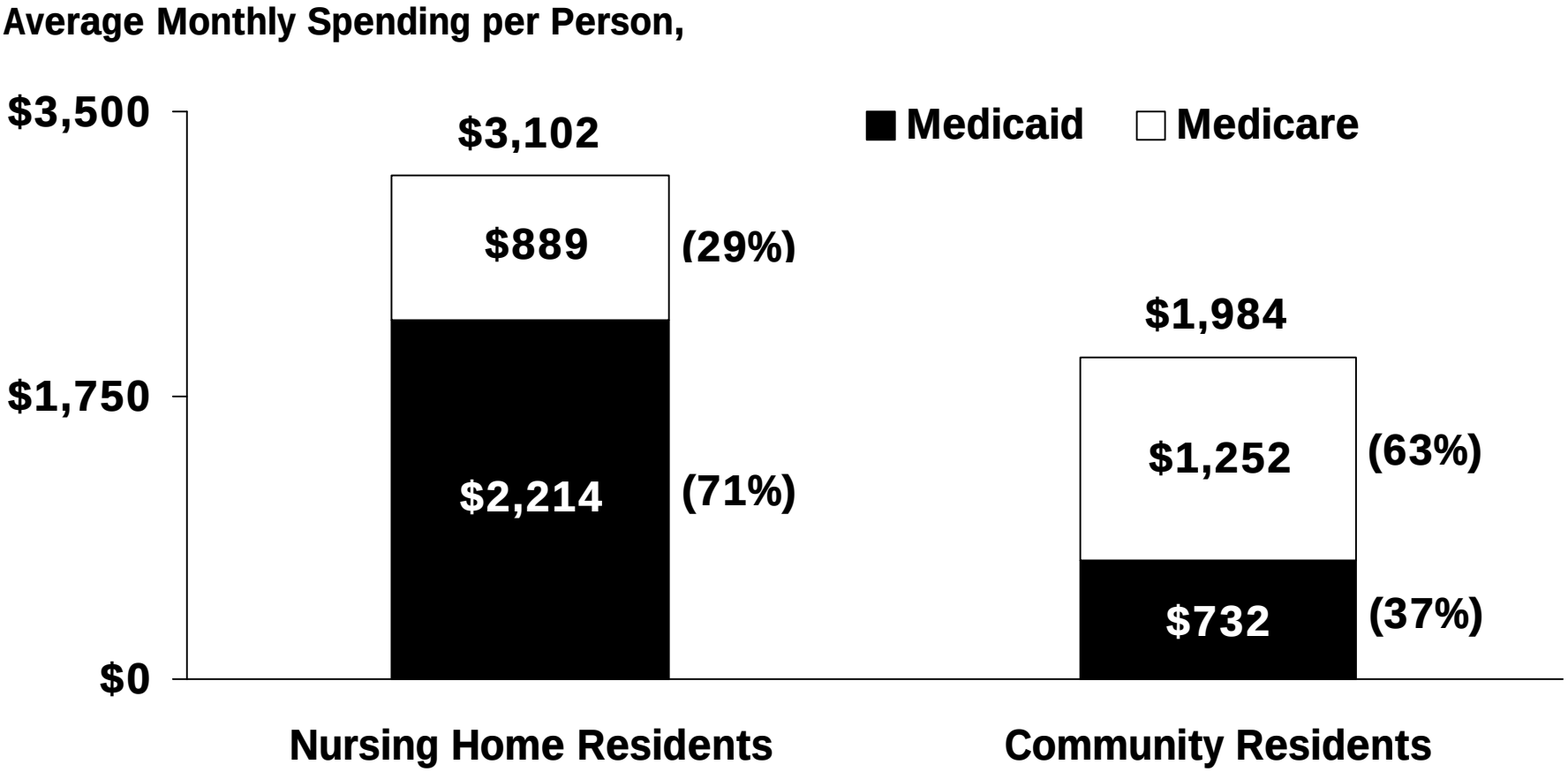
- Total Medicare and Medicaid spending for elderly Medicare–Medicaid nursing home residents is about one and a half times as high as it is for elderly Medicare–Medicaid long-term care users living in the community. Average monthly spending for nursing home residents in the four states was $3,102 per person (or about $37,200 for a year), compared with a monthly average of $1,984 (or about $23,800 yearly) for community-based long-term care users.

- Medicare spending per person was more than 40 percent greater for community-based long-term care users than for nursing home residents, averaging $1,252 per month, compared with $889. This difference reflects the relatively greater use of both inpatient hospital care and home health care by the community-based group.

- Medicaid was the main payer for care for the nursing home group, paying for 71 percent of their care, while Medicare paid for the majority of care for the community-based population (63%).

- The ratio of total Medicare and Medicaid spending for nursing home residents to spending for community long-term care users was similar among each of the four states—about 1.5 to 1.6 (Appendix Table IV-9). However, Medicaid's share of total spending for each group varied among states. For nursing home residents, Medicaid's share of total Medicare and Medicaid spending ranged from 65 percent in Georgia to 80 percent in Wisconsin. For community-based long-term care users, Medicaid's share of spending ranged from 26 percent in Georgia to 53 percent in Wisconsin. The higher proportions in Wisconsin are consistent with that state's relatively low per person Medicare spending (seen in Chart III-2).

Chart IV-9. Medicare and Medicaid Spending for Elderly Medicare–Medicaid Long-Term Care Users, by Nursing Home and Community Residence



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Medicare spending for long-term care users in the community was higher than for nursing home residents (Chart IV-10).

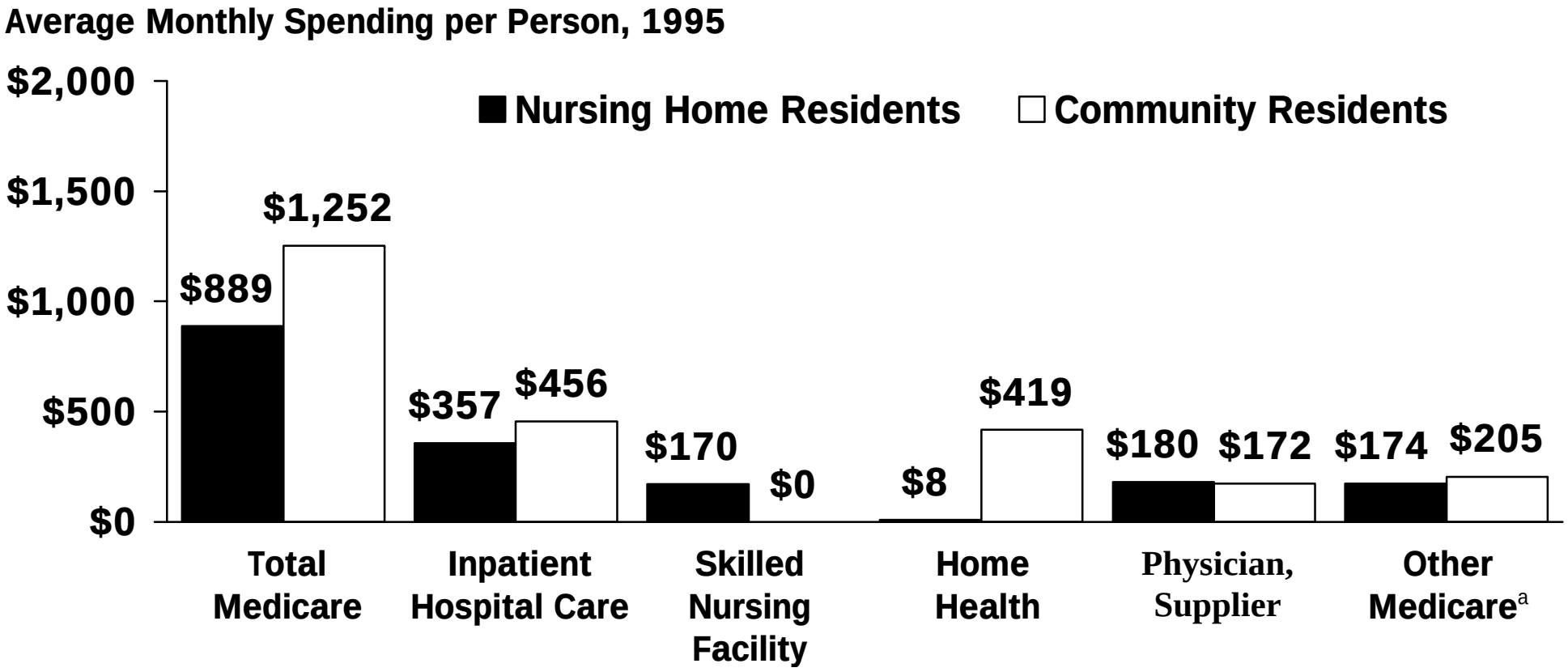
- For the four states combined, monthly Medicare spending averaged $1,252 per person for community-based elderly Medicare–Medicaid long-term care users, compared with $889 per month for their counterparts who lived in nursing homes. Excluding spending for skilled nursing facility services and home health care, monthly spending averaged $833 for community long-term care users and $711 for nursing home residents.

- Spending for many acute care services was fairly similar for community-based long-term care users and nursing home residents. For example, Medicare spending for physician services averaged $172 per person per month for community long-term care users, compared with $180 for nursing home residents. Similarly, Medicaid spending for prescription drugs averaged $113 per person per month for community residents, compared with an average of $114 for nursing home residents (see Chart IV-11).

- The key exception is inpatient hospital care, which was 28 percent higher for the community-based population, averaging $456 per person per month, compared with $357.

Note: In the method used to define nursing home and community long-term care users, a month in which a person used both home-based long-term care services and nursing facility care was classified as a nursing home month; therefore, the spending for nursing home residents includes a small amount of home health and home care spending.

Chart IV-10. Elderly Medicare–Medicaid Long-Term Care Users: Average Monthly Spending for Medicare Services, by Nursing Home and Community Residence



[a] Consists of outpatient, durable medical equipment, chronic care and rehabilitation facilities, and hospice.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Medicaid spending is three times greater, on average, for nursing home residents than for long-term care users living in the community (Chart IV-11).

- Medicaid spending for elderly Medicare–Medicaid enrollees in nursing homes averaged $2,214 per person per month across the four states, compared with an average of $732 per month for Medicare–Medicaid enrollees using Medicare or Medicaid long-term care services in the community.

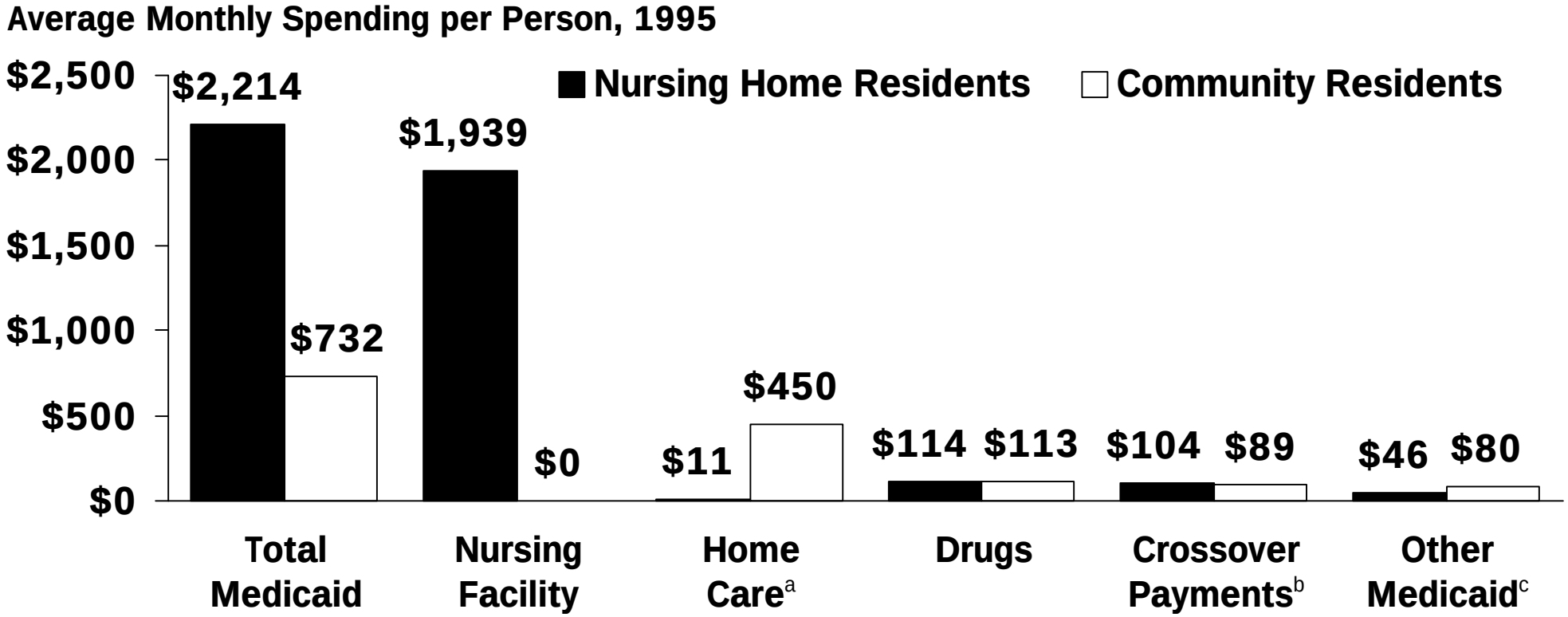
- For elderly Medicare–Medicaid nursing home residents, nursing home spending accounted for 88 percent of Medicaid spending in the four states. Across both Medicare and Medicaid programs, more than two-thirds of spending for nursing home residents was for nursing home care. Medicaid nursing home spending accounted for 62 percent of spending, and Medicare-financed skilled nursing facility services accounted for an additional 5 percent.

- Medicaid nursing facility spending averaged $1,939 per month for this population (or $23,300 on a yearly basis). In addition, Medicare skilled nursing facility spending averaged $170 per month for nursing home residents (see Chart IV-10). Combined, average monthly nursing home spending was $2,109 (or $25,300 per year).

- Medicaid spending for nursing home care varied among states, ranging from a monthly average of $1,573 per nursing home resident in Georgia to $2,253 (or about 43% more) per nursing home resident in Massachusetts (Appendix Table IV-11).

- For community-based long-term care users, Medicare and Medicaid home care together accounted for 44 percent of spending across both programs, averaging $869 per person per month (or about $10,400 on a yearly basis). For the four states combined, just over half this home care spending was financed by Medicaid$450 per month, compared with Medicare's average of $419 per month.

Chart IV-11. Elderly Medicare–Medicaid Long-Term Care Users: Average Monthly Spending for Medicaid Services, by Nursing Home and Community Residence



[a] Consists of home health, personal care, and home- and community-based waiver services.
[b] Medicaid payments for third-party (primarily Medicare) deductibles and copayments.
[c] Consists of professional services, supplies, and transportation; inpatient hospital; and outpatient.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

The proportion of home care spending financed by Medicare and Medicaid varies among states (Chart IV-12).

- Combining the four states, Medicare and Medicaid accounted for similar proportions of home care spending for elderly Medicare-Medicaid enrollees living in the community. Medicare accounted for 48 percent (averaging $419 per person per month), and Medicaid for 52 percent (or an average of $450 per person per month).

- However, the Medicare and Medicaid programs' relative shares of spending varied considerably among states. Only one state-Massachusetts-was consistent with the average proportion.

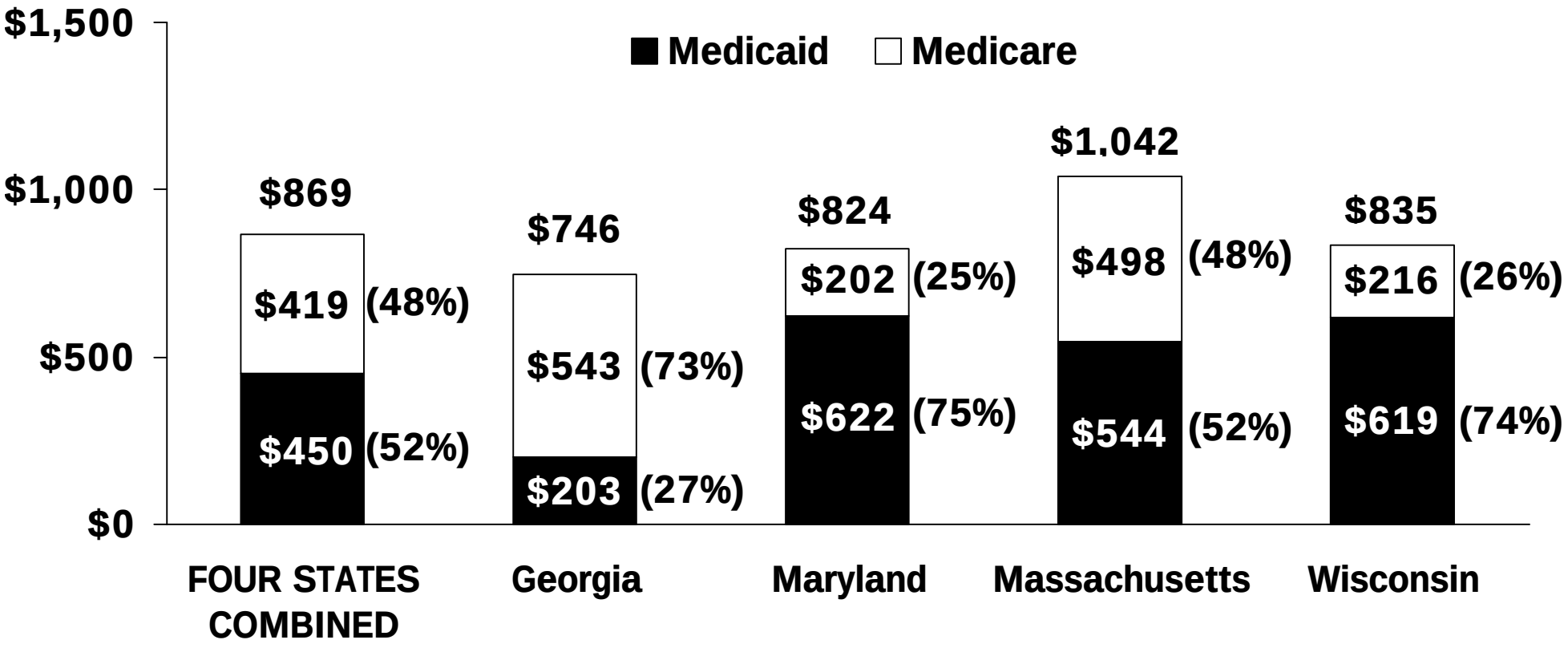
- In Maryland and Wisconsin, Medicare accounted for about one-quarter of home care spending for long-term care users in the community, and Medicaid for about three-quarters.

- Georgia experienced the opposite pattern-Medicare accounted for nearly three-quarters, and Medicaid for the remaining one-quarter.

- Total Medicare and Medicaid spending for home care also varied somewhat among states. Average Medicare and Medicaid spending for home care by community long-term care users ranged from $746 per month in Georgia to $1,042 in Massachusetts, or about 40 percent more (similar to the proportionate difference in average nursing home spending for nursing home residents between those two states).

Chart IV-12. Spending for Home Care for Elderly Medicare–Medicaid Long-Term Care Users Living in the Community

Average Monthly Spending per Community-Based Long-Term Care User, 1995



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

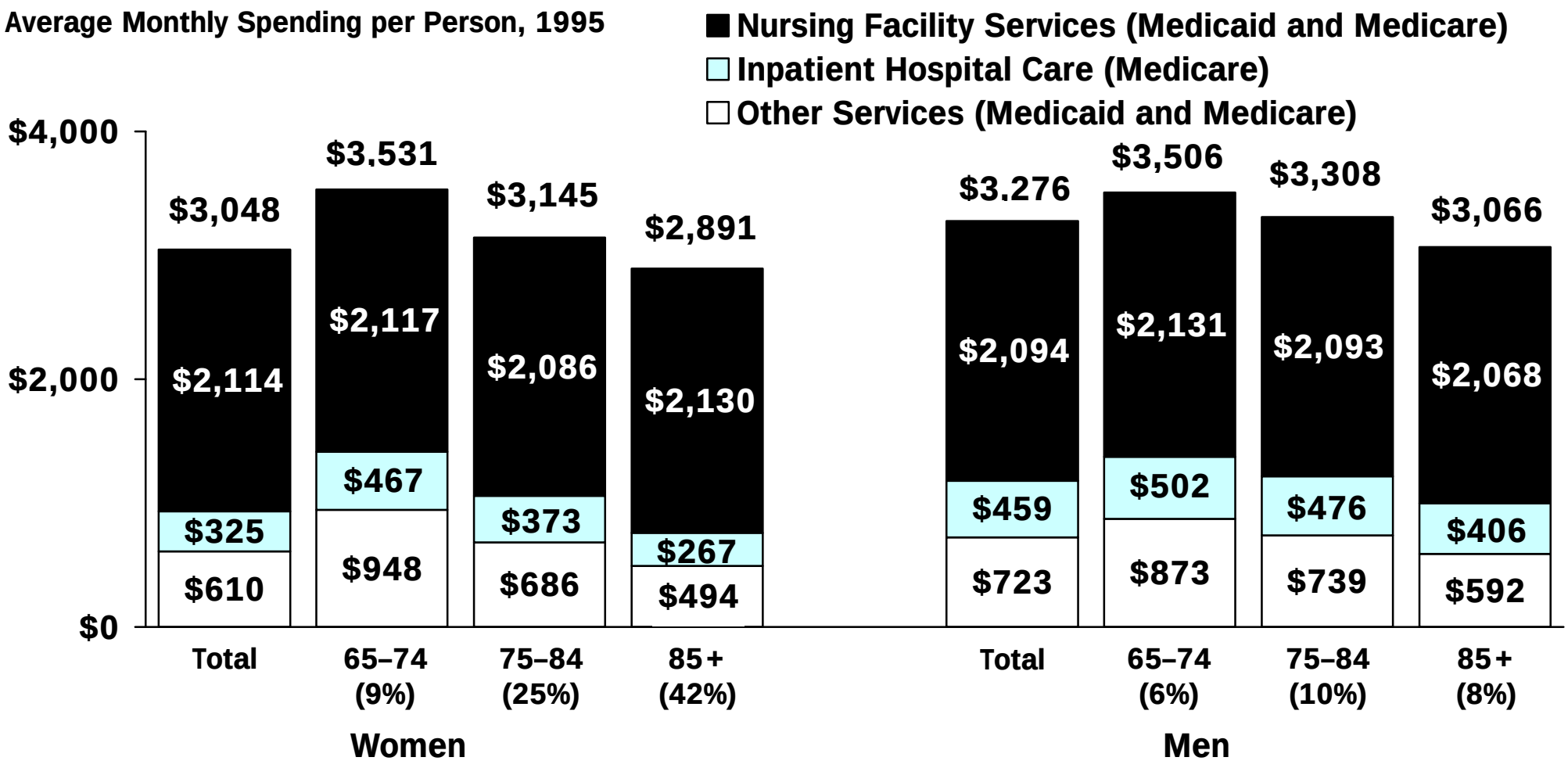
Among nursing home residents, acute care spending declines with increasing age (Chart IV-13).

- For both men and women, total spending across both programs was significantly higher for nursing home residents age 65~~7~~4 than for older groups.

- While nursing home expenses are quite similar across age groups, the difference reflects greater use of inpatient hospital care and other medical care services by the younger seniors.

- Spending for men is somewhat higher than for women age 75 and over, but not for younger seniors. The higher spending is attributable to higher inpatient hospital and other medical care expenses, and not to differences in nursing facility spending.

Chart IV-13. Elderly Medicare–Medicaid Long-Term Care Users Living in Nursing Homes: Spending by Gender and Age



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

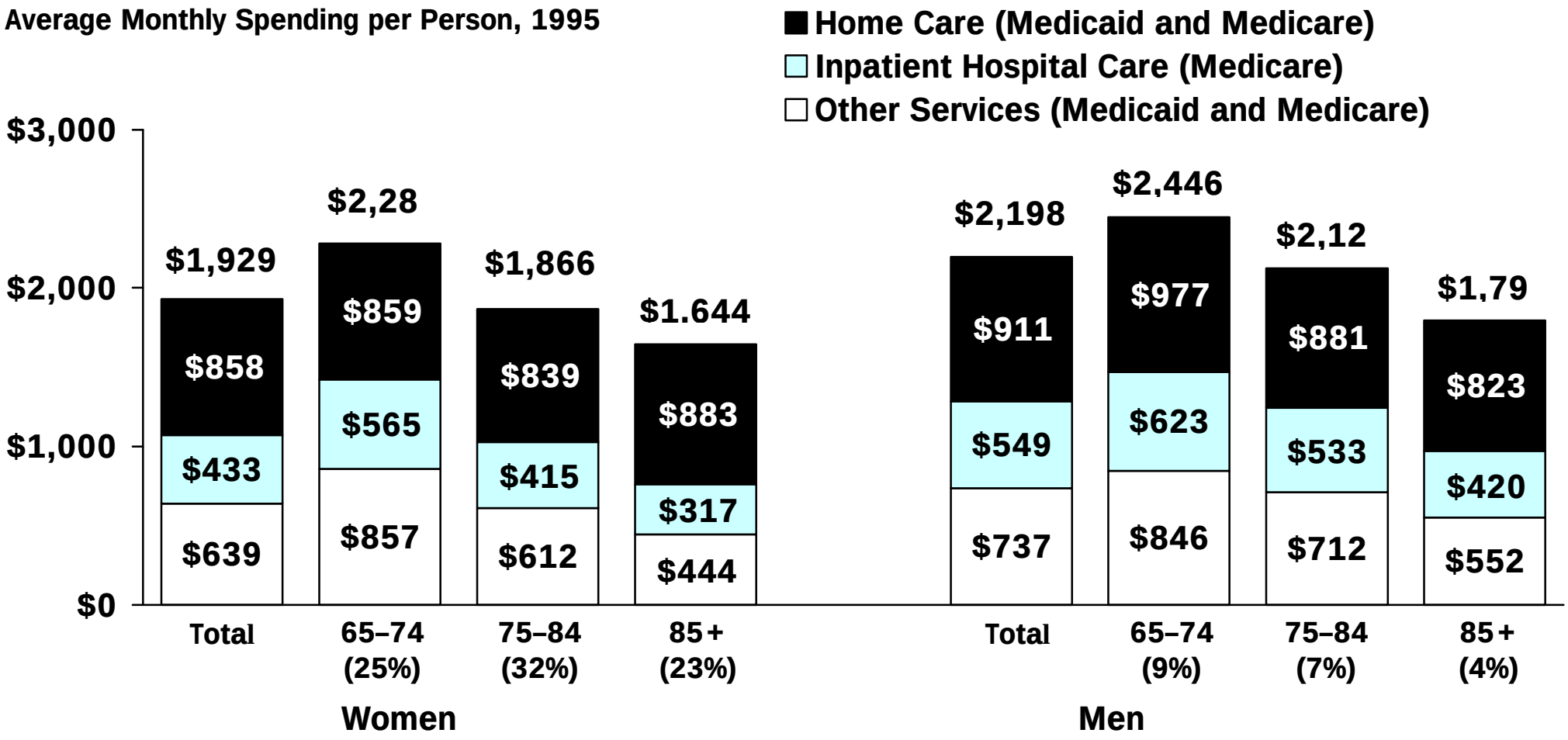
Similarly, spending decreases with age among community-based long-term care users (Chart IV-14).

- The pattern among different age groups for elderly Medicare–Medicaid enrollees using long-term care services in the community is very similar to that for their nursing home counterparts: average spending declines with age for both men and women, with acute care accounting for most of the difference.

- In every age group, average spending for men is somewhat greater than for women, with both home-based long-term care services and medical care services contributing to the difference for those groups under age 85.

- For Medicare–Medicaid enrollees age 85 and older, average spending for home-based care is greater for women than men, although total spending for women is less. This contrasts with the pattern for nursing home residents for whom there was little difference in nursing home spending between women and men.

Chart IV-14. Elderly Medicare–Medicaid Long-Term Care Users Living in the Community: Spending by Gender and Age



Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix: Tables with State-Level Data

Appendix Table II-3
Which Program Were Medicare–Medicaid Enrollees Covered by First?

Age*	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Under 65 Disabled, Total	100%	100%	100%	100%	100%
Medicare First	38	43	39	29	40
Medicaid First	61	55	59	70	58
First Covered by Both Programs in the Same Month	1	1	1	1	1
65 and Over, Total	100%	100%	100%	100%	100%
Medicare First	83	83	83	78	89
Medicaid First	14	13	15	19	10
First Covered by Both Programs in the Same Month	3	5	3	3	2

* Age in first month of dual Medicare–Medicaid enrollment.

Note: Table is based on 1994–1995 data for Medicare–Medicaid enrollees in 1995 who first became covered by both programs after January 1994. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table II-4
Distribution of Medicare–Medicaid Enrollees, by Months of Medicare–Medicaid Status During the Year, 1995

	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Full Year[a]	75%	76%	72%	77%	72%
Part Year	25	24	28	23	28
Became newly enrolled[b]	14	14	16	13	15
Died	7	7	8	7	8
Enrollment ended or lapsed[c]	4	3	5	3	5
Medicare–Medicaid enrollees					
Total during the year	527,000	184,000	73,000	161,000	109,000
Average per month	459,000	161,000	62,000	143,000	93,000
Medicare–Medicaid enrollees, excluding managed care enrollees[d]					
Total during the year	524,000	184,000	72,000	161,000	107,000
Average per month	457,000	161,000	62,000	142,000	92,000

[a] Includes people who died during the last month of the year (about 1% in each state).
[b] Includes people who became newly enrolled and also died or had enrollment end or lapse (1% in Massachusetts, 2% in the other states).
[c] Includes people who moved to other states (percentage unknown).
[d] Excludes people enrolled in Medicare or Medicaid managed care plans any time during the year. These enrollees were excluded from analyses of spending and service use because of incomplete data.

Note: Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table II-5
Medicare–Medicaid Enrollees as a Percentage of Medicare Enrollees, by Age, 1995

	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Total	15%	19%	10%	15%	12%
Under 65 (Disabled)	31	28	24	36	33
65 and Over	12	17	8	12	9
65–74	8	12	5	8	5
75–84	13	20	9	12	10
85 and Over	29	39	20	30	26

Note: Medicare–Medicaid enrollees (numerator) and all Medicare enrollees (denominator) were weighted by the proportion of months in the year of Medicare–Medicaid status and Medicare status, respectively.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin; data for all Medicare enrollees from the Medicare 5 Percent Denominator File.

Appendix Table II-6
Age Distribution of Medicare–Medicaid Enrollees Compared with All Medicare Enrollees, 1995

	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Medicare–Medicaid Enrollees, Total	100%	100%	100%	100%	100%
Under 65	31	28	30	33	34
65–74	25	28	27	23	20
75–84	25	27	25	23	24
85 and Over	19	17	18	20	22
All Medicare Enrollees, Total	100%	100%	100%	100%	100%
Under 65	15	19	13	14	13
65–74	47	46	51	46	47
75–84	28	26	27	29	29
85 and Over	10	8	9	11	10

Note: Medicare–Medicaid enrollees and all Medicare enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status and Medicare status, respectively. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin; data for all Medicare enrollees from the Medicare 5 Percent Denominator File.

Appendix Table II-7
Gender Distribution of Medicare–Medicaid Enrollees Compared with All Medicare Enrollees, by Age, 1995

	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Medicare–Medicaid Enrollees					
All Ages	100%	100%	100%	100%	100%
Male	32	29	32	33	35
Female	68	71	68	67	65
Under 65, Total	100%	100%	100%	100%	100%
Male	51	48	53	54	52
Female	49	52	47	46	48
65 and Over, Total	100%	100%	100%	100%	100%
Male	23	22	23	22	26
Female	77	78	77	78	74
All Medicare Enrollees					
All Ages	100%	100%	100%	100%	100%
Male	32	33	32	32	33
Female	68	67	68	68	67
Under 65, Total	100%	100%	100%	100%	100%
Male	57	56	57	57	56
Female	43	44	43	43	44
65 and Over, Total	100%	100%	100%	100%	100%
Male	28	27	28	28	30
Female	72	73	72	72	70

Note: Medicare–Medicaid enrollees and all Medicare enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status and Medicare status, respectively.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin; data for all enrollees from the Medicare 5 Percent Denominator File.

Appendix Table II-8
Distribution of Medicare–Medicaid Enrollees by Nursing Home or Community Residence, by Age, 1995

Age and Residence	Four States	Georgia	Maryland	Massachusetts	Wisconsin
All Ages	100%	100%	100%	100%	100%
Nursing Home	26	19	29	29	34
Community	74	81	71	71	66
Under 65	100%	100%	100%	100%	100%
Nursing Home	8	6	9	7	11
Community	92	94	91	93	89
Age 65 and Over	100%	100%	100%	100%	100%
Nursing Home	35	24	37	39	46
Community	65	76	63	61	54
Age 65–74	100%	100%	100%	100%	100%
Nursing Home	14	10	16	15	21
Community	86	90	84	85	79
Age 75–84	100%	100%	100%	100%	100%
Nursing Home	34	24	37	38	43
Community	66	76	63	62	57
Age 85 and Over	100%	100%	100%	100%	100%
Nursing Home	62	46	68	68	71
Community	38	54	32	32	29

Note: Enrollees were weighted by the proportion of months of designated status during the year.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table III-3
Medicare Spending for Elderly Medicare–Medicaid Enrollees Compared with All Medicare Enrollees, by Type of Service, 1995

	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Elderly Medicare–Medicaid Enrollees					
Medicare, Total	$694	$715	$749	$777	$492
Inpatient Hospital	284	291	368	292	202
Skilled Nursing Facility	66	47	56	92	64
Home Health	82	122	30	92	35
Physician and Supplier	133	126	167	155	89
Outpatient	70	70	81	72	62
Other	59	60	47	74	41
All Medicare Enrollees (all ages)					
Medicare, Total	$413	$399	$446	$506	$298
Inpatient Hospital	188	185	201	216	148
Skilled Nursing Facility	19	12	15	31	19
Home Health	38	52	21	55	15
Physician and Supplier	101	101	117	108	78
Outpatient	38	34	46	43	29
Other	30	15	45	53	10

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Sources: For Medicare–Medicaid enrollees: authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin. For all enrollees: authors' tabulations of data from *Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 1997* (Baltimore, MD: U.S. Department of Health and Human Services, Health Care Financing Administration, October 1997).

Appendix Table III-4
Medicare and Medicaid Spending for Elderly Medicare–Medicaid Enrollees, by Type of Service, 1995
Average Monthly Spending per Person (and Distribution)

Type of Service	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Medicare and Medicaid, Total	**$1,675 (100%)**	**$1,377 (100%)**	**$1,729 (100%)**	**$1,991 (100%)**	**$1,649 (100%)**
Medicare, Total	**694 (41%)**	**715 (52%)**	**749 (43%)**	**777 (39%)**	**492 (30%)**
Inpatient Hospital	284 (17%)	291 (21%)	368 (21%)	292 (15%)	202 (12%)
Skilled Nursing Facility	66 (4%)	47 (3%)	56 (3%)	92 (5%)	64 (4%)
Home Health	82 (5%)	122 (9%)	30 (2%)	92 (5%)	35 (2%)
Physician Supplier	133 (8%)	126 (9%)	167 (10%)	155 (8%)	89 (5%)
Other Medicare[a]	129 (8%)	130 (9%)	128 (7%)	146 (7%)	103 (6%)
Medicaid, Total	**982 (59%)**	**662 (48%)**	**980 (57%)**	**1,214 (61%)**	**1,157 (70%)**
Nursing Facility	716 (43%)	436 (32%)	760 (44%)	906 (46%)	858 (52%)
Home Care[b]	54 (3%)	25 (2%)	58 (3%)	67 (3%)	78 (5%)
Prescription Drugs	88 (5%)	82 (6%)	98 (6%)	76 (4%)	109 (7%)
Crossover Payments[c]	73 (4%)	93 (7%)	43 (3%)	68 (3%)	65 (4%)
Other Medicaid[d]	52 (3%)	26 (2%)	21 (1%)	96 (5%)	47 (3%)

[a] Consists of outpatient, durable medical equipment, chronic care and rehabilitation facilities, and hospice.
[b] Consists of home health, personal care, and home- and community-based waiver services.
[c] Medicaid payments for third-party (primarily Medicare) deductibles and copayments.
[d] Consists of professional services, supplies, and transportation; inpatient hospital; and outpatient.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table III-5
Percentage of Elderly Medicare–Medicaid Enrollees Using Each Selected Type of Medicare Service, 1995

Type of Medicare Service	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Any Medicare Service	93%	93%	92%	92%	94%
Inpatient Hospital	29	31	31	27	25
Skilled Nursing Facility	9	7	9	12	9
Home Health	16	21	10	18	10
Physician, Supplier	91	91	91	91	93
Outpatient	72	71	64	72	76
Durable Medical Equipment	24	28	23	19	24
Rehabilitation or Chronic Care Facility	3	2	1	4	2

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table III-6
Percentage of Elderly Medicare–Medicaid Enrollees Using Each Selected Type of Medicaid Service, 1995

Type of Medicaid Service	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Any Medicaid Service	95%	95%	93%	95%	97%
Nursing Facility	38	29	38	40	48
Home Care[a]	9	9	8	9	8
Home- and Community-Based Waiver Services	3	0*	1	4	9
Prescription Drugs	91	93	90	89	91
Crossover Payments[b]	85	90	80	81	85
Physician, Supplies, Transportation	52	39	25	62	76

* Less than 0.5%.

[a] Does not include home- and community-based waiver services.
[b] Medicaid payments for third-party (primarily Medicare) deductibles and copayments.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Enrollees were weighted by the proportion of months in the year of Medicare–Medicaid status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table III-7
Average Monthly Medicare and Medicaid Spending for Elderly Medicare–Medicaid Enrollees, by Age, 1995

	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Age 65–74, Total	**$1,198**	**$1,030**	**$1,283**	**$1,318**	**$1,259**
Medicare	646	625	722	697	534
Medicaid	552	406	561	622	724
Age 75–84, Total	**$1,692**	**$1,425**	**$1,768**	**$1,996**	**$1,653**
Medicare	738	752	790	833	535
Medicaid	954	673	979	1,163	1,118
Age 85 and Over, Total	**$2,237**	**$1,828**	**$2,328**	**$2,718**	**$1,841**
Medicare	698	795	732	802	600
Medicaid	1,539	1,033	1,597	1,916	1,240
Medicaid as a Percent of Total Medicare and Medicaid Spending					
Age 65–74	46%	39%	44%	47%	58%
Age 75–84	56%	47%	55%	58%	68%
Age 85 and Over	69%	57%	69%	70%	67%

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-1
Elderly Medicare–Medicaid Enrollees: Distributions of Enrollees and Spending, by Use of Long-Term Care Services, 1995

Category of Enrollees	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Distribution of Medicare–Medicaid Enrollees					
Total	100%	100%	100%	100%	100%
Long-Term Care Users	48	39	47	51	58
Other Enrollees	52	61	53	49	42
Distribution of Total Medicare and Medicaid Spending					
Total	100%	100%	100%	100%	100%
Long-Term Care Users	82	73	84	84	88
Other Enrollees	18	27	16	16	12

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Enrollees were weighted by the proportion of months in the year of designated status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-2
Characteristics of Elderly Medicare–Medicaid Enrollees, by Use of Long-Term Care Services, 1995

Characteristics	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Long-Term Care Users, Total	100%	100%	100%	100%	100%
Female	77	79	77	79	73
Age 65–74	19	20	21	18	18
Age 75–84	36	40	37	34	35
Age 85 and Over	45	41	43	48	47
Hospital Use During the Year	38	45	43	36	30
Died During the Year	12	12	13	11	13
Medicare–Medicaid Enrollees Not Using Long-Term Care, Total	100%	100%	100%	100%	100%
Female	77	78	78	76	76
Age 65–74	50	49	54	51	48
Age 75–84	36	36	35	35	37
Age 85 and Over	14	15	11	14	14
Hospital Use During the Year	22	23	23	19	22
Died During the Year	3	3	2	2	3

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Enrollees were weighted by the proportion of months in the year of designated status.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-3
Average Monthly Spending for Elderly Medicare–Medicaid Enrollees, by Use of Long-Term Care Services, 1995

Spending Category	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Long-Term Care Users, Total	**$2,850**	**$2,576**	**$3,063**	**$3,255**	**$2,484**
Medicare	980	1,116	1,104	1,094	602
Medicaid	1,870	1,460	1,959	2,161	1,882
Other Medicare–Medicaid Enrollees, Total	**$590**	**$605**	**$533**	**$654**	**$487**
Medicare	429	456	431	441	340
Medicaid	161	148	102	213	147
Medicaid as a Percent of Total Medicare and Medicaid Spending					
Long-Term Care Users	66%	57%	64%	66%	76%
Other Medicare–Medicaid Enrollees	27%	25%	19%	33%	30%

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-4
Average Monthly Spending for Medicare Services for Elderly Medicare–Medicaid Enrollees, by Use of Long-Term Care Services, 1995

Medicare Services	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Long-Term Care Users, Total	**$980**	**$1,116**	**$1,104**	**$1,094**	**$602**
Inpatient Hospital	384	444	532	391	224
Skilled Nursing Facility	132	115	116	174	102
Home Health	103	165	42	118	49
Physician, Supplier	179	180	234	216	97
Other Medicare[a]	182	212	179	195	131
Other Medicare–Medicaid Enrollees, Total	**$429**	**$456**	**$431**	**$441**	**$340**
Inpatient Hospital	191	191	221	187	172
Skilled Nursing Facility	5	3	2	5	12
Home Health	62	94	19	64	15
Physician, Supplier	91	91	106	91	77
Other Medicare[a]	80	77	82	93	63

[a] "Other Medicare" consists of outpatient, durable medical equipment, chronic care and rehabilitation facilities, and hospice.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-5
Average Monthly Spending for Medicaid Services for Elderly Medicare–Medicaid Enrollees, by Use of Long-Term Care Services, 1995

Medicaid Services	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Long-Term Care Users, Total	**$1,870**	**$1,460**	**$1,959**	**$2,161**	**$1,882**
Nursing Facility	1,490	1,112	1,607	1,763	1,474
Home Care[a]	112	64	123	131	133
Prescription Drugs	114	108	138	95	133
Crossover Payments[b]	101	144	58	97	81
Other Medicaid[c]	54	31	34	76	61
Other Medicare–Medicaid Enrollees, Total	**$161**	**$148**	**$102**	**$213**	**$147**
Nursing Facility	0	0	0	0	0
Home Care[a]	0	0	0	0	0
Prescription Drugs	64	64	62	57	75
Crossover Payments[b]	47	60	30	38	44
Other Medicaid[c]	50	23	9	118	27

[a] Consists of home health, personal care, and home- and community-based waiver services.
[b] Medicaid payments for third-party (primary Medicare) deductibles and copayments.
[c] "Other Medicaid" consists of professional services, medical supplies, and transportation; inpatient hospital; and outpatient.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-8
Characteristics of Elderly Medicare–Medicaid Long-Term Care Users, by Nursing Home and Community Residence, 1995

Characteristics	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Nursing Home Residents, Total	100%	100%	100%	100%	100%
Female	76	78	76	79	72
Male	24	22	24	21	28
Both Genders					
Age 65–74	15	16	17	13	14
Age 75–84	35	39	36	33	34
Age 85 and Over	50	45	47	54	52
Female					
Age 65–74	9	10	10	8	8
Age 75–84	25	29	27	24	22
Age 85 and Over	42	39	40	46	42
Male					
Age 65–74	6	6	7	5	6
Age 75–84	10	10	10	9	12
Age 85 and Over	8	6	7	7	11
Hospital Use During the Year	35	43	41	33	26
Died During the Year	14	14	14	12	14

Appendix Table IV-8 (continued)

Characteristics	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Community Residents Using Long-Term Care, Total	100%	100%	100%	100%	100%
Female	80	81	81	80	76
Male	20	19	19	20	24
Both Genders					
Age 65–74	33	30	38	37	31
Age 75–84	39	41	38	37	40
Age 85 and Over	27	29	24	26	29
Female					
Age 65–74	25	23	29	27	22
Age 75–84	31	34	31	30	31
Age 85 and Over	23	25	21	23	23
Male					
Age 65–74	9	7	9	10	9
Age 75–84	8	8	7	7	9
Age 85 and Older	4	4	3	3	6
Hospital Use During the Year	47	50	49	46	45
Died During the Year	7	7	6	5	8

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-9
Medicare and Medicaid Spending for Elderly Medicare–Medicaid Long-Term Care Users, by Nursing Home and Community Residence, 1995

	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Nursing Home Residents, Total	**$3,102**	**$2,864**	**$3,277**	**$3,511**	**$2,687**
Medicare	889	995	1,060	988	547
Medicaid	2,214	1,869	2,216	2,523	2,139
Community Residents Using Long-Term Care, Total	**$1,984**	**$1,855**	**$2,052**	**$2,294**	**$1,712**
Medicare	1,252	1,381	1,230	1,432	804
Medicaid	732	473	822	862	909
Medicaid as a Percent of Total Medicare and Medicaid Spending					
Nursing Home Residents	71%	65%	68%	72%	80%
Community Residents	37%	26%	40%	38%	53%

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-10
Elderly Medicare–Medicaid Long-Term Care Users: Average Monthly Spending for Medicare Services, by Nursing Home and Community Residence, 1995

Medicare Service	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Nursing Home Residents, Total	**$889**	**$995**	**$1,060**	**$988**	**$547**
Inpatient Hospital	357	432	498	358	199
Skilled Nursing Facility	170	161	141	220	128
Home Health	8	8	6	12	4
Physician, Supplier	180	181	239	220	90
Other Medicare[a]	174	213	177	178	126
Community Residents, Total	**$1,252**	**$1,381**	**$1,230**	**$1,432**	**$804**
Inpatient Hospital	456	460	637	492	314
Skilled Nursing Facility	0	0	0	0	0
Home Health	419	543	202	498	216
Physician, Supplier	172	173	205	194	120
Other Medicare[a]	205	205	186	248	153

[a] "Other Medicare" consists of outpatient, durable medical equipment, chronic care and rehabilitation facilities, and hospice.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-11
Elderly Medicare–Medicaid Long-Term Care Users: Average Monthly Spending for Medicaid Services, by Nursing Home and Community Residence, 1995

Medicaid Service	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Nursing Home Residents, Total	**$2,214**	**$1,869**	**$2,216**	**$2,523**	**$2,139**
Nursing Facility	1,939	1,573	1,967	2,253	1,864
Home Care[a]	11	7	12	17	5
Prescription Drugs	114	110	146	93	130
Crossover Payments[b]	104	153	54	103	83
Other Medicaid[c]	46	25	37	57	57
Community Residents, Total	**$732**	**$473**	**$822**	**$862**	**$909**
Nursing Facility	0	0	0	0	0
Home Care[a]	450	203	622	544	619
Prescription Drugs	113	104	104	103	145
Crossover Payments[b]	89	120	73	74	71
Other Medicaid[c]	80	47	23	142	74

[a] Consists of home health, personal care, and home- and community-based waiver services.
[b] Medicaid payments for third-party (primarily Medicare) deductibles and copayments.
[c] "Other Medicaid" consists of professional services, medical supplies, and transportation; inpatient hospital; and outpatient.

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-13
Elderly Medicare–Medicaid Long-Term Care Users Living in Nursing Homes: Average Monthly Medicare and Medicaid Spending, by Gender and Age, 1995

Medicare and Medicaid Services	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Women, Total	**$3,048**	**$2,797**	**$3,217**	**$3,450**	**$2,619**
Nursing Facility Services	2,114	1,728	2,131	2,482	1,973
Inpatient Hospital Care	325	395	449	324	175
Other Services	610	674	638	644	471
Age 65–74	**$3,531**	**$3,192**	**$3,892**	**$3,832**	**$3,264**
Nursing Facility Services	2,117	1,799	2,122	2,358	2,177
Inpatient Hospital Care	467	464	716	456	299
Other Services	948	929	1,054	1,019	788
Age 75–84	**$3,145**	**$2,856**	**$3,329**	**$3,565**	**$2,774**
Nursing Facility Services	2,086	1,720	2,119	2,452	1,999
Inpatient Hospital Care	373	419	508	375	220
Other Services	686	717	703	738	556
Age 85 and Over	**$2,891**	**$2,653**	**$2,973**	**$3,322**	**$2,421**
Nursing Facility Services	2,130	1,717	2,141	2,520	1,923
Inpatient Hospital Care	267	359	342	273	130
Other Services	494	577	490	528	368

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Appendix Table IV-13 (continued)

Medicare and Medicaid Services	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Men, Total	**$3,276**	**$3,100**	**$3,465**	**$3,742**	**$2,856**
Nursing Facility Services	2,094	1,755	2,037	2,440	2,040
Inpatient Hospital Care	459	562	655	485	257
Other Services	723	783	773	817	559
Age 65–74	**$3,506**	**$3,269**	**$3,699**	**$3,870**	**$3,229**
Nursing Facility Services	2,131	1,835	2,049	2,401	2,183
Inpatient Hospital Care	502	548	708	503	327
Other Services	873	886	942	966	719
Age 75–84	**$3,308**	**$3,091**	**$3,475**	**$3,813**	**$2,888**
Nursing Facility Services	2,093	1,727	2,018	2,469	2,047
Inpatient Hospital Care	476	583	667	490	270
Other Services	739	781	771	853	571
Age 85 and Over	**$3,066**	**$2,953**	**$3,226**	**$3,571**	**$2,594**
Nursing Facility Services	2,068	1,719	2,052	2,433	1,945
Inpatient Hospital Care	406	545	562	466	200
Other Services	592	689	612	672	449

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.

Appendix Table IV-14
Elderly Medicare–Medicaid Long-Term Care Users Living in the Community: Average Monthly Medicare and Medicaid Spending, by Gender and Age, 1995

Medicare and Medicaid Services	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Women, Total	**$1,929**	**$1,809**	**$1,965**	**$2,202**	**$1,704**
Home Care	858	749	750	1,018	854
Inpatient Hospital Care	433	431	623	460	298
Other Services	639	629	593	724	552
Age 65–74	**$2,280**	**$2,172**	**$2,394**	**$2,505**	**$1,989**
Home Care	859	721	834	1,036	782
Inpatient Hospital Care	565	570	781	571	413
Other Services	857	881	779	899	794
Age 75–84	**$1,866**	**$1,757**	**$1,878**	**$2,163**	**$1,632**
Home Care	839	742	724	1,002	833
Inpatient Hospital Care	415	417	592	448	278
Other Services	612	597	562	713	520
Age 85 and Over	**$1,644**	**$1,550**	**$1,504**	**$1,887**	**$1,525**
Home Care	883	785	672	1,017	951
Inpatient Hospital Care	317	323	450	343	213
Other Services	444	442	382	527	361

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Appendix Table IV-14 (continued)

Medicare and Medicaid Services	Four States	Georgia	Maryland	Massachusetts	Wisconsin
Men, Total	**$2,198**	**$2,048**	**$2,421**	**$2,667**	**$1,741**
Home Care	911	734	1,137	1,139	774
Inpatient Hospital Care	549	583	698	619	367
Other Services	737	731	586	909	600
Age 65–74	**$2,446**	**$2,292**	**$2,714**	**$2,784**	**$1,973**
Home Care	977	720	1,286	1,211	773
Inpatient Hospital Care	623	685	787	639	443
Other Services	846	888	642	935	757
Age 75–84	**$2,126**	**$2,039**	**$2,265**	**$2,635**	**$1,655**
Home Care	881	766	1,056	1,108	732
Inpatient Hospital Care	533	575	636	611	358
Other Services	712	697	573	916	564
Age 85 and Over	**$1,794**	**$1,654**	**$1,819**	**$2,362**	**$1,504**
Home Care	823	700	839	975	844
Inpatient Hospital Care	420	426	553	573	257
Other Services	552	528	427	813	403

Note: Based on Medicare–Medicaid enrollees estimated to have full Medicaid benefits. Components may not sum to totals because of rounding.

Source: Authors' analysis of Medicare and Medicaid enrollment and claims data for Georgia, Maryland, Massachusetts, and Wisconsin.