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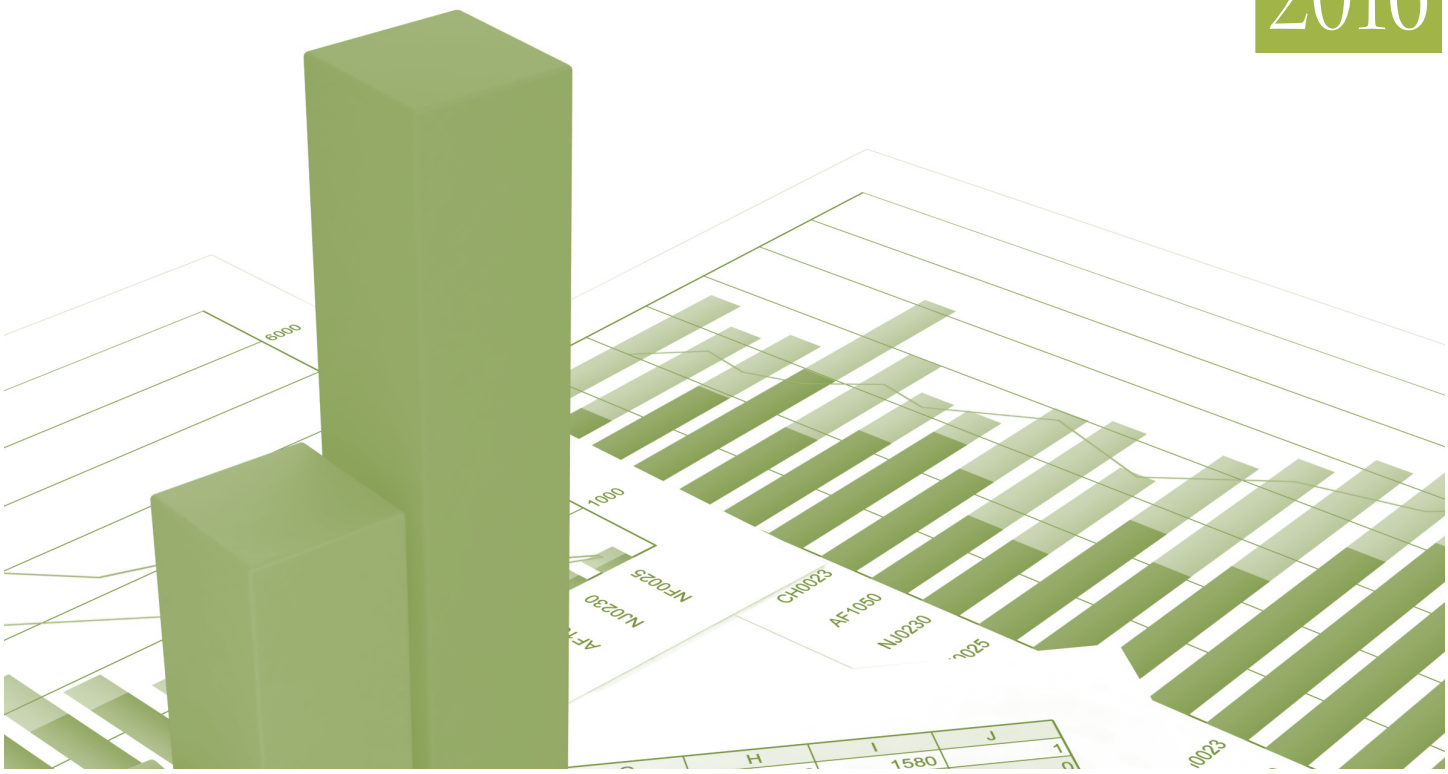

DATA BOOK

BENEFICIARIES DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID

A data book jointly produced by the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission

MEDPAC Medicare Payment Advisory Commission

MACPAC Medicaid and CHIP Payment and Access Commission

Acknowledgments

We would like to thank Sharon Donovan from the Centers for Medicare & Medicaid Services, as well as Martha Kelly and the team from Acumen LLC for their insights and assistance as we produced this data book. We would also like to acknowledge the work of April Grady, who was MACPAC's lead on this project until leaving in December 2015.

About MedPAC

The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, its 17 commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services, health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlet for Commission recommendations. In addition to these reports and others on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

About MACPAC

The Medicaid and CHIP Payment and Access Commission (MACPAC) is a nonpartisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide array of issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). The U.S. Comptroller General appoints MACPAC's 17 commissioners, who come from diverse regions across the United States and bring broad expertise and a wide range of perspectives on Medicaid and CHIP.

MACPAC serves as an independent source of information on Medicaid and CHIP, publishing issue briefs and data reports throughout the year to support policy analysis and program accountability. MACPAC's authorizing statute, 42 U.S.C. 1396, outlines a number of areas for analysis, including:

- payment,
- eligibility,
- enrollment and retention,
- coverage,
- access to care,
- quality of care, and
- the programs' interaction with Medicare and the health care system generally.

MACPAC's authorizing statute also requires the Commission to submit reports to the Congress by March 15 and June 15 of each year. In carrying out its work, MACPAC holds public meetings and regularly consults with state officials, congressional and executive branch staff, beneficiaries, health care providers, researchers, and policy experts.

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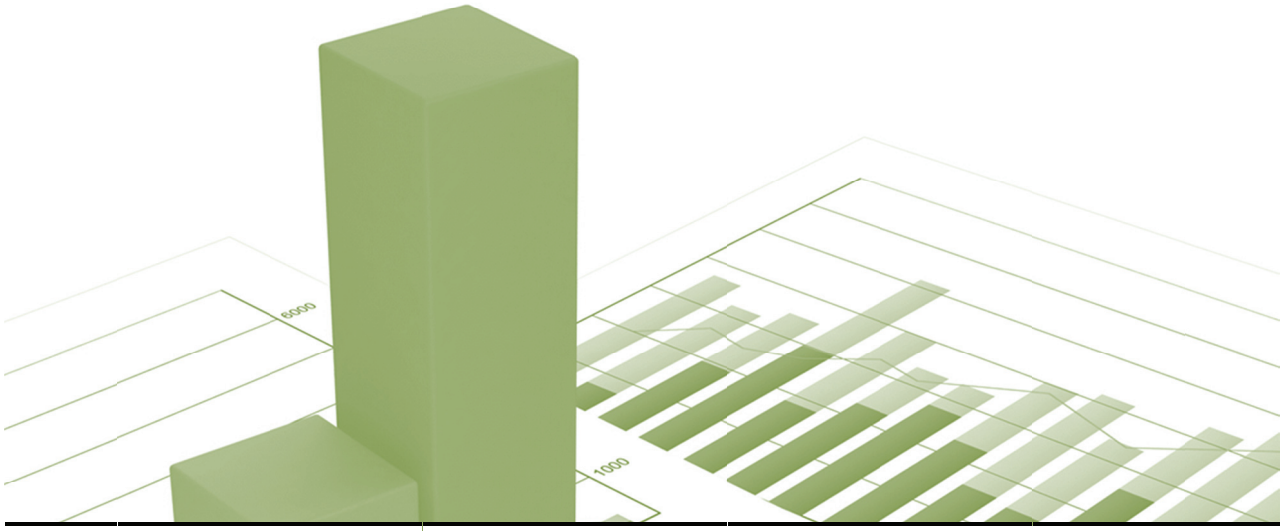
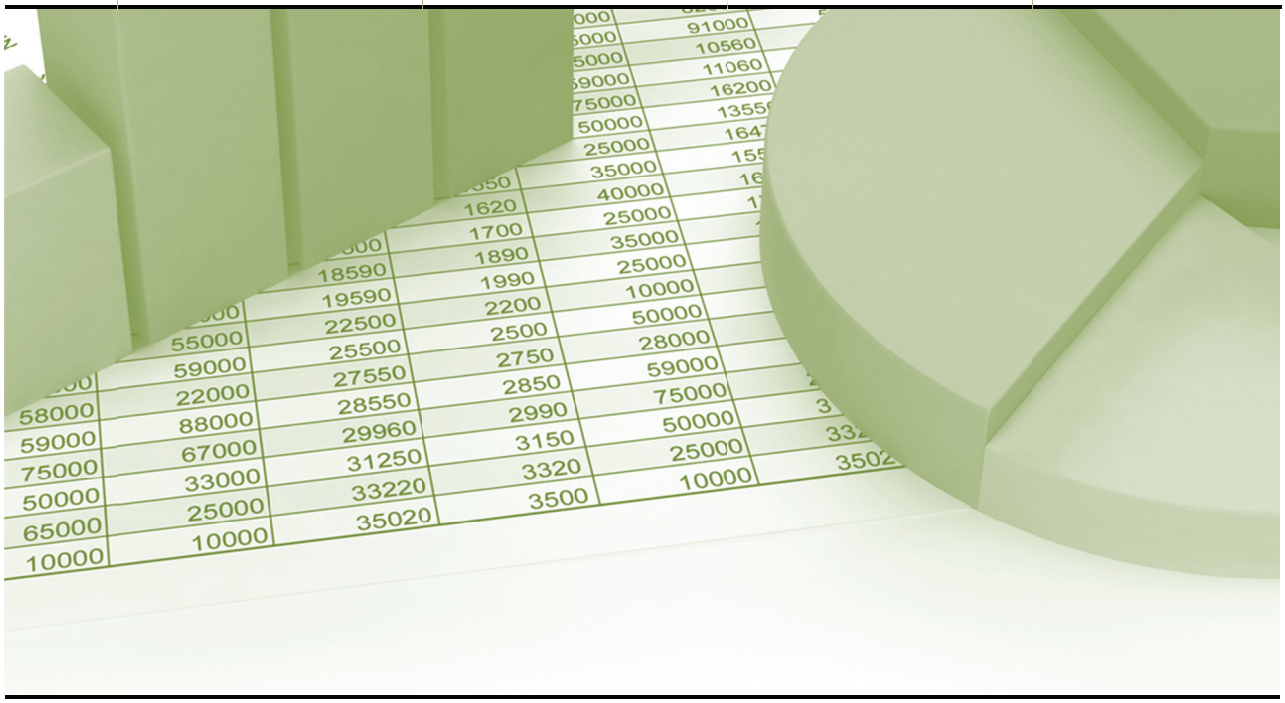


Introduction



This data book is a joint project of the Medicaid and CHIP Payment and Access Commission (MACPAC) and the Medicare Payment Advisory Commission (MedPAC). The data book presents information on the demographic and other personal characteristics, expenditures, and health care utilization of individuals who are dually eligible for Medicare and Medicaid coverage. Dual-eligible beneficiaries receive both Medicare and Medicaid benefits by virtue of their age or disability and low incomes. This population is diverse and includes individuals with multiple chronic conditions, physical disabilities, and cognitive impairments such as dementia, developmental disabilities, and mental illness. It also includes some individuals who are relatively healthy.

For dual-eligible beneficiaries, Medicare is the primary payer for acute and post-acute care services covered by that program. Medicaid provides varying levels of assistance with Medicare premiums and cost sharing and, for many beneficiaries, covers services not included in the Medicare benefit, such as long-term services and supports (LTSS). Full-benefit dual-eligible beneficiaries receive the full range of Medicaid benefits offered in a given state. For partial-benefit dual-eligible beneficiaries, Medicaid pays Medicare premiums and may also pay the cost sharing for Medicare services.

Policymakers have expressed particular interest in dual-eligible beneficiaries because of the relatively large expenditures by both Medicare and Medicaid for this relatively small group of individuals. Concerns have also been raised as to how the existence of separate funding streams creates barriers to coordination of care and the extent to which lack of coordination increases costs and leads to poor health outcomes. Because these issues are of concern to both commissions, we thought it prudent to combine resources and conduct a joint analysis of federal Medicare and Medicaid data. This data book, the third in a series, is an effort to create a common understanding of the characteristics of dual-eligible beneficiaries and their use of services.

This data book is organized into the following sections:

- overview of dual-eligible beneficiaries;
- characteristics of dual-eligible beneficiaries;
- eligibility pathways, managed care enrollment, and continuity of enrollment;
- dual-eligible beneficiaries' utilization of and spending on Medicare and Medicaid services;
- Medicare and Medicaid spending for dual-eligible beneficiaries by LTSS use; and
- trends in dual-eligible population composition, spending, and service use.

In each section, we compare subgroups of dual-eligible beneficiaries, including those with full versus partial benefits and those under age 65 versus those ages 65 and older. We also compare dual-eligible beneficiaries with non-dual Medicare and Medicaid beneficiaries. In the case of Medicaid, we generally limit our comparisons to non-dual Medicaid beneficiaries under age 65 who are eligible for that program on the basis of a disability, rather than the overall Medicaid population, which includes a large number of nondisabled children and adults. In the case of Medicare, our non-dual comparison group includes all non-dual Medicare beneficiaries, who may qualify for coverage on the basis of age, disability, or end-stage renal disease.

In addition to presenting data for calendar year (CY) 2011, the most recent year for which complete Medicare and Medicaid claims data were available when the analytic work for this data book began, we include information on trends in the dual-eligible population between CY 2007 and CY 2011.

The role of Medicare and Medicaid for dual-eligible beneficiaries

Medicare is the primary payer for dual-eligible beneficiaries and mainly covers medical services such as professional (e.g., physician) services, inpatient and outpatient acute care, and post-acute skilled-level care. Dual-eligible beneficiaries are eligible for the same Medicare benefits as other Medicare beneficiaries but

have low incomes that make it difficult to afford the premiums and cost sharing required by Medicare, as well as the cost of services not covered by the Medicare program.

Medicaid programs wrap around Medicare's coverage by providing financial assistance to dual-eligible beneficiaries in the form of payment of Medicare premiums and cost sharing, as well as coverage of some services not included in the Medicare benefit. Not all dual-eligible beneficiaries receive the same level of Medicaid assistance, as described later in this section.

Medicare is a federal program with uniform eligibility rules and a standard benefit package, whereas Medicaid is a joint federal–state program with eligibility rules and benefits that vary by state. Unlike the Medicaid program, where provider payment methodologies and payments are set at the state level, most Medicare payments are governed by formulas that allow for geographic variation but are determined at the national level. The programs also differ in their financing. Medicare is funded from sources such as premiums, payroll taxes, general revenues, and state contributions toward drug coverage for dual-eligible beneficiaries. Federal and state governments share most Medicaid costs according to the federal medical assistance percentage (FMAP), which is based on a formula that provides for a larger federal share in states with lower per capita incomes relative to the national average (and vice versa). For fiscal year 2016, the FMAP ranges from 50 percent to about 74 percent (Office of the Assistant Secretary for Planning and Evaluation 2014).

Categories of dual-eligible beneficiaries

Different types of dual-eligible beneficiaries receive different levels of Medicaid assistance (Table 1). Under mandatory Medicaid eligibility pathways referred to as Medicare Savings Programs (MSPs), dual-eligible beneficiaries qualify for assistance that is limited to payment of Medicare premiums and, in some cases, Medicare cost sharing. Individuals who only receive assistance through the MSPs are referred to as partial-benefit dual-eligible beneficiaries. In addition, individuals may qualify for full Medicaid benefits under separate non-MSP pathways. Those who qualify for full Medicaid benefits, who may or may not receive assistance through the MSPs, are referred to as full-benefit dual-eligible beneficiaries.

Table 1. Medicaid eligibility and benefits by type of dual-eligible beneficiary

Type	Full or partial Medicaid benefits	Federal income and resource (individual / couple) limits for eligibility in 2015	Benefits
Medicare Savings Program (MSP) beneficiaries			
Qualified Medicare beneficiary (QMB)	Partial: QMB only	▪ At or below 100% FPL ▪ $7,280 / $10,930	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: ▪ Medicare Part A premiums (if needed) ▪ Medicare Part B premiums ▪ At state option, certain premiums charged by Medicare Advantage plans ▪ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program)
	Full: QMB plus	▪ At or below 100% FPL ▪ $2,000 / $3,000	Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of: ▪ Medicare Part A premiums (if needed) ▪ Medicare Part B premiums

			▪ At state option, certain premiums charged by Medicare Advantage plans ▪ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D) ▪ All Medicaid-covered services
Specified low-income Medicare beneficiary (SLMB)	Partial: SLMB only	▪ 101%–120% FPL ▪ $7,280 / $10,930	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: ▪ Medicare Part B premiums
	Full: SLMB plus	▪ 101%–120% FPL ▪ $2,000 / $3,000	Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of: ▪ Medicare Part B premiums ▪ At state option, certain premiums charged by Medicare Advantage plans ▪ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid ▪ All Medicaid-covered services
Qualifying individuals (QI)	Partial	▪ 121%–135% FPL ▪ $7,280 / $10,930	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: ▪ Medicare Part B premiums
Qualified disabled and working individuals	Partial	▪ At or below 200% FPL ▪ $4,000 / $6,000	Lost Medicare Part A benefits because of their return to work but eligible to purchase Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: ▪ Medicare Part A premiums
Non-MSP beneficiaries			
Other full-benefit dual-eligible beneficiaries	Full	▪ Income limit varies, but generally at or below 300% of the federal Supplemental Security Income benefit rate (about 225% FPL for an individual) ▪ $2,000 / $3,000	Eligible under a mandatory or optional Medicaid pathway, not eligible for MSP, and qualify for Medicaid payment of: ▪ At state option, certain premiums charged by Medicare Advantage plans ▪ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid ▪ All Medicaid-covered services

Note: *FPL (federal poverty level), MSP (Medicare Savings Program), QI (qualifying individual), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary). Medicaid benefits for dual-eligible beneficiaries are jointly financed by state and federal governments. Although certain categories of dual-eligible beneficiaries are eligible for Medicaid coverage of their Medicare cost sharing, the Balanced Budget Act of 1997 gives states the option of paying the lesser of (1) the full amount of Medicare deductibles and coinsurance or (2) the amount, if any, by which Medicaid's rate for a service exceeds the amount already paid by Medicare. Resource limits for QMB, SLMB, and QI are adjusted annually for inflation. Not all income and resources (such as the value of a house or a vehicle) are counted toward limits. In addition, states may use less restrictive methodologies for counting income and resources, enabling them to expand eligibility above the limits shown here. Eleven 209(b) states may use more restrictive limits and methodologies when determining eligibility for full Medicaid benefits.*

Source: *Social Security Act; Social Security Administration 2014; Centers for Medicare & Medicaid Services 2011, 2013a, and 2013b; Office of Inspector General, Department of Health and Human Services 2012.*

Medicare and Medicaid benefits for dual-eligible beneficiaries

Medicare. Medicare benefits consist of two parts, Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Part A covers inpatient hospital and skilled nursing facility care, post-acute home health care, and hospice care. Part B covers physician services and the services of other practitioners, outpatient hospital care and care in other outpatient settings, home health care not paid for under Part A, other medical services and supplies, and drugs that cannot be self-administered. Part D is the outpatient drug component of the Medicare program.

The Medicare entitlement gives individuals premium-free Part A, but Part B is a voluntary program for which there are monthly premiums that a beneficiary, or a party on behalf of the beneficiary, must pay to the federal government. Part D is also voluntary, and beneficiaries may pay a monthly premium to obtain the coverage through private plans that receive the premium payment. Most Medicare beneficiaries, including dual-eligible beneficiaries, have the choice of receiving their Medicare Part A and Part B benefits through private health plans (Medicare Advantage (MA) plans) if those plans are available in the beneficiaries' geographic area. MA plans are required to provide the Part A and Part B benefit following Medicare coverage rules, but the cost-sharing structure of such plans can be different from that of traditional fee-for-service (FFS) Medicare. Enrollees in MA plans who have Part D coverage must receive their Part D benefits through the MA plan (referred to as MA prescription drug, or MA–PD, plans), with certain exceptions (see Table 2 and Table 3 for more detailed information about the Medicare benefit). Dual-eligible special needs plans (D–SNPs) are a type of MA plan that only enrolls dual-eligible beneficiaries. D–SNPs are required to contract with states to cover some Medicaid benefits for dual-eligible beneficiaries, such as cost-sharing assistance, wraparound services (e.g., vision and dental services), behavioral health services, or long-term care services and supports.

Medicaid. The Medicaid benefit package varies depending on the type of dual-eligible beneficiary (Table 1). For many beneficiaries, Medicaid pays Medicare premiums and is the secondary payer of Medicare-covered services. For full-benefit dual-eligible beneficiaries, states must cover certain Medicaid benefits, such as Medicare cost sharing (discussed below), inpatient hospital and nursing facility services when Medicare coverage is exhausted (that is, when limits on covered days are reached), nursing home care not covered by Medicare, and transportation to medical appointments (Table 2). However, with certain exceptions (e.g., for children under age 21), states may place limits on both mandatory and optional benefits by defining medical necessity and the amount, duration, and scope of covered services. States have the option to cover additional benefits, including personal care and a wide range of other home- and community-based services (HCBS), dental care, vision and hearing services, and supplies. There is considerable variation across states in the optional Medicaid services covered. This variation results in different benefits for dual-eligible beneficiaries depending on where they live.

As with Medicare, managed care plans may provide Medicaid benefits, but the range of services and populations covered by these plans varies across and within states. Comprehensive managed care plans generally include most of the acute care services covered by a state's Medicaid program, but certain items may be carved out and provided separately under the state's FFS system or a limited-benefit managed care plan. In states with limited-benefit Medicaid managed care, the plans most often provide transportation, behavioral health care, or dental services.

Table 2. Items and services covered by Medicare and Medicaid

Category	Medicare	Medicaid
Inpatient and institutional	Inpatient hospital services, with limits on covered days in a benefit period (see Table 3)	Mandatory: Inpatient hospital services
	Inpatient psychiatric services, with limits on covered days and a lifetime limit on total covered days in a psychiatric hospital (see Table 3)	Optional: Inpatient psychiatric services for individuals under age 21 and mental health facility services for individuals ages 65 and older
	SNF, long-term care hospital, and inpatient rehabilitation facility services (all limited to post-acute care); SNF coverage has a limit on covered days (see Table 3), and other settings are subject to hospital covered-day limits	Mandatory: Nursing facility services (for both post-acute and long-term care)
		Optional: Intermediate care facility services for individuals with intellectual disabilities
Outpatient and home- and community-based	Home health services (limited to individuals who require skilled care)	Mandatory: Home health (not limited to individuals who require skilled care)
	Outpatient hospital, federally qualified health center, rural health clinic, ambulatory surgical center, and dialysis facility services	Mandatory: Outpatient hospital, federally qualified health center, rural health clinic, and freestanding birth center services
		Optional: Other clinic services
	Services of physicians and other practitioners and suppliers	Mandatory: Physician, nurse practitioner, nurse midwife, lab and X-ray, and family planning services and supplies
		Optional: Chiropractor and other licensed-practitioner services
	Durable medical equipment	Optional: Durable medical equipment; hospice; prescription drugs; personal and other home- and community-based care; targeted case management; rehabilitation; private-duty nursing; dental; vision; speech and hearing; occupational and physical therapy; and other diagnostic, screening, preventive, and rehabilitative services
	Hospice services	
	Prescription drugs	
Other	Not applicable	Mandatory: Nonemergency transportation to medical care
		See Table 1 for Medicaid coverage of Medicare premiums and cost sharing for dual-eligible beneficiaries. See Table 3 for Medicare premium and cost-sharing amounts.

Note: *SNF (skilled nursing facility). Certain Medicaid beneficiaries are not entitled to full benefits and receive a more limited set of services (see Table 1 for information on dual-eligible beneficiaries who receive limited Medicaid benefits). With certain exceptions, states may place limits on the coverage of mandatory and optional Medicaid benefits for beneficiaries, including those who are dually eligible.*
Source: *Social Security Act and Centers for Medicare & Medicaid Services 2013c.*

Medicare premiums and cost-sharing amounts vary based on a number of factors (Table 3). For Medicare premiums paid on behalf of dual-eligible beneficiaries, state Medicaid programs must pay the full amount, and they receive federal matching funds at the regular Medicaid match rate for those expenditures (with the exception of the qualifying individual (QI) group of dual-eligible beneficiaries, for whom 100 percent federal match is provided).

However, states have flexibility in how they pay providers for Medicare Part A and Part B cost-sharing amounts. Most states choose to limit their payment of Medicare cost sharing for Part A and Part B services to the lesser of

(1) the full amount of Medicare cost sharing (deductibles, coinsurance, or copayments) for a given service, or (2) the amount, if any, by which the Medicaid payment rate exceeds the amount already paid by Medicare (MACPAC 2015a). In cases where Medicaid payment rates are lower than Medicare, these lesser-of policies result in states paying less than the full amount of the Medicare cost-sharing liability. If a state pays less than the full amount, providers are barred from billing qualified Medicare beneficiaries (QMBs) for any remaining cost sharing. Unlike Medicare Part A and Part B services, Medicaid does not pay for cost sharing associated with drugs under Part D, which has its own subsidies for dual-eligible and other low-income beneficiaries.

Table 3. Medicare premiums and cost-sharing amounts, 2015 and 2011

Part A	
Premium	Premium-free for insured individuals and their dependents and survivors; for uninsured individuals "buying in," $407 per month in 2015 or $224 for individuals with at least 30 quarters of coverage ($450 and $248 in 2011), plus the Part B premium (Part A cannot be purchased by itself)
Hospital stays	$1,260 deductible in 2015 for days 1–60 of each benefit period ($1,132 in 2011)
	$315 per day in 2015 for days 61–90 of each benefit period (1/4 of hospital deductible each year) ($283 in 2011)
	$630 per "lifetime reserve day" in 2015 (1/2 of hospital deductible each year) after day 90 of each benefit period (up to 60 days over lifetime) ($566 in 2011)
Skilled nursing facility stays	$0 for the first 20 days of each benefit period; stays are covered if preceded by a 3-day hospital stay
	$157.50 per day in 2015 (1/8 of hospital deductible each year) for days 21–100 of each benefit period ($141.50 in 2011)
	All costs for each day after day 100 of each benefit period
Hospice care	$0 for hospice visits; up to a $5 copay for outpatient prescription drugs
	5% of the Medicare-approved amount for inpatient respite care
Blood	All costs for the first three pints (unless donated to replace what is used)
Part B	
Premium	$104.90 per month in 2015 ($115.40 in 2011); higher for higher income individuals beginning in 2007
Deductible	The first $147 of Part B–covered services or items in 2015 ($162 in 2011)
Physician and other medical services	20% of the Medicare-approved amount for physician services, outpatient therapy (subject to limits), and most preventive services
Outpatient hospital services	A coinsurance or copayment amount that varies by service, projected to average 20% in 2015 (22.1% in 2011); no copayment for a single service can be more than the Part A hospital deductible
Mental health services	20% of the Medicare-approved amount for outpatient mental health care in 2015 (45% in 2011)
Clinical laboratory services	$0 for Medicare-approved services
Home health care	$0 for home health care services
Durable medical equipment	20% of the Medicare-approved amount
Blood	All costs for the first three pints, then 20% of the Medicare-approved amount of additional pints (unless donated to replace what is used)
Part D, standard benefit	
Premium	Varies from year to year and plan to plan in relation to national average bid of sponsoring plans. The Part D weighted basic beneficiary premium for 2015 is $33.13 ($32.34 in 2011); higher premiums for higher income individuals as of 2011; dual-eligible beneficiaries have access to at least one plan in which the plan premium is fully subsidized; other low-income individuals can have partial subsidization of their premiums.

Deductible	$320 in 2015 ($310 in 2011); not applied to dual-eligible beneficiaries; dual-eligible beneficiaries pay only nominal copayments
Initial coverage limit	$2,960 in 2015 ($2,840 in 2011); dual-eligible beneficiaries pay only nominal copayments
Out-of-pocket threshold (catastrophic cap)	$4,700 in 2015 ($4,550 in 2011); after this point, dual-eligible beneficiaries have no financial obligation for covered drugs
Copayment rules	Copayments vary from plan to plan, but minimum copayment amounts are required for beneficiaries who have reached the out-of-pocket threshold. For dual-eligible beneficiaries, there are no copayments for institutionalized beneficiaries at any level of utilization. For other dual-eligible beneficiaries, maximum copayment limits are set for utilization up to the out-of-pocket threshold: $1.20 for generic or preferred multisource drugs and $3.60 for other drugs.
Rules for Medicare Advantage plans	
Part A and Part B premiums and cost sharing	Plans can vary the services for which cost sharing is charged and the level of cost sharing, but for certain services the cost sharing cannot exceed Medicare levels or other limits as specified in Medicare rules. In addition, the overall cost sharing in the plan for Part A and Part B services may not exceed, on average, the actuarial value of the cost sharing of traditional FFS Medicare. In lieu of cost sharing at the point of service, plans may obtain cost-sharing revenue through a monthly premium that all enrollees would pay. MA plans are prohibited from billing QMBs and full-benefit dual-eligible beneficiaries for Medicare cost sharing if the state has financial responsibility for the cost sharing, but the plan can require beneficiaries to pay cost sharing at levels permitted under the Medicaid program of a given state. The MA plan or its providers can bill the state for any cost sharing that is payable by the state.

Note: *FFS (fee-for-service), MA (Medicare Advantage), QMB (qualified Medicare beneficiary). A benefit period in Part A begins the day a beneficiary is admitted to a hospital or skilled nursing facility and ends when the beneficiary has not received hospital or skilled nursing care for 60 days in a row. If the beneficiary is admitted to the hospital after one benefit period has ended, a new benefit period begins and the beneficiary must again pay the inpatient hospital deductible. There is no limit to the number of benefit periods. Part A cost sharing increases over time by the same percentage update applied to payments to inpatient hospitals and is adjusted to reflect real change in case mix.*
Source: *Medicare Payment Advisory Commission 2012 and Centers for Medicare & Medicaid Services 2010a, 2010b, 2010c, 2014a, 2014b.*

Additional information on program eligibility

Medicare. Medicare is an entitlement program for workers, their dependents, and their survivors who meet certain qualifying conditions as provided for under Title XVIII of the Social Security Act; dual-eligible beneficiaries gain eligibility in the same manner as non-dual beneficiaries. There are three main pathways to Medicare eligibility: age, end-stage renal disease (ESRD), or disability. Individuals qualify for Medicare based on age if they are 65 or older, and most of these individuals are qualified to receive Social Security benefit payments (or Railroad Retirement Board benefit payments). Individuals of any age with ESRD can be entitled to Medicare after a waiting period of three months or less.

Individuals ages 18 to 64 can qualify for Medicare benefits on the basis of disability. When determining whether an individual qualifies on the basis of a disability, Medicare uses disability criteria that apply in both the federal Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. Individuals who qualify for Social Security (generally SSDI) benefits on the basis of a disability have a 24-month waiting period before Medicare benefits begin (the waiting period is waived for people with amyotrophic lateral sclerosis). During the waiting period, low-income individuals can qualify as disabled under the SSI program and can receive Medicaid coverage.

In this data book, we distinguish between two types of disabled individuals under age 65: those who qualify for Medicare based on their own work history and those who qualify for Medicare based on a spouse's or parent's work history. Individuals in the former group have worked enough quarters to qualify for Medicare benefits. Individuals in the latter group have not worked enough quarters to qualify for Medicare benefits. These individuals are often disabled widow(er)s and surviving divorced spouses, ages 50 and older, or adult children ages 18 and older who have a disabling condition that began before the age of 22. In most cases, these dependents and survivors of workers receive monthly dependent or survivor benefit payments from Social Security (or the Railroad Retirement Board).

Medicaid. Medicaid eligibility pathways are typically defined by the populations they cover and the financial criteria that apply. As noted earlier, the MSP pathways to limited Medicaid coverage of Medicare premiums and cost sharing are by definition designed for low-income Medicare beneficiaries. In contrast, pathways to full Medicaid coverage do not specifically target Medicare beneficiaries. They instead cover groups that include low-income individuals ages 65 and older and younger persons with disabilities, many of whom happen to be Medicare beneficiaries. About half of dual-eligible beneficiaries who receive full Medicaid benefits qualify under a mandatory eligibility pathway based on their receipt of federal SSI benefits. SSI is available to individuals with limited incomes (up to about 75 percent of the federal poverty level (FPL)) and resources ($2,000 for an individual and $3,000 for a couple) who are under age 65 and disabled or who are ages 65 and older. For most eligibility pathways that apply to individuals with disabilities and those ages 65 and older, all states may opt to use less restrictive methodologies for counting income and resources to expand eligibility, and 11 states (referred to as 209(b) states) may opt to use more restrictive criteria. Additional non-SSI pathways to full Medicaid for individuals with disabilities and those ages 65 and older include but are not limited to:

- **Poverty level.** States may opt to cover individuals with disabilities and those ages 65 and older with incomes up to 100 percent of the FPL.
- **Medically needy.** Under this option, individuals with higher incomes can "spend down" to a state-specified medically needy income level by incurring medical expenses.
- **Special income level.** States can cover individuals with incomes up to 300 percent of the SSI benefit rate (about 225 percent of the FPL for an individual) who are receiving long-term care in an institution. States may also extend this eligibility to individuals who use home- and community-based waiver services as an alternative to institutionalization.

As a result of differences in states' use of optional eligibility pathways, the extent to which eligible individuals are enrolled, and differences in demography at the state level, there is considerable variation in the share of each state's population that is covered by Medicaid (Table 7). Given that Medicare eligibility criteria do not vary by state, differences in the share of the population covered by that program are largely driven by demographics, such as the share of the population ages 65 and older.

Methods

Sources of data

The data presented are for 2007 through 2011. When the analytic work for this data book began, CY 2011 was the most recent year for which complete claims data were available for the Medicare and Medicaid programs. The sources of data include:

- Medicare enrollment data from Enrollment Database and Common Medicare Environment (CME) files,
- Medicare Part A, Part B, and Part D claims from Common Working File and Part D Prescription Drug Event data,

- Medicare Part C payment data from Medicare Advantage Prescription Drug files,
- Medicaid enrollment and claims data from Medicaid Statistical Information System (MSIS) files, and
- other data sources noted in specific exhibits as warranted.

Acumen LLC created the analytic files used for this data book based on these sources. These files are similar to files created for research purposes by the Centers for Medicare & Medicaid Services (CMS), such as the Medicare–Medicaid Linked Enrollee Analytic Data Source. However, differences in the methodology for creating analytic files (such as the incorporation of revised MSIS data submitted by states that may not always be reflected in the research files from CMS) may lead to estimates of enrollment and spending slightly different from other analyses that use CMS research files. Regardless of which file versions are used, differences in how analytic populations are defined (such as counting dual-eligible beneficiaries using an ever-enrolled rather than an average monthly or point-in-time measure) may also explain differences between the estimates presented here and those published elsewhere by MedPAC, MACPAC, CMS, and others.

Each Medicare and Medicaid beneficiary represented in these datasets was assigned a unique identification (ID) number using an algorithm that incorporates program-specific identifiers (such as Health Insurance Claim (HIC) numbers for Medicare and MSIS IDs for Medicaid) and beneficiary characteristics (such as date of birth and gender). This unique ID was used to link an individual's records across all data sources, including both Medicare and Medicaid files for dual-eligible beneficiaries, and to create unduplicated beneficiary counts. Although dual-eligible beneficiaries may be identified in several ways, this data book uses the dual-eligible indicators in Medicare CME data that are derived from state-submitted Medicare Modernization Act files. Results may differ slightly from analyses that use other data sources (such as MSIS) for this purpose. In our analysis, the dual-eligible population consists of individuals with at least one month of dual-eligible enrollment during the year. Non-dual Medicare and Medicaid beneficiaries were identified as individuals with zero months of dual-eligible enrollment during the year.

A variety of analytic variables were created using information from the underlying data files. Noteworthy items include:

- *Identification of chronic conditions.* To identify beneficiaries with chronic conditions, we applied algorithms that were developed by CMS for the data files in its Chronic Condition Warehouse (CCW). The CCW has traditionally used Medicare FFS claims data to identify chronic conditions but has recently begun using Medicaid FFS claims as well. In this data book, we report chronic conditions based on Medicare FFS claims only. Chronic conditions among MA enrollees and non-dual Medicaid beneficiaries, therefore, were not identified.

  Our data describe beneficiaries who currently have a particular condition rather than the larger group of beneficiaries who ever had that condition. For a beneficiary to be identified as having a particular condition, the CCW has a condition-specific "look-back" or reference period that requires continuous FFS enrollment during the period as well as the presence of FFS claims for the condition during the period. For example, there is a three-year reference period for Alzheimer's disease and a one-year reference period for the presence of anemia.

- *Medicare entitlement based on disability.* In this data book, primary claimant information contained in an individual's Medicare HIC number was used to separate disabled beneficiaries with entitlement to Medicare based on their own work history from those with entitlement based on another individual's work history. We separated these groups because the latter includes a large number of individuals whose disabilities began in childhood and whose characteristics may therefore differ from those of individuals who became disabled as working-age adults. As discussed previously, disabled beneficiaries entitled to Medicare based on another individual's work history

include disabled adult children who receive benefits through a disabled, retired, or deceased parent as well as disabled individuals ages 50 and older who receive benefits through a deceased spouse or deceased former (divorced) spouse.

- *Medicaid LTSS.* Medicaid LTSS are defined by FFS use of the following Medicaid services: institutional (nursing facility, intermediate care facility for persons with intellectual disabilities, and mental health facility for individuals ages 65 and older or age 21 and under), HCBS under a waiver (including any type of service provided under such a waiver), or HCBS under a state plan (nonwaiver home health and personal care services). We separate these groups because HCBS waiver users are required to meet an institutional level of care and may receive a wide array of services, whereas HCBS state-plan users are not required to meet an institutional level of care and often use fewer services. Beneficiaries whose only Medicaid LTSS use was through a managed care entity are not captured in this definition. However, the number of Medicaid managed care LTSS users in 2011–2012 (389,000 individuals, according to Saucier et al. (2012)) was relatively small compared with the total number of dually eligible and non-dual Medicaid FFS LTSS users in 2011 identified through analyses completed for this data book (4.3 million). More recent state-reported figures show that 917,259 individuals were enrolled in Medicaid managed care plans covering LTSS as of July 1, 2013 (Centers for Medicare & Medicaid Services 2015).

Known issues with some of the data sources used in the analysis include:

- *Reporting of Medicaid data by states.* MSIS data are known to undercount total Medicaid spending at the national level relative to data submitted by states in a data source referred to as the CMS–64 to obtain federal matching funds, with variation by state and type of service. For example, MSIS data generally exclude lump-sum supplemental payments to hospitals that are made in addition to rate-based payments for service use by individual beneficiaries. Such supplemental payments account for more than 40 percent of Medicaid FFS spending on inpatient and outpatient hospital services (MACPAC 2015b). The MSIS data also exclude Medicaid payments for Medicare premiums—$14 billion in 2011, of which $9 billion was the federal share and $5 billion was the state share (MACPAC 2015c)—that finance a portion of Medicare spending. Other known issues with state reporting of MSIS data, such as errors in coding individuals in the proper eligibility group, are documented in an anomalies report updated by CMS on an ongoing basis (Mathematica 2015). A disconnect between managed care enrollment and payment data was one example of a possible reporting error that we observed in the Medicaid data. For some individuals, enrollment data indicated that an individual was in one type of managed care plan (e.g., limited benefit) while payment data indicated another plan type (e.g., comprehensive). We did not attempt to correct for such reporting errors in our analysis.

  The Medicaid spending amounts presented in this data book have not been adjusted to match CMS–64 totals in part because there is no universally agreed-upon method for doing so. For example, the issue of whether and how lump-sum supplemental payments to hospitals should be distributed among individual beneficiaries may depend on the purpose of a particular analysis. CMS analyses of dual-eligible beneficiaries generally do not adjust the MSIS spending reported by states. MACPAC adjusts the MSIS spending published in the MACStats section of its reports, but collapses nearly 30 service types into just 7 broad categories of service that are comparable between the MSIS and CMS–64 data.

- *Identification of Medicaid payments for Medicare cost sharing.* States are instructed to report Medicaid payments for Medicare deductibles and coinsurance in MSIS. The completeness of this reporting may vary by state and type of service. Moreover, payments for Medicare-covered services (such as coinsurance for inpatient hospital or skilled nursing facility stays) cannot always be

separated from payments for Medicaid-covered services (such as hospital days in excess of Medicare limits or nursing facility stays that do not meet Medicare's coverage requirements). As a result, to the extent that Medicaid payments for Medicare deductibles and coinsurance are reported, they are embedded in the spending for each Medicaid service type shown.

Although the amount of Medicare cost sharing *paid* by Medicaid cannot be separated in MSIS data, the cost-sharing obligations *incurred* by dual-eligible and non-dual beneficiaries are available in Medicare claims data (Table 4). As noted earlier, most states only pay Medicare cost sharing up to the rate that Medicaid would have paid for a service. As a result, the amounts paid by Medicaid for Medicare cost sharing are likely to be lower than the amounts incurred by beneficiaries.

Table 4. Fee-for-service Medicare Part A and Part B cost sharing incurred by dual-eligible and non-dual Medicare beneficiaries (dollars in billions), CY 2011

Type of cost sharing	Full-benefit dual-eligible beneficiaries			Limited-benefit dual-eligible beneficiaries		Non-dual Medicare beneficiaries
	QMB plus	SLMB plus	Other full benefit	QMB only	SLMB only, QI, and QDWI	
Part A total	**$2.8**	**$0.3**	**$1.7**	**$0.4**	**$0.4**	**$9.6**
Hospital deductible	1.4	0.1	0.5	0.3	0.3	6.1
Hospital-day copayments	0.3	<0.1	0.2	<0.1	<0.1	0.5
SNF-day copayments	1.1	0.2	1.0	0.1	0.1	3.0
Part B total	**5.5**	**0.4**	**2.0**	**1.1**	**1.0**	**28.0**
Deductible	0.5	<0.1	0.2	0.1	0.1	3.7
Coinsurance	5.0	0.3	1.8	1.0	0.9	24.3
Part A and Part B total	**8.3**	**0.7**	**3.7**	**1.5**	**1.4**	**37.6**

Note: *QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual), QDWI (qualified disabled working individual), SNF (skilled nursing facility). See Table 1 for a description of each dual-eligible group, not all of which are entitled to Medicaid payment of Medicare cost sharing. Unlike all other exhibits in this data book, which attribute a dual-eligible beneficiary's annual dollar amount to a particular category (QMB plus, SLMB plus, etc.) based on their most recent enrollment, this table reflects the sum of monthly amounts while individuals were in a particular category. Amounts shown reflect only the Medicare cost sharing incurred by beneficiaries using fee-for-service Medicare Part A and Part B services. They do not reflect the actual cost-sharing amounts paid to providers by beneficiaries, Medicaid, or other third parties such as Medigap plans. Totals may not sum due to rounding.*
Source: *Acumen LLC analysis of Medicare and Medicaid enrollment and claims data for MedPAC and MACPAC.*

Population definitions

Because an individual's enrollment in Medicare and Medicaid may vary over the course of a year and appropriate subgroups for analyses may vary based on factors such as FFS or managed care participation, each exhibit in this data book specifies the analytic population used. Here we summarize considerations that were taken into account in developing the analytic populations.

- *Enrollment and residence.* In this data book, Medicare beneficiaries are individuals with at least one month of enrollment in Part A or Part B of that program. Medicaid beneficiaries are individuals

with at least one month of regular Medicaid or Medicaid-expansion State Children's Health Insurance Program (CHIP) enrollment. Individuals residing outside of the 50 states and the District of Columbia are excluded from the analysis.

- *Counting and categorizing dual-eligible beneficiaries.* For most Medicare beneficiaries, including dual-eligible beneficiaries, Medicare entitlement status does not change from month to month. By contrast, Medicaid eligibility is less stable, with some beneficiaries losing and regaining eligibility over the course of a year or changing the nature of their eligibility. For dual-eligible beneficiaries, the status change can be from partial-benefit to full-benefit Medicaid coverage.

  In this data book, the dual-eligible population consists of individuals with at least one month of dual-eligible enrollment during the year. Dual-eligible beneficiaries are categorized as having full or partial Medicaid benefits based on their most recent month of dual enrollment. Non-dual Medicare and Medicaid beneficiaries are individuals with zero months of dual-eligible enrollment during the year. The total number of beneficiaries in each program reflects all individuals with at least one month of enrollment, which is referred to as an "ever-enrolled" count. Counting beneficiaries in this manner ensures that each Medicare and Medicaid beneficiary will be counted only once.

  The choice of whether to count beneficiaries using an ever-enrolled or an average monthly measure makes a much larger difference for the Medicaid population (where average monthly beneficiary counts were 83 percent of ever-enrolled counts) than the Medicare population (where average monthly counts were 95 percent of ever-enrolled counts) (Table 5). For dual-eligible beneficiaries, average monthly counts were 88 percent of ever-enrolled counts.

Table 5. Comparison of dual-eligible and non-dual Medicare and Medicaid beneficiary counts using ever-enrolled and average monthly measures, CY 2011

	Number of beneficiaries (millions)		Average monthly as a percent of ever enrolled
	Ever enrolled	Average monthly	
Dual-eligible beneficiaries	**10.0**	**8.8**	**88%**
Under age 65	4.1	3.7	89
Ages 65 and older	5.9	5.2	88
Medicare beneficiaries with no dual-eligible enrollment	**40.4**	**38.9**	**96**
Under age 65	4.4	4.3	99
Ages 65 and older	36.0	34.6	96
Medicaid beneficiaries with no dual-eligible enrollment	**59.8**	**49.0**	**82**
Nondisabled under age 65	53.1	42.9	81
Disabled under age 65	6.0	5.5	91
Ages 65 and older	0.6	0.6	93
All Medicare beneficiaries	**50.4**	**47.7**	**95**
All Medicaid beneficiaries	**69.9**	**57.8**	**83**

Note: *Medicaid beneficiaries include Medicaid-expansion State Children's Health Insurance Program enrollees. Figures may not sum to subtotals due to rounding.*
Source: *Acumen LLC analysis of Medicare and Medicaid enrollment files for MedPAC and MACPAC.*

- *Attributing spending and utilization.* Beneficiaries' spending and utilization are attributed to them after they are counted and categorized as dual-eligible beneficiaries, non-dual Medicare beneficiaries, or non-dual Medicaid beneficiaries. To avoid double-counting spending and utilization, we attribute all spending and utilization an individual incurs in a year to that individual's category. That is, for individuals identified as dual-eligible beneficiaries, their dual type (full or partial) is assigned based on their most recent month of dual-eligible enrollment, and their spending and utilization for the entire year are attributed to that individual and counted as spending for a dual-eligible beneficiary. The advantage of this methodology is that spending and utilization are not double-counted. However, some dual-eligible beneficiaries switched between non-dual and dual-eligible status during the year or between subgroups of dual-eligible beneficiaries.

  A limitation of this methodology is that we are at times attributing spending and utilization to a category (e.g., dual-eligible beneficiary, non-dual beneficiary) when in fact that spending and utilization were incurred while the individual was in a different category. Most dual-eligible beneficiaries did not switch between dual and non-dual or full-benefit and partial-benefit categories in 2011 (Exhibit 13). Therefore, our attribution method for counting beneficiaries, spending, and utilization likely does not have a large impact on our results.

- *Fee-for-service and managed care enrollment status.* Many of the tables in this data book provide information about expenditures and utilization for particular categories of services. Since managed care plans are paid by per member, per month capitation rates, data are not available on the expenditures associated with each service provided to individuals enrolled in managed care. MA plans did not begin submitting encounter data to CMS showing utilization among plan members until 2013. Although many states submitted Medicaid managed care encounter data to CMS in 2011, concerns about completeness and comparability across states prevented us from using the Medicaid encounter data for reporting national totals. Therefore, most tables in this data book are limited to the FFS population.

  In the exhibits, we define the FFS population as individuals for whom all Medicare enrollment months were in FFS Medicare and for whom all Medicaid enrollment months were in FFS Medicaid or limited-benefit managed care. Limited-benefit plans cover a subset of Medicaid services, such as behavioral health, transportation, or dental care, with the remainder of the services covered either through FFS Medicaid or through a comprehensive Medicaid managed care plan. Because our FFS definition includes individuals with limited-benefit Medicaid managed care enrollment, total Medicaid spending reported for this population includes both FFS payments and a small amount of capitation payments.

  Where data are presented on the managed care population, that population is defined as individuals for whom all Medicare enrollment months were in an MA plan or for whom all Medicaid enrollment months were in Medicaid comprehensive managed care. An additional segment of the population consists of individuals who are managed care enrollees for a portion of the year but in Medicare or Medicaid FFS status for the remaining portion of the year.

  About 22 percent of the dual-eligible population was enrolled in an MA plan for all or part of the year in 2011 (Exhibit 11). Dual-eligible beneficiaries were less likely to have been MA enrollees but more likely than non-dual Medicare beneficiaries to have had a mix of MA and FFS enrollment in the year (4 percent versus 1 percent). This difference reflects the ability of dual-eligible beneficiaries to enroll in or disenroll from MA on a month-by-month basis (whereas non-dual Medicare beneficiaries generally can only make changes during a limited open enrollment period

each year). Dual-eligible beneficiaries were less likely to have been in comprehensive Medicaid managed care plans than non-dual disabled Medicaid beneficiaries under age 65 (14 percent versus 45 percent, Exhibit 12).

- *Beneficiaries with end-stage renal disease (ESRD).* About 1.1 percent of all Medicare beneficiaries and 2.4 percent of dual-eligible beneficiaries have ESRD (Table 6). Unless otherwise indicated, the tables in this data book showing utilization and expenditure statistics exclude beneficiaries with ESRD. Although 42 percent of beneficiaries with ESRD are dual-eligible beneficiaries, we excluded them from most of the exhibits in this data book because of the disproportionate share of Medicare spending they represent. In addition, because they are the only class of Medicare beneficiaries specifically prohibited from enrolling in MA plans (except in certain circumstances), they are disproportionately represented in the FFS population. This prohibition on MA enrollment further skews the utilization and expenditure statistics for the FFS population, which is the population examined in most of the exhibits.

Table 6. Beneficiaries with end-stage renal disease and their expenditures, CY 2011

	All beneficiaries	Non-ESRD	ESRD	ESRD as percent of total
Population				
All Medicare beneficiaries (in millions)	50.4	49.9	0.6	1.1%
Dual-eligible beneficiaries (in millions)	10.0	9.8	0.2	2.4
Dual-eligible beneficiaries as percent of category	20%	20%	42%	
Medicare expenditures				
Total spending (in billions)	$521.9	$487.0	$34.9	6.7
Per person per year	10,348	9,769	60,366	
Spending on dual-eligible beneficiaries (in billions)	180.2	161.7	18.5	10.3
Per person per year	17,963	16,515	76,442	
Spending on non-dual beneficiaries (in billions)	341.6	325.3	16.3	4.8
Per person per year	8,457	8,120	48,733	
Medicaid expenditures				
Spending on dual-eligible beneficiaries (in billions)	$114.1	$110.4	$3.7	3.3
Per person per year	11,377	11,276	15,464	

Note: *ESRD (end-stage renal disease). ESRD status is based on at least one month of having ESRD in the year. Figures may not sum due to rounding.*
Source: *Acumen LLC analysis of Medicare and Medicaid enrollment, claims, and managed care payment data for MedPAC and MACPAC.*

The share of spending on beneficiaries with ESRD is disproportionate in relation to their share of the population, but the differences between the two populations are greater for Medicare expenditures than for Medicaid expenditures in the case of dual-eligible beneficiaries. In 2011, annual per capita Medicare spending for dual-eligible ESRD beneficiaries was $76,442; per capita Medicaid spending was $15,464. With the ESRD population included, annual per capita Medicare spending for dual-eligible beneficiaries averaged $17,963 in 2011; excluding ESRD beneficiaries, per capita Medicare spending on dual-eligible beneficiaries

averaged $16,515 for the year. In comparison, Medicaid per capita spending on dual-eligible beneficiaries including the ESRD population was $11,377; excluding these individuals, the amount was $11,276.

Table 7. Dual-eligible, Medicare, and Medicaid beneficiaries as a percent of population by state, CY 2011 (continued next page)

State	Total population (thousands)	Dual-eligible beneficiaries						All Medicare beneficiaries		All Medicaid beneficiaries	
		All		Full		Partial					
		Number (thousands)	Percent of total population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of total population	Number (thousands)	Percent of total population
National	311,592	10,033	3%	7,349	73%	2,684	27%	50,430	16%	69,861	22%
Alabama	4,803	211	4	95	45	116	55	914	19	1,056	22
Alaska	723	16	2	15	96	1	4	73	10	147	20
Arizona	6,483	172	3	133	77	39	23	1,007	16	1,675	26
Arkansas	2,938	130	4	74	57	56	43	572	19	762	26
California	37,692	1,300	3	1,261	97	39	3	5,226	14	12,076	32
Colorado	5,117	94	2	69	74	25	26	688	13	763	15
Connecticut	3,581	155	4	82	53	73	47	610	17	785	22
Delaware	907	27	3	12	46	15	54	163	18	241	27
District of Columbia	618	25	4	19	75	6	25	85	14	222	36
Florida	19,058	727	4	372	51	355	49	3,654	19	3,957	21
Georgia	9,815	298	3	152	51	146	49	1,361	14	1,860	19
Hawaii	1,375	36	3	32	88	4	12	224	16	310	23
Idaho	1,585	36	2	24	66	12	34	251	16	275	17
Illinois	12,869	363	3	320	88	43	12	1,984	15	3,044	24
Indiana	6,517	178	3	113	64	65	36	1,088	17	1,252	19
Iowa	3,062	87	3	70	80	17	20	553	18	604	20
Kansas	2,871	71	2	47	67	24	33	467	16	406	14
Kentucky	4,369	188	4	106	56	82	44	822	19	959	22
Louisiana	4,575	203	4	113	56	90	44	748	16	1,406	31
Maine	1,328	103	8	58	56	45	44	287	22	441	33
Maryland	5,828	127	2	81	64	45	36	858	15	1,148	20
Massachusetts	6,588	211	3	193	91	18	9	1,080	16	999	15
Michigan	9,876	304	3	258	85	47	15	1,790	18	2,311	23
Minnesota	5,345	143	3	126	88	17	12	851	16	1,102	21
Mississippi	2,979	163	5	85	52	78	48	536	18	775	26
Missouri	6,011	189	3	158	84	31	16	1,072	18	1,176	20

State	Total population (thousands)	Dual-eligible beneficiaries						All Medicare beneficiaries		All Medicaid beneficiaries	
		All		Full		Partial					
		Number (thousands)	Percent of total population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of total population	Number (thousands)	Percent of total population
Montana	998	25	3	17	67	8	33	184	18	140	14
Nebraska	1,843	37	2	34	94	2	6	291	16	288	16
Nevada	2,723	49	2	24	50	25	50	392	14	376	14
New Hampshire	1,318	34	3	22	66	12	34	241	18	169	13
New Jersey	8,821	218	2	190	87	28	13	1,428	16	1,393	16
New Mexico	2,082	73	4	41	56	32	44	342	16	639	31
New York	19,465	829	4	701	85	128	15	3,215	17	5,766	30
North Carolina	9,656	334	3	258	77	76	23	1,619	17	1,968	20
North Dakota	684	14	2	13	89	2	11	114	17	83	12
Ohio	11,545	349	3	231	66	118	34	2,053	18	2,512	22
Oklahoma	3,792	122	3	99	81	23	19	652	17	967	26
Oregon	3,872	109	3	69	63	41	37	679	18	720	19
Pennsylvania	12,743	441	3	364	83	77	17	2,447	19	2,518	20
Rhode Island	1,051	41	4	34	84	6	16	194	18	223	21
South Carolina	4,679	158	3	136	86	22	14	844	18	1,028	22
South Dakota	824	22	3	14	63	8	37	146	18	142	17
Tennessee	6,403	277	4	154	56	123	44	1,152	18	1,532	24
Texas	25,675	686	3	403	59	283	41	3,289	13	5,112	20
Utah	2,817	36	1	31	86	5	14	309	11	370	13
Vermont	626	30	5	21	70	9	30	122	19	200	32
Virginia	8,097	190	2	127	67	63	33	1,242	15	1,098	14
Washington	6,830	179	3	130	73	49	27	1,067	16	1,378	20
West Virginia	1,855	87	5	51	59	36	41	409	22	430	23
Wisconsin	5,712	168	3	146	87	22	13	984	17	1,321	23
Wyoming	568	11	2	7	63	4	37	87	15	85	15

Note: *"State" reflects an individual's most recent month of enrollment. For Medicaid beneficiaries, including dual-eligible Medicaid beneficiaries, the sum of the state counts exceeds the unduplicated national count because a small number (less than 1 percent) were reported in more than one state Medicaid program as of their most recent month of enrollment. Medicaid beneficiaries include Medicaid-expansion State Children's Health Insurance Program enrollees.*

Source: *Acumen LLC analysis of the Census Bureau's "Vintage 2011 State Population Datasets - Single year of age and sex population estimates: April 1, 2010 to July 1, 2011 - RESIDENT" and Medicare and Medicaid enrollment data for MedPAC and MACPAC.*

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Section

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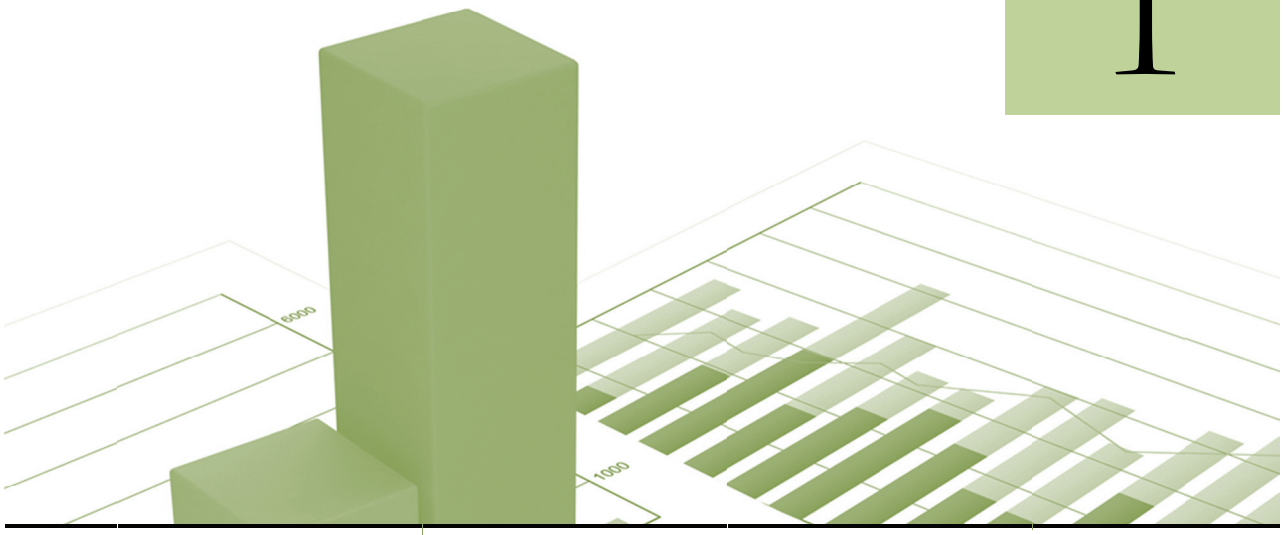


Overview of dual-eligible beneficiaries

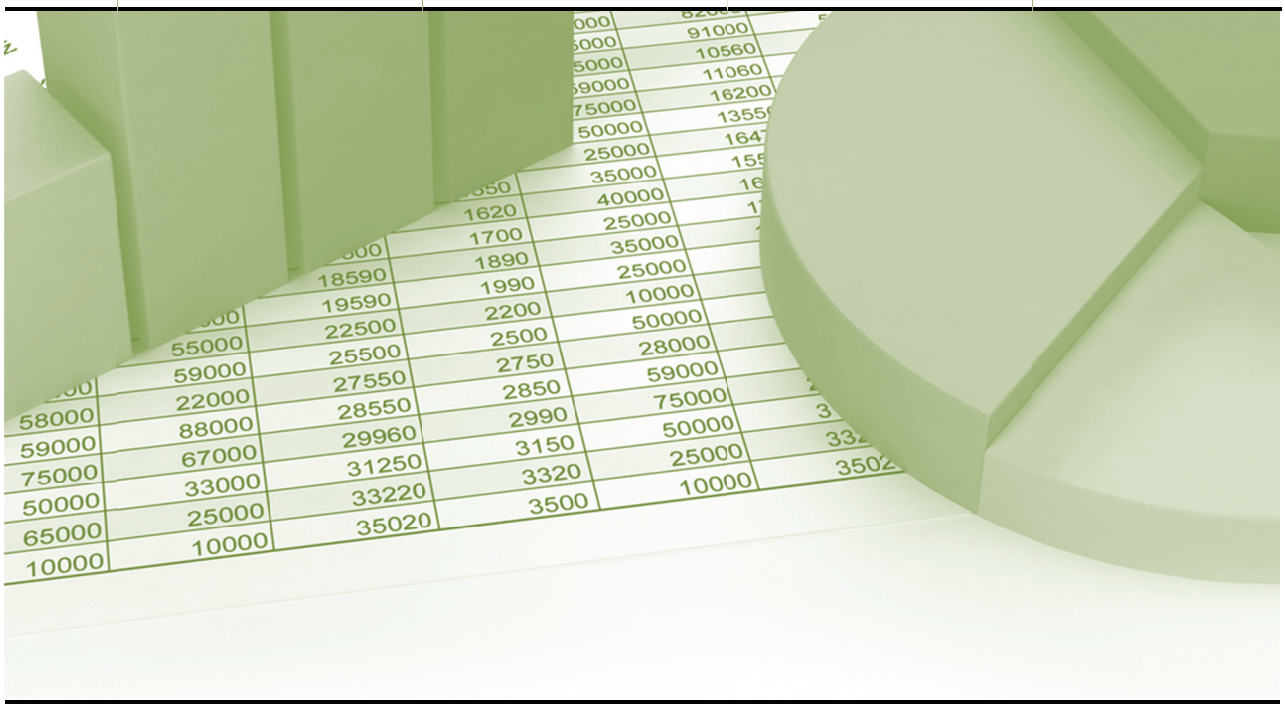
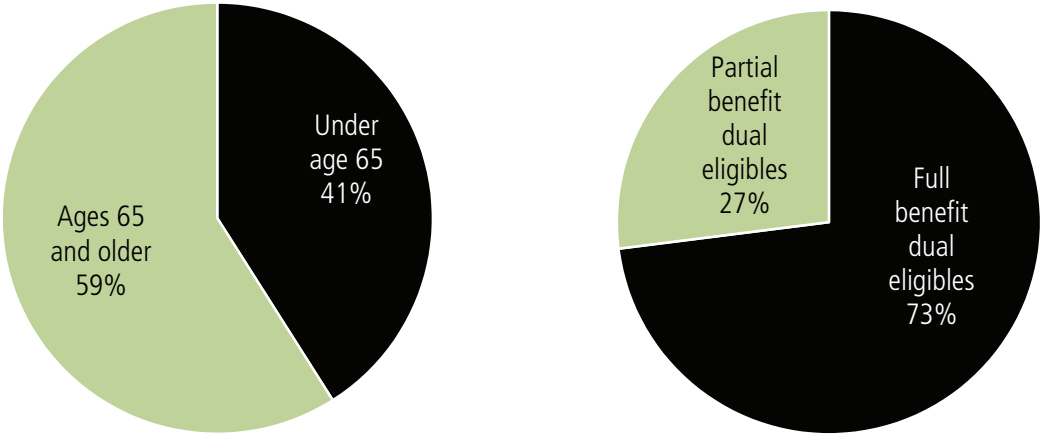


Exhibit 1

Snapshot of dual-eligible beneficiaries by age and type of benefit, CY 2011

10.0 million dual-eligible beneficiaries



Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease).*

- A total of 10.0 million individuals were dually eligible for Medicare and Medicaid benefits in at least one month of CY 2011. The majority (59 percent) of dual-eligible beneficiaries were ages 65 and older.
- Most dual-eligible beneficiaries (73 percent) were eligible for full Medicaid benefits.

Exhibit 2

Dual-eligible beneficiary enrollment in full- and partial-benefit categories, CY 2011

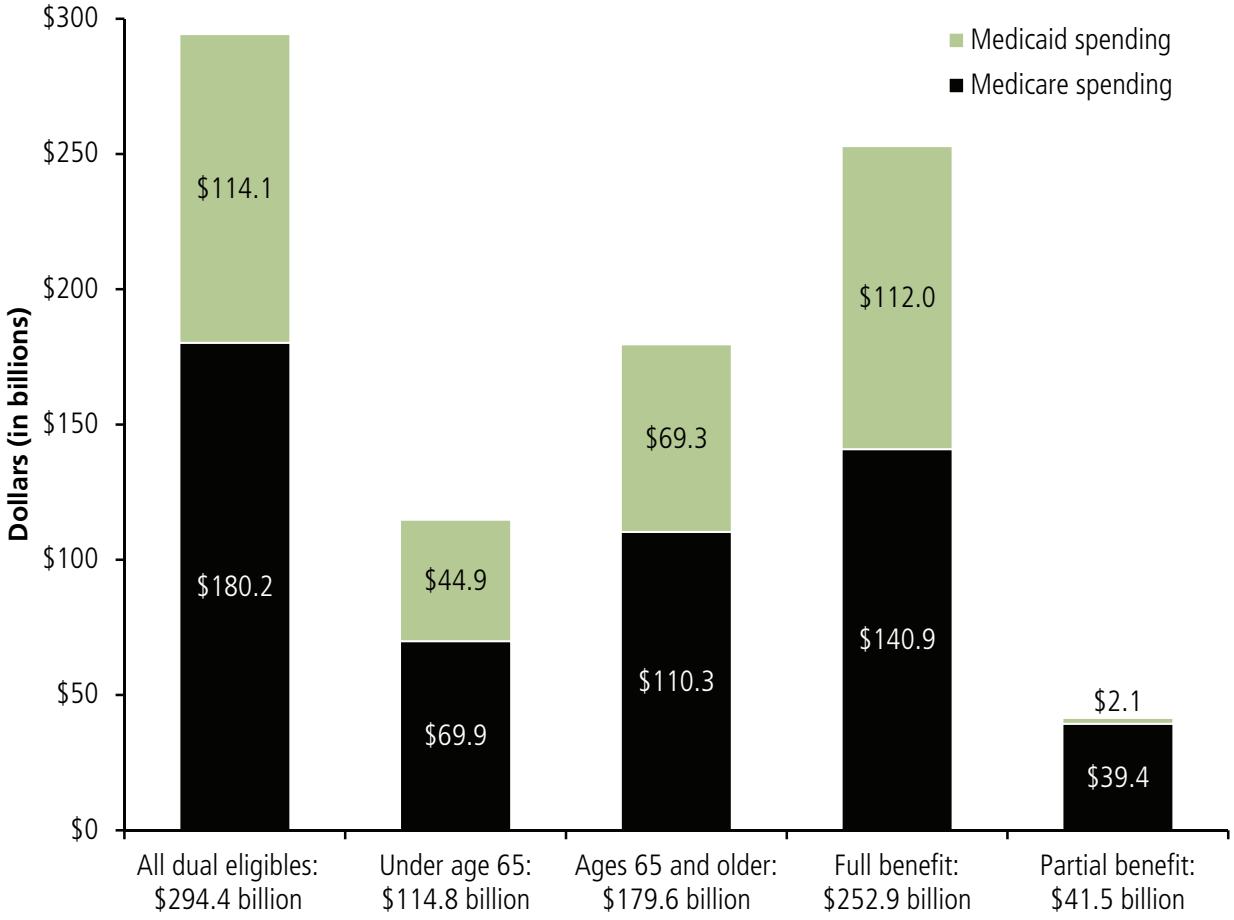
Benefit categories	Dual-eligible beneficiaries		
	All	Under age 65	Ages 65 and older
Full-benefit dual-eligible beneficiaries	**73%**	**73%**	**74%**
QMB plus	52	54	51
SLMB plus	3	3	3
Other full benefit	19	16	20
Partial-benefit dual-eligible beneficiaries	**27**	**27**	**26**
QMB only	12	14	12
SLMB only	9	9	9
QI	5	5	6
QDWI	<1	<1	<1

Note: *CY (calendar year), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual), QDWI (qualified disabled working individual). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Percentages may not sum to 100 or to totals due to rounding.*

- In CY 2011, about three-quarters of individuals who were dually eligible for Medicare and Medicaid were eligible for full Medicaid benefits.
- Among the partial-benefit dual-eligible beneficiary categories, the greatest enrollment (12 percent) was in the QMB-only category.

Exhibit 3

Medicare and Medicaid spending on dual-eligible beneficiaries by age and type of benefit, CY 2011

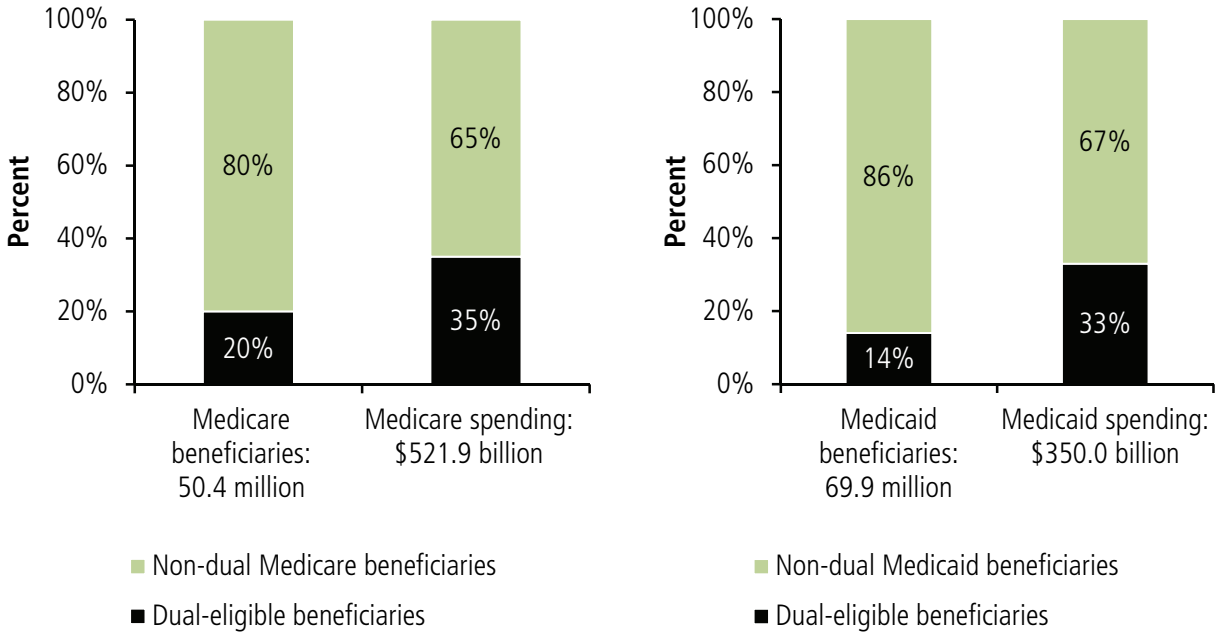


Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Totals may not sum due to rounding. Exhibit excludes administrative spending.*

- Combined Medicare and Medicaid spending on individuals who were dually eligible for both Medicare and Medicaid was $294.4 billion in CY 2011. Medicare accounted for more than half of combined spending ($180.2 billion).
- By age group, most Medicare and Medicaid spending on dual-eligible beneficiaries was accounted for by beneficiaries ages 65 and older ($179.6 billion combined spending).
- Full-benefit dual-eligible beneficiaries represented a higher share of combined spending than partial-benefit dual-eligible beneficiaries ($252.9 billion compared with $41.5 billion, respectively).

Exhibit 4

Dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2011



Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Medicaid figures include enrollment and spending for Medicaid-expansion State Children's Health Insurance Program beneficiaries. Exhibit excludes administrative spending.*

- Individuals dually eligible for Medicare and Medicaid benefits accounted for disproportionate shares of Medicare and Medicaid spending in CY 2011.
- Dual-eligible beneficiaries totaled 20 percent of the Medicare population in 2011 but accounted for 35 percent of Medicare spending.
- Similarly, dual-eligible beneficiaries comprised 14 percent of all Medicaid beneficiaries but accounted for 33 percent of Medicaid spending.

Exhibit 5

Selected subgroups of dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2011

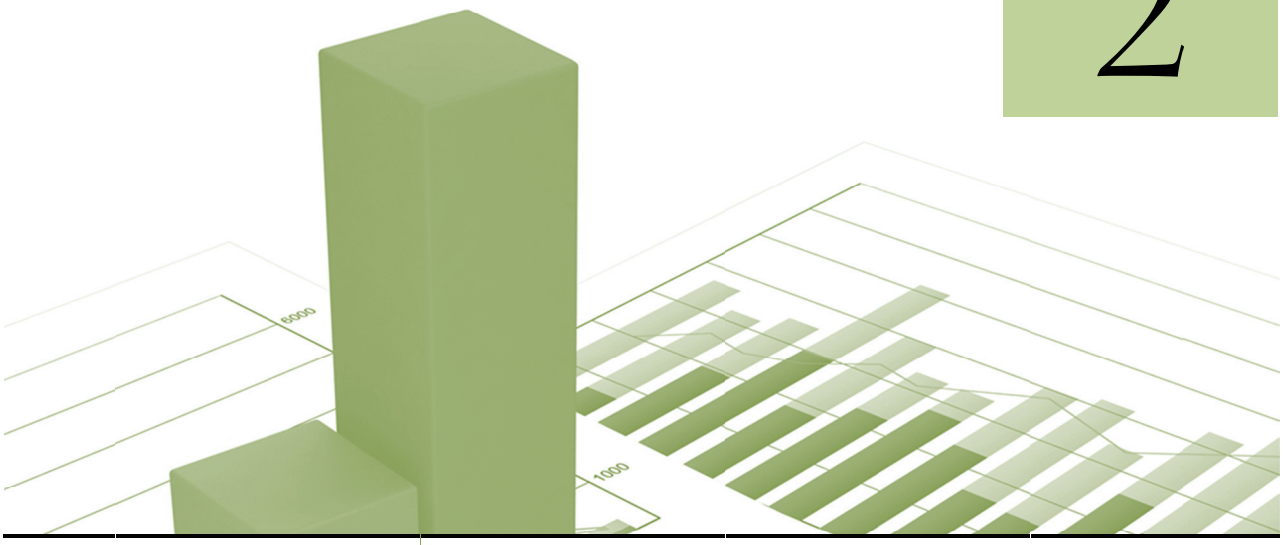
Dual-eligible beneficiary subgroup	Percent of all Medicare beneficiaries	Percent of all Medicare spending	Percent of all Medicaid beneficiaries	Percent of all Medicaid spending
Age				
Under age 65	8%	13%	6%	13%
Ages 65 and older	12	21	8	20
Type of benefit				
Full benefit	15%	27%	11%	32%
Partial benefit	5	8	4	<1

Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). The sum of the subgroups as a percent of the total Medicare and Medicaid population or spending may not sum to the values in Exhibit 4 due to rounding. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending.*

- Certain subgroups of individuals dually eligible for Medicare and Medicaid benefits accounted for disproportionate shares of Medicare and Medicaid spending.
- Dual-eligible beneficiaries ages 65 and older were 12 percent of the Medicare population in CY 2011 but accounted for 21 percent of Medicare spending. These beneficiaries also accounted for 8 percent of the Medicaid population but 20 percent of Medicaid spending.
- Full-benefit dual-eligible beneficiaries also incurred disproportionate spending, particularly in Medicaid. They accounted for 15 percent of all Medicare enrollment but 27 percent of all Medicare spending and 11 percent of all Medicaid enrollment but 32 percent of all Medicaid spending.

Section

2



Characteristics of dual-eligible beneficiaries

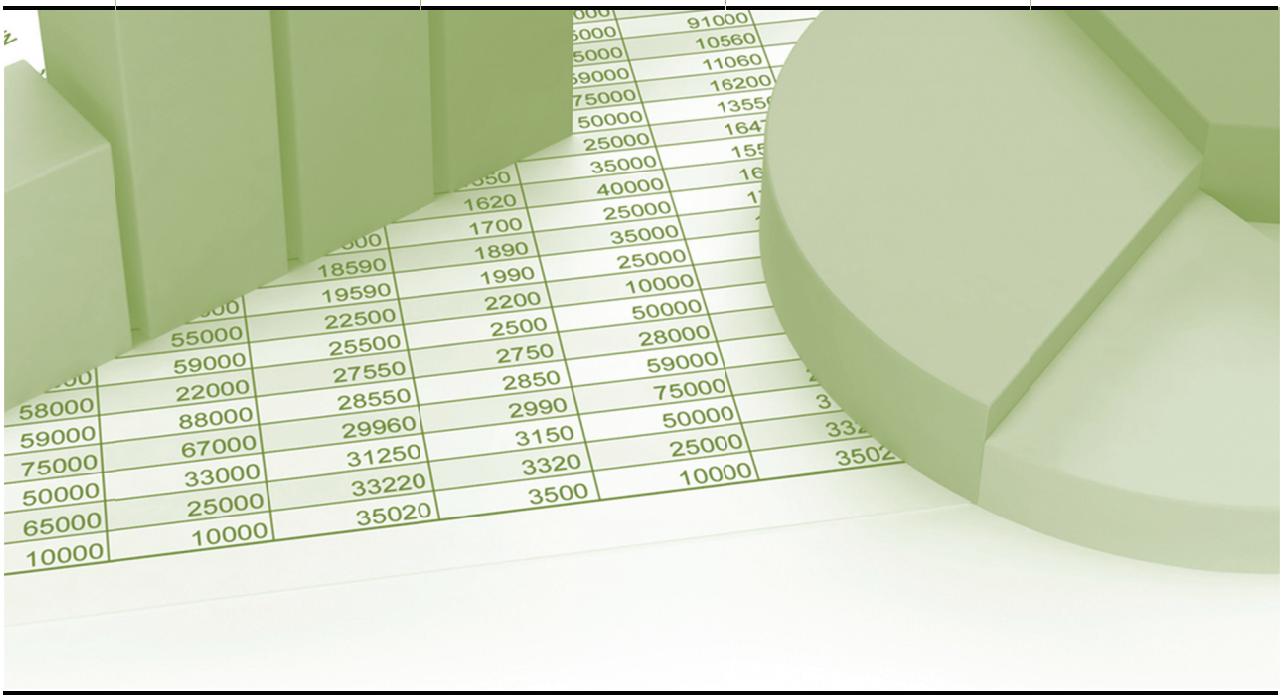


Exhibit 6

Demographic characteristics of dual-eligible and non-dual Medicare and Medicaid beneficiaries, CY 2011

Demographic characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries	Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit		
Gender							
Male	39%	48%	32%	38%	40%	47%	53%
Female	61	52	68	62	60	53	47
Race/Ethnicity							
White/non-Hispanic	57%	62%	54%	55%	63%	85%	52%
African American/non-Hispanic	20	24	18	20	22	8	31
Hispanic	16	11	19	17	12	5	13
Other	7	3	9	8	2	2	4
Residence							
Urban	75%	74%	77%	78%	69%	77%	78%
Rural	25	26	23	22	31	23	22

Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries and non-dual Medicare beneficiaries (fee-for-service, managed care, and end-stage renal disease) not missing demographic characteristics (the share of beneficiaries with missing information was 2 percent or less for all statistics with the exception of race/ethnicity for non-dual disabled Medicaid beneficiaries, where the share of beneficiaries with missing information was 14.6 percent). The non-dual Medicaid beneficiary category excludes nondisabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries ages 65 and older who do not have Medicare coverage. Percentages may not sum to 100 due to rounding.*

- Overall, most individuals dually eligible for Medicare and Medicaid benefits in CY 2011 were female (61 percent), White (57 percent), and lived in an urban area (75 percent).
- Dual-eligible beneficiaries were proportionately more likely to be White (57 percent) than non-dual Medicaid beneficiaries who were eligible on the basis of a disability (52 percent), but less likely than non-dual Medicare beneficiaries (85 percent). There were proportionately more African American (20 percent) and Hispanic (16 percent) dual-eligible beneficiaries than African American and Hispanic non-dual Medicare beneficiaries (8 percent and 5 percent, respectively).
- By age, dual-eligible beneficiaries under age 65 were more likely than dual-eligible beneficiaries ages 65 and older to be male (48 percent vs. 32 percent), White (62 percent vs. 54 percent), or African American (24 percent vs. 18 percent). More of the ages 65 and older dual-eligible beneficiaries were Hispanic (19 percent vs. 11 percent).
- Comparing full-benefit and partial-benefit dual-eligible beneficiaries, more full-benefit beneficiaries were Hispanic (17 percent vs. 12 percent) or lived in an urban area (78 percent vs. 69 percent).

Exhibit 7

Additional characteristics of dual-eligible beneficiaries, CY 2011

Characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
Limitations in ADLs						
None	45%	45%	44%	38%	62%	74%
1–2 ADL limitations	24	31	19	23	27	17
3–6 ADL limitations	32	24	37	40	11	9
Self-reported health status						
Excellent or very good	21%	16%	23%	18%	27%	49%
Good or fair	61	60	62	63	58	45
Poor	17	22	14	18	15	6
Unknown	1	1	1	1	<1	<1
Living arrangement						
Institution	21%	13%	26%	27%	4%	5%
Alone	30	29	30	26	41	27
Spouse	15	11	17	13	20	54
Children, nonrelatives, others	34	48	27	34	36	14
Education						
No high school diploma	48%	37%	54%	50%	42%	17%
High school diploma only	26	31	23	26	27	29
Some college	24	30	20	21	30	53
Other	3	2	3	3	1	1

Note: *CY (calendar year), ADL (activity of daily living). Exhibit includes all dual-eligible and non-dual beneficiaries (fee-for-service, managed care, and end-stage renal disease) who were linked to the Medicare Current Beneficiary Survey. Non-dual disabled Medicaid beneficiaries are not included because data are not available for these beneficiaries through the Medicare Current Beneficiary Survey. Percentages may not sum to 100 due to rounding.*
Source: *2011 Medicare Current Beneficiary Survey.*

- More than half (56 percent) of individuals dually eligible for Medicare and Medicaid benefits in CY 2011 had at least one ADL limitation. Close to half (48 percent) of the dual-eligible population did not graduate from high school.
- Compared with non-dual Medicare beneficiaries, more dual-eligible beneficiaries reported being in poor health (17 percent vs. 6 percent). Dual-eligible beneficiaries were also more likely than non-dual Medicare beneficiaries to live in an institution (21 percent vs. 5 percent).
- Dual-eligible beneficiaries ages 65 and older had more ADL limitations than those under age 65 (37 percent with three to six ADL limitations vs. 24 percent with three to six ADL limitations). Dual-eligible beneficiaries ages 65 and older were also more likely than the younger dual-eligible beneficiaries to live in an institution (26 percent vs. 13 percent). More of the under age 65 dual-eligible beneficiaries reported being in poor health (22 percent vs. 14 percent).
- Between full-benefit and partial-benefit dual-eligible beneficiaries, more of the partial-benefit beneficiaries had no ADL limitations (62 percent vs. 38 percent). Over one-fourth (27 percent) of full-benefit dual-eligible beneficiaries lived in an institution, while few (4 percent) partial-benefit dual-eligible beneficiaries resided in an institution.

Exhibit 8

Selected conditions for FFS dual-eligible beneficiaries by age group, CY 2011

Condition	FFS dual-eligible beneficiaries	
	Under age 65	Ages 65 and older
Cognitive impairment		
Alzheimer's disease or related dementia	3%	23%
Intellectual disabilities and related conditions	8	1
Medical conditions		
Diabetes	22%	35%
Heart failure	8	23
Hypertension	39	66
Ischemic heart disease	14	34
Behavioral health conditions		
Anxiety disorders	21%	12%
Bipolar disorder	14	3
Depression	31	21
Schizophrenia and other psychotic disorders	13	7

Note: *CY (calendar year), FFS (fee-for-service). Chronic conditions are identified using Medicare FFS claims. Exhibit excludes beneficiaries enrolled in Medicare Advantage plans because Medicare FFS claims are not available for those individuals. Beneficiaries with end-stage renal disease are also excluded.*

- The share of individuals dually eligible for Medicare and Medicaid benefits with selected chronic conditions varied between those under age 65 versus those ages 65 and older.
- With respect to cognitive impairment, Alzheimer's disease or related dementia was much more common among the older dual-eligible beneficiaries (23 percent vs. 3 percent). More dual-eligible beneficiaries under age 65 had an intellectual disability (8 percent vs. 1 percent).
- Compared with the under age 65 population, those ages 65 and older generally had higher rates of medical conditions, including diabetes, heart failure, hypertension, and ischemic heart disease.
- Behavioral health conditions—anxiety disorders, bipolar disorder, depression, and schizophrenia and other psychotic disorders—were consistently more common among the dual-eligible population under age 65 than those ages 65 and older.

Section

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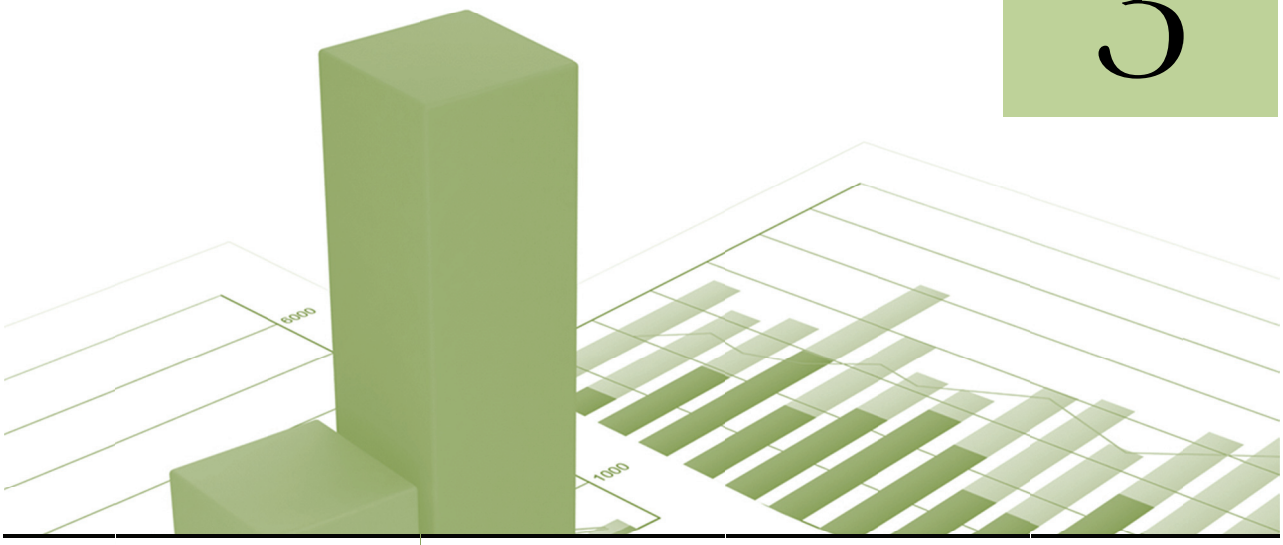

Eligibility pathways, managed care enrollment, and continuity of enrollment

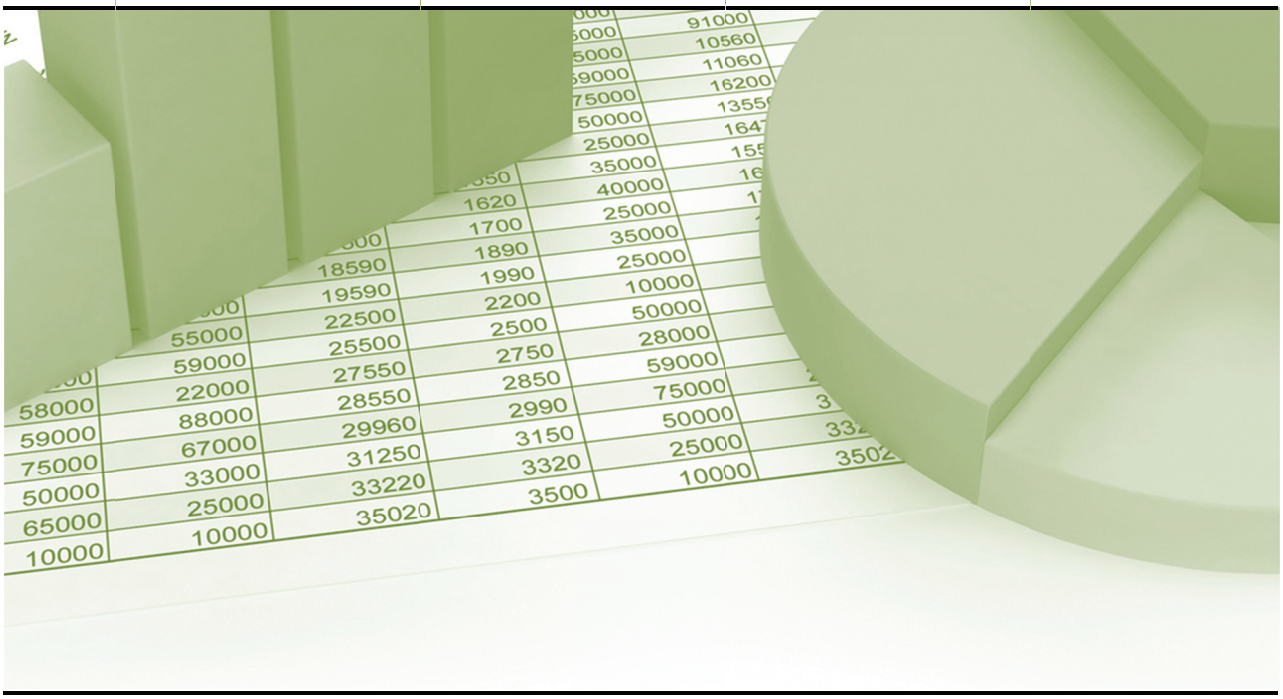

Exhibit 9

Medicare eligibility pathways, CY 2011

Original reason for entitlement to Medicare	Dual-eligible beneficiaries			Non-dual Medicare beneficiaries
	All	Full benefit	Partial benefit	
Age	47%	48%	45%	83%
ESRD	1	1	1	<1
Disability	51	50	54	17
Based on own record	79	74	90	94
Based on another's record	21	26	10	6

Note: *CY (calendar year), ESRD (end-stage renal disease). Exhibit includes all dual-eligible beneficiaries and non-dual Medicare beneficiaries (fee-for-service, managed care, and ESRD). Percentages may not sum to 100 due to rounding.*

- Overall, individuals dually eligible for Medicare and Medicaid benefits in CY 2011 were nearly split between those who originally qualified for Medicare benefits based on age (47 percent) and those who qualified for Medicare benefits based on disability (51 percent).
- In contrast to dual-eligible beneficiaries, most non-dual Medicare beneficiaries (83 percent) originally qualified for Medicare benefits based on their age.
- Most (74 percent) full-benefit dual-eligible beneficiaries who originally qualified for Medicare due to disability were individuals with sufficient employment history to be eligible based on their own work record. A higher portion (90 percent) of partial-benefit dual-eligible beneficiaries who originally qualified for Medicare benefits due to disability did so based on their own employment record.
- The remaining dual-eligible beneficiaries (26 percent among those with full benefits and 10 percent among those with partial benefits) who originally qualified for Medicare due to disability were eligible based on another individual's work record. These beneficiaries include, among others, adult children ages 18 and older who have been disabled since childhood.

Exhibit 10

Medicaid eligibility pathways, CY 2011

Medicaid eligibility group	Dual-eligible beneficiaries			Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	
SSI	36%	37%	36%	80%
Poverty related	36	39	34	5
Medically needy	9	7	10	5
Section 1115 waiver	<1	1	<1	2
Special income limit and other	18	16	20	8

Note: *CY (calendar year), SSI (Supplemental Security Income). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). The non-dual Medicaid beneficiary category excludes nondisabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries ages 65 and older who do not have Medicare coverage. Percentages may not sum to 100 due to rounding.*

- Overall, most individuals dually eligible for Medicare and Medicaid benefits in CY 2011 qualified for Medicaid benefits through the SSI program (36 percent) or through poverty-related eligibility pathways (36 percent).
- In contrast to dual-eligible beneficiaries, most non-dual Medicaid beneficiaries eligible on the basis of a disability (80 percent) qualified for Medicaid benefits through the SSI program.
- Compared with those under age 65, dual-eligible beneficiaries ages 65 and older were more likely to have been eligible for Medicaid through pathways that cover individuals who have high medical costs (medically needy group) or who require an institutional level of care (special income limit and other group).

Exhibit 11

Medicare fee-for-service and managed care enrollment, CY 2011

Type of Medicare enrollment	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
FFS only	78%	84%	74%	82%	68%	74%
MA only	18	12	22	14	28	25
Both FFS and MA	4	4	4	4	4	1

Note: *CY (calendar year), FFS (fee-for-service), MA (Medicare Advantage). Exhibit includes all dual-eligible beneficiaries and non-dual Medicare beneficiaries (fee-for-service, managed care, and ESRD). Percentages may not sum to 100 due to rounding.*

- In CY 2011, most individuals dually eligible for Medicare and Medicaid services (78 percent) were enrolled only in Medicare FFS.
- Non-dual Medicare beneficiaries had higher rates of exclusive enrollment in the MA program than dual-eligible beneficiaries (25 percent vs. 18 percent).
- Dual-eligible beneficiaries ages 65 and older were more likely to be exclusively enrolled in an MA plan than those under age 65 (22 percent vs. 12 percent).
- Partial-benefit dual-eligible beneficiaries were more likely to be exclusively enrolled in an MA plan than full-benefit beneficiaries (28 percent vs. 14 percent), while full-benefit beneficiaries were more likely to be in FFS only (82 percent vs. 68 percent).

Exhibit 12

Medicaid fee-for-service and managed care enrollment, CY 2011

Type of Medicaid enrollment	Dual-eligible beneficiaries					Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
FFS only	58%	58%	59%	45%	94%	27%
FFS and limited-benefit managed care only	28	28	28	37	4	28
At least one month of comprehensive managed care	14	15	13	18	2	45

Note: *CY (calendar year), FFS (fee-for-service). Exhibit includes all dual-eligible beneficiaries (FFS, managed care, and end-stage renal disease). The non-dual Medicaid beneficiary category excludes nondisabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries ages 65 and older who do not have Medicare coverage. Percentages may not sum to 100 due to rounding.*

- Most individuals dually eligible for Medicare and Medicaid services in CY 2011 were either enrolled only in Medicaid FFS (58 percent) or only in Medicaid FFS and a limited-benefit Medicaid managed care plan (28 percent).
- Non-dual Medicaid beneficiaries eligible on the basis of a disability were more likely than dual-eligible beneficiaries to have at least one month of enrollment in a comprehensive managed care plan (45 percent vs. 14 percent) and less likely to be enrolled in Medicaid FFS only (27 percent vs. 58 percent).
- Dual-eligible beneficiaries under age 65 and ages 65 and older had similar patterns of Medicaid FFS and managed care enrollment.
- More than half of full-benefit dual-eligible beneficiaries were enrolled in some type of Medicaid managed care plan during the year.

Exhibit 13

Continuity of enrollment status for dual-eligible beneficiaries, CY 2011

Enrollment status	Dual-eligible beneficiaries				
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit
Full-year enrollment status					
Enrolled 12 months, all with dual-eligible status	73%	74%	72%	75%	67%
Enrolled 12 months, some with Medicare or Medicaid only	20	22	19	17	27
Enrolled less than 12 months	7	5	9	8	6
Consistency of full and partial dual-eligible status during the year					
Exclusively full or exclusively partial	96	94	96	97	92
Switched between full and partial	4	6	4	3	8
Attainment of dual-eligible status during the year					
Was previously dually eligible	88	87	88	89	85
Became dually eligible	12	13	12	11	15
Of those who became dually eligible during the year, percent who were:					
Medicare beneficiaries who gained Medicaid coverage	54	32	72	48	69
Medicaid beneficiaries who gained Medicare coverage	40	65	22	49	23
Individuals who gained Medicare and Medicaid coverage simultaneously	5	4	6	3	8

Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Beneficiaries who became dually eligible during the year are those with no dual-eligible enrollment in the previous two years. Percentages may not sum to 100 due to rounding.*

- Overall, most individuals dually eligible for Medicare and Medicaid benefits (73 percent) were dual-eligible beneficiaries during every month of CY 2011.
- Only 4 percent of all dual-eligible beneficiaries in 2011 switched between full-benefit and partial-benefit dual-eligible status.
- Twelve percent of dual-eligible beneficiaries first became dually eligible during 2011. Among those individuals, more than half (54 percent) were non-dual Medicare beneficiaries who subsequently gained Medicaid coverage.
- Among beneficiaries who became dually eligible during 2011, those under age 65 were more likely to have been non-dual Medicaid beneficiaries before they became dual-eligible beneficiaries (65 percent). Those ages 65 and older were more likely to have been non-dual Medicare beneficiaries before becoming dual-eligible beneficiaries (72 percent).
- Full-benefit beneficiaries who became dually eligible during the year were almost equally split between those who were non-dual Medicare beneficiaries first (48 percent) and those who were non-dual disabled Medicaid beneficiaries first (49 percent).

Section

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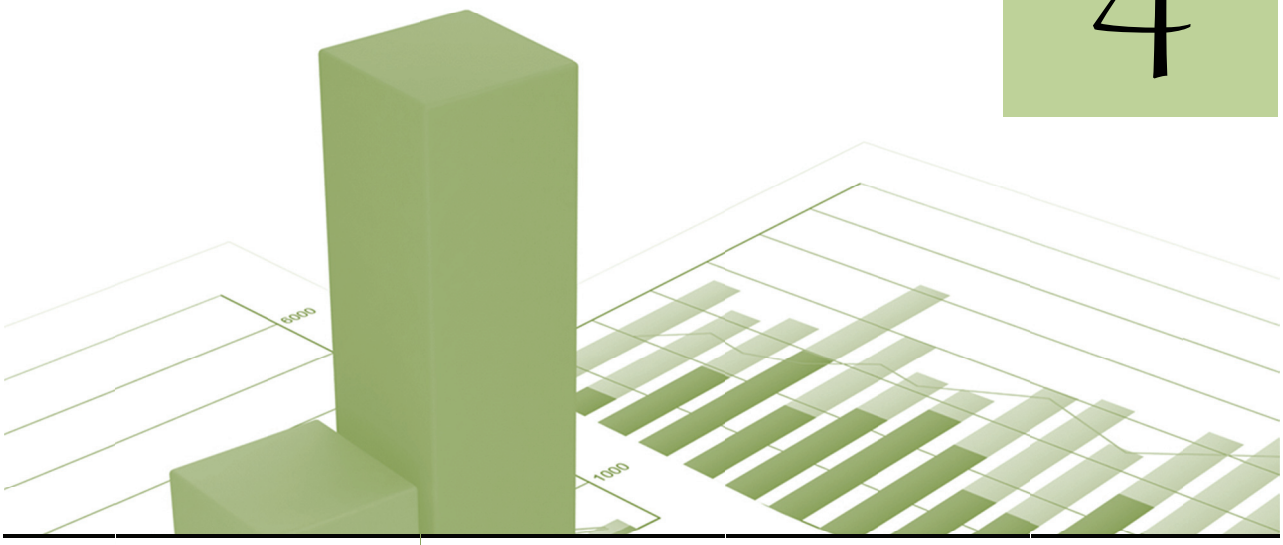

Dual-eligible beneficiaries' utilization of and spending on Medicare and Medicaid services

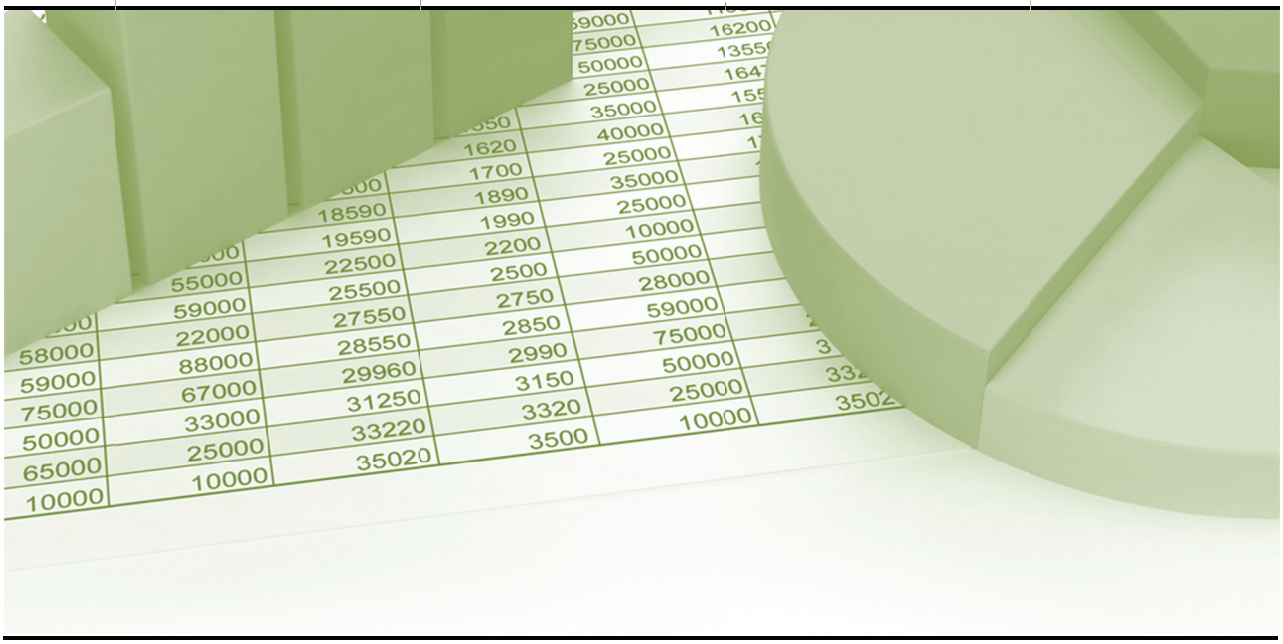

Exhibit 14

Use of Medicare services and per user Medicare spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2011

Selected FFS Medicare services	Full-benefit FFS dual-eligible beneficiaries			FFS non-dual Medicare beneficiaries		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
Inpatient hospital	28%	$18,708	28%	17%	$15,516	31%
Skilled nursing facility	11	19,467	11	4	14,777	7
Home health	14	5,906	5	9	4,672	5
Other outpatient	94	5,904	30	92	4,367	47
Part D drugs	92	4,976	24	36	1,620	7

Note: *FFS (fee-for-service), CY (calendar year). Dual-eligible beneficiaries are limited to full-benefit dual eligibles in Medicare and Medicaid FFS. End-stage renal disease is excluded. "Inpatient hospital" includes psychiatric hospital services. "Other outpatient" includes physician services, hospice, durable medical equipment, hospital outpatient, emergency room not preceding an inpatient stay, and other outpatient facilities. The "percent of total spending" columns do not sum to 100 because spending is shown only for selected services. For Part D drugs, we calculated the figures for "percent using service" using the number of beneficiaries who filled Part D prescriptions (as opposed to simply being enrolled in Part D) as the numerator and the total number of Medicare beneficiaries in each group, including those who are not enrolled in Part D, as the denominator. Almost all full-benefit FFS dual-eligible beneficiaries are enrolled in Part D, so including those who are not enrolled in Part D in our calculations had very little impact on their figures. In contrast, a significant number of FFS non-dual Medicare beneficiaries are not enrolled in Part D. For this group, the figures for "percent using service" and "percent of total spending" are thus artificially low.*

- Individuals dually eligible for Medicare and Medicaid services in CY 2011 had higher use of certain FFS Medicare services (inpatient hospital, skilled nursing facility, home health, other outpatient services, and Part D drugs) than non-dual Medicare beneficiaries.
- Per user Medicare FFS spending for these services was higher for dual-eligible beneficiaries than for non-dual Medicare beneficiaries.
- Skilled nursing facility services accounted for higher portions of Medicare FFS spending on dual-eligible beneficiaries than of Medicare FFS spending on non-dual Medicare beneficiaries (11 percent vs. 7 percent).

Exhibit 15

Use of Medicaid services and per user Medicaid spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2011

Selected Medicaid services	Full-benefit FFS dual-eligible beneficiaries			Full-benefit FFS non-dual Medicaid beneficiaries (disabled, under age 65)		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
Inpatient hospital	14%	$2,115	2%	17%	$21,145	19%
Outpatient	87	2,390	12	84	5,537	25
Institutional LTSS	21	41,789	50	5	58,067	14
HCBS state plan	14	10,020	8	11	9,791	6
HCBS waiver	14	29,511	23	9	29,556	15
Drugs	50	277	1	74	4,020	16
Managed care capitation	32	2,391	4	57	1,518	5

Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Dual-eligible beneficiaries are limited to full-benefit dual eligibles in Medicare and Medicaid FFS. End-stage renal disease is excluded. "Outpatient" includes all Medicaid services that are not inpatient, LTSS (institutional or HCBS), drugs, or managed care capitation (for FFS beneficiaries in limited-benefit plans). The non-dual Medicaid beneficiary category excludes nondisabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries ages 65 and older who did not have Medicare coverage. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. The "percent of total spending" columns do not sum to 100 because spending is shown only for selected services. Exhibit excludes administrative spending.*

- Compared with non-dual Medicaid beneficiaries eligible on the basis of a disability, individuals dually eligible for Medicare and Medicaid had higher use of FFS Medicaid–covered institutional LTSS (21 percent utilization among dual-eligible beneficiaries vs. 5 percent utilization among non-dual disabled Medicaid beneficiaries). Institutional LTSS also accounted for a higher portion of Medicaid spending on FFS dual-eligible beneficiaries than of Medicaid spending on non-dual disabled FFS Medicaid beneficiaries (50 percent vs. 14 percent).
- However, per user FFS spending on institutional LTSS was higher for non-dual disabled Medicaid beneficiaries than for dual-eligible beneficiaries ($58,067 for non-dual disabled Medicaid beneficiaries vs. $41,789 for dual-eligible beneficiaries).
- Although the same portion of FFS dual-eligible beneficiaries used Medicaid HCBS services through a state plan as through an HCBS waiver (14 percent), Medicaid FFS per user spending was higher for HCBS waiver services than for state plan HCBS services ($29,511 vs. $10,020), and HCBS waiver services accounted for a higher portion of Medicaid FFS spending on dual-eligible beneficiaries than state plan HCBS services (23 percent vs. 8 percent).

Exhibit 16

Use of Medicare and Medicaid services and per user Medicare and Medicaid spending for FFS dual-eligible beneficiaries by age, CY 2011

Selected services	Full-benefit FFS dual-eligible beneficiaries under age 65			Full-benefit FFS dual-eligible beneficiaries ages 65 and older		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
Medicare FFS services						
Inpatient hospital	22%	$19,359	27%	32%	$18,357	28%
Skilled nursing facility	4	18,635	4	16	19,618	15
Home health	9	5,316	3	19	6,117	6
Other outpatient	93	5,062	30	96	6,533	30
Part D drugs	91	5,862	34	92	4,299	19
Medicaid services						
Inpatient hospital	13%	$2,786	2%	15%	$1,654	1%
Outpatient	90	2,760	15	84	2,085	10
Institutional LTSS	8	66,869	32	31	36,749	63
HCBS state plan	11	7,967	5	16	11,139	10
HCBS waiver	16	41,511	40	12	16,735	11
Drugs	50	390	1	51	189	1
Managed care capitation	38	2,154	5	27	2,644	4

Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicare "inpatient hospital" includes psychiatric hospital services. Medicare "other outpatient" includes physician services, hospice, durable medical equipment, hospital outpatient, emergency room not preceding an inpatient stay, and other outpatient facilities. Medicaid "outpatient" includes all Medicaid services that are not inpatient, LTSS (institutional or HCBS), drugs, or managed care capitation (for FFS beneficiaries in limited-benefit plans). Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. The "percent of total spending" columns do not sum to 100 because spending is shown only for selected services. Exhibit excludes administrative spending. "Part D drugs" reflects beneficiaries who filled Part D prescriptions, not the number of beneficiaries enrolled in Part D plans.*

- Individuals dually eligible for Medicare and Medicaid services who were ages 65 and older in CY 2011 had higher use of Medicare FFS services than dual-eligible beneficiaries under age 65. Among the FFS services shown here, use of skilled nursing facilities differed the most between the two groups. Four times as many dual-eligible beneficiaries ages 65 and older used FFS skilled nursing facility services compared with those under age 65. Per user FFS Medicare spending was higher for dual-eligible beneficiaries ages 65 and older compared with those under age 65 for skilled nursing facilities, home health care, and other outpatient services.
- Compared with those ages 65 and older, FFS dual-eligible beneficiaries under age 65 had lower use of Medicaid-covered institutional LTSS (8 percent vs. 31 percent). Institutional LTSS also accounted for a higher portion of Medicaid spending on FFS dual-eligible beneficiaries 65 and older compared with those under age 65 (63 percent vs. 32 percent).

Section

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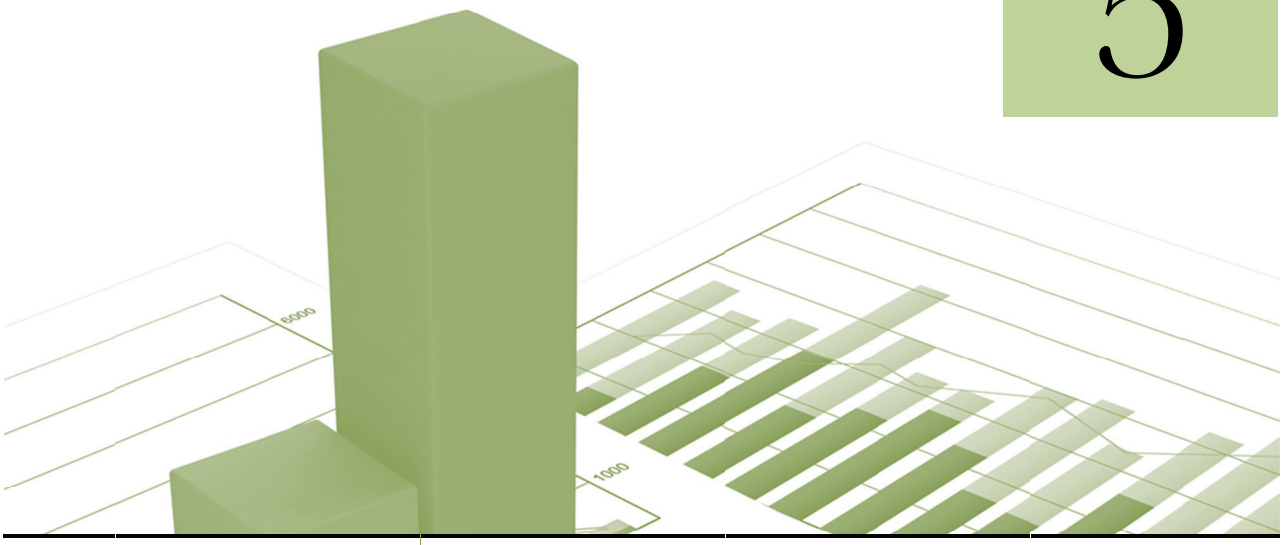


Medicare and Medicaid spending for dual-eligible beneficiaries by LTSS use

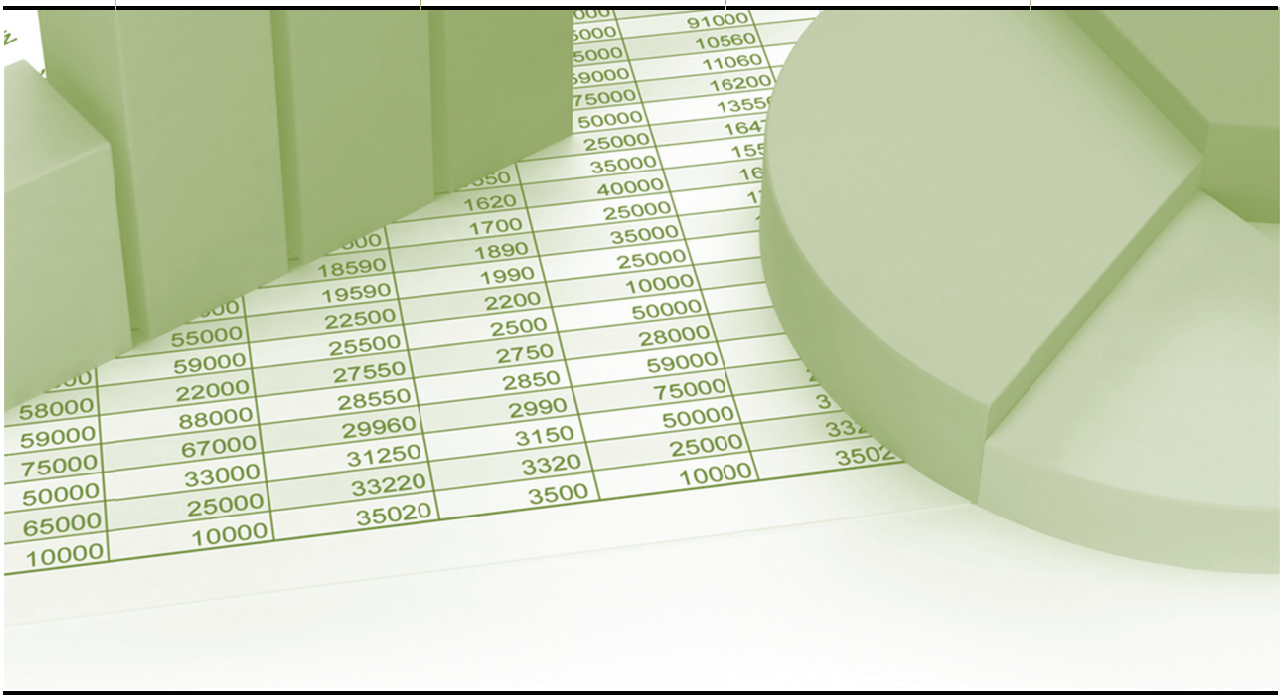
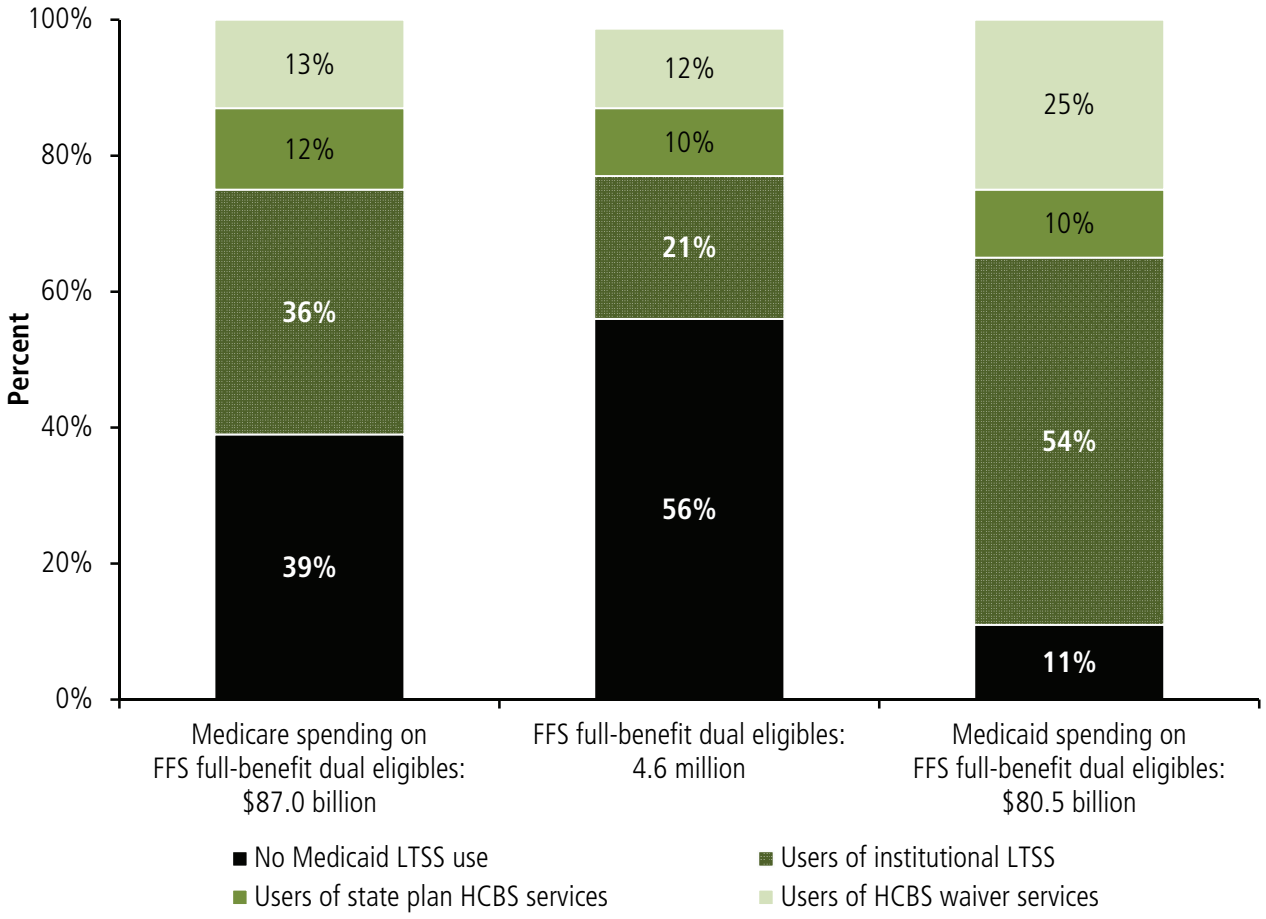


Exhibit 17

Medicare and Medicaid spending on FFS full-benefit dual-eligibles by type of Medicaid LTSS services, CY 2011

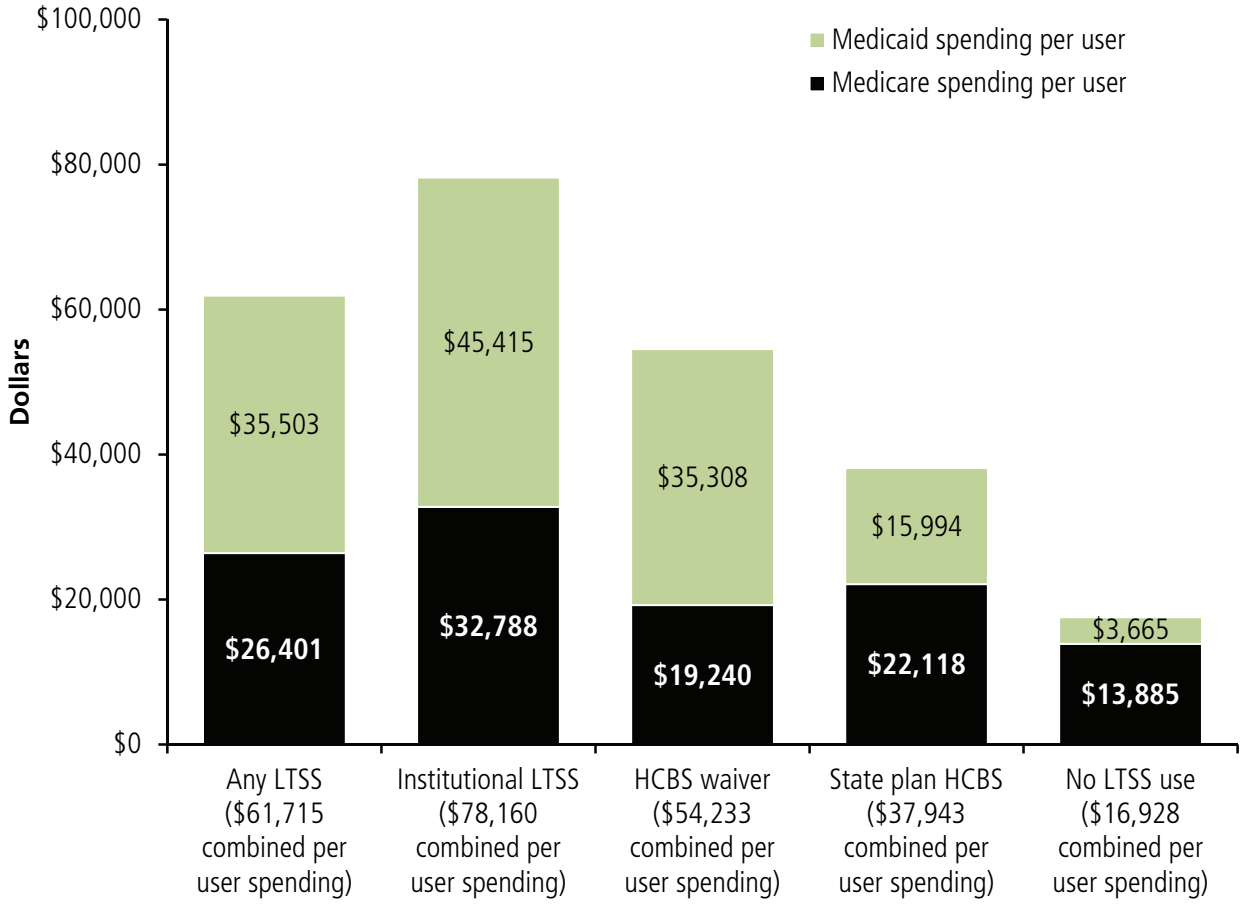


Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Percentages may not sum to 100 due to rounding.*

- Use of Medicaid-covered institutional LTSS among individuals dually eligible for Medicare and Medicaid services resulted in disproportionately high Medicare and Medicaid spending.
- In CY 2011, the majority (56 percent) of FFS full-benefit dual-eligible beneficiaries did not use Medicaid LTSS services. However, 21 percent of FFS full-benefit dual-eligible beneficiaries used Medicaid institutional LTSS care.
- The 21 percent of FFS full-benefit dual-eligible beneficiaries who used Medicaid institutional LTSS services accounted for 36 percent of Medicare spending on FFS full-benefit dual-eligible beneficiaries and more than half (54 percent) of Medicaid spending on FFS full-benefit dual-eligible beneficiaries.

Exhibit 18

Per user Medicare and Medicaid spending on FFS full-benefit dual-eligible Medicaid LTSS users and non-users, CY 2011

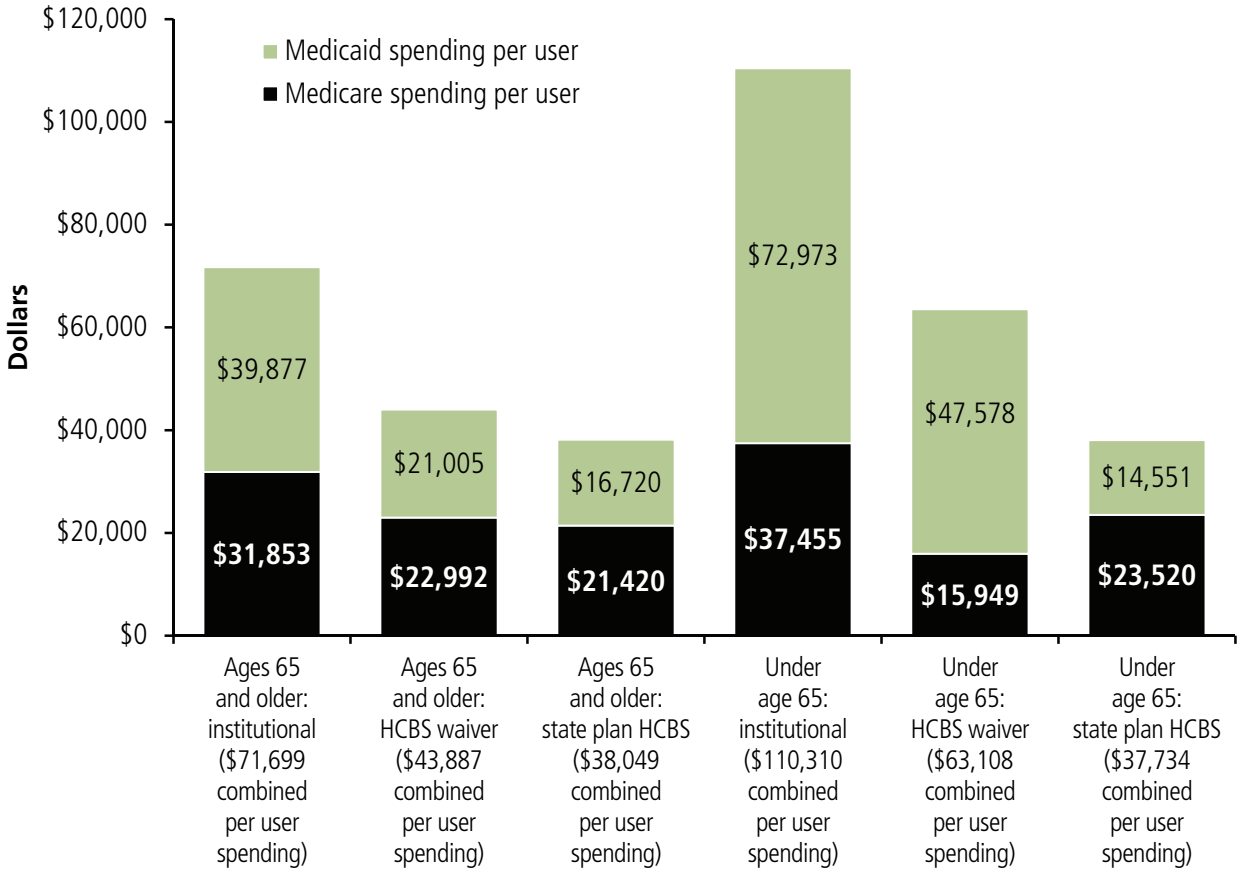


Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Medicare and Medicaid spending components sum to an amount greater than the total because combined per user spending includes a small number of individuals who used either Medicare or Medicaid services, but not both.*

- Users of Medicaid-covered institutional LTSS services (21 percent of full-benefit dual-eligible beneficiaries, see Exhibit 17) had the highest Medicare and Medicaid per user spending in CY 2011 ($32,788 and $45,415, respectively) compared with users of other types of Medicaid LTSS services and non-LTSS users.
- Medicare and Medicaid per user spending on any type of Medicaid LTSS user (institutional, HCBS waiver, or state plan HCBS) was higher than per user spending on non-LTSS users.
- Medicaid per user spending was generally higher than Medicare per user spending for Medicaid LTSS users (with the exception of users of state plan HCBS). However, Medicare per user spending exceeded Medicaid per user spending for non-LTSS users.

Exhibit 19

Per user Medicare and Medicaid spending on FFS full-benefit dual-eligible Medicaid LTSS users by age, CY 2011

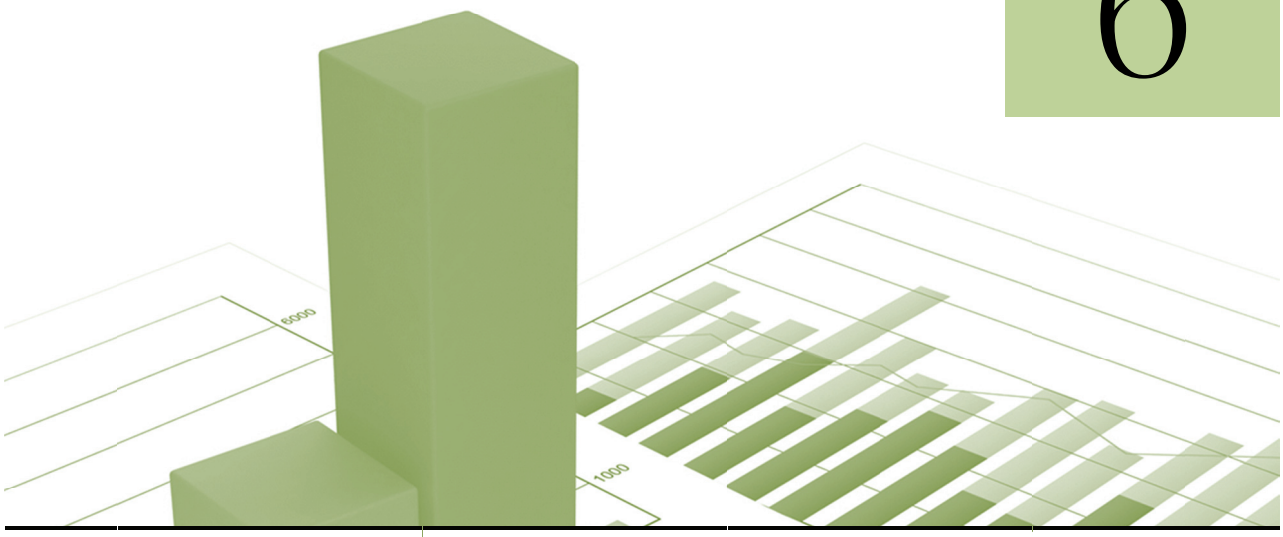


Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Medicare and Medicaid spending components sum to an amount greater than the total because combined per user spending includes a small number of individuals who used either Medicare or Medicaid services, but not both.*

- Among Medicaid LTSS users who were ages 65 and older, Medicare and Medicaid per user spending was higher for those who received Medicaid LTSS in an institution ($31,853 and $39,877) than for those who received Medicaid LTSS in the community through HCBS waivers ($22,992 and $21,005) or through state plan HCBS ($21,420 and $16,720).
- Among Medicaid LTSS users under age 65, Medicare per user spending was higher for those who received Medicaid institutional LTSS compared with those receiving home- and community-based Medicaid LTSS.
- Medicaid per user spending on Medicaid institutional LTSS users under age 65 ($72,973) was higher than per user spending on any other subgroup of Medicaid LTSS users. It was also almost twice as high as per user spending on Medicaid institutional LTSS users who were ages 65 and older ($39,877).

Section

6



Trends in dual-eligible population composition, spending, and service use

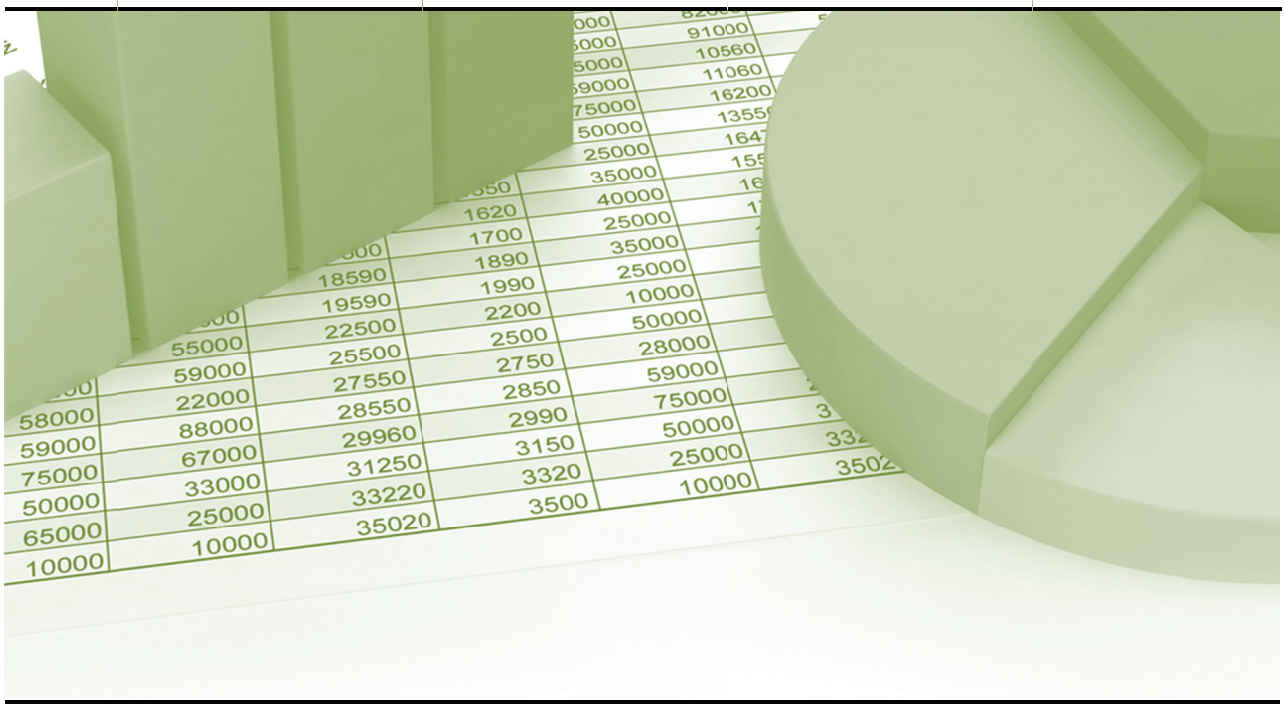
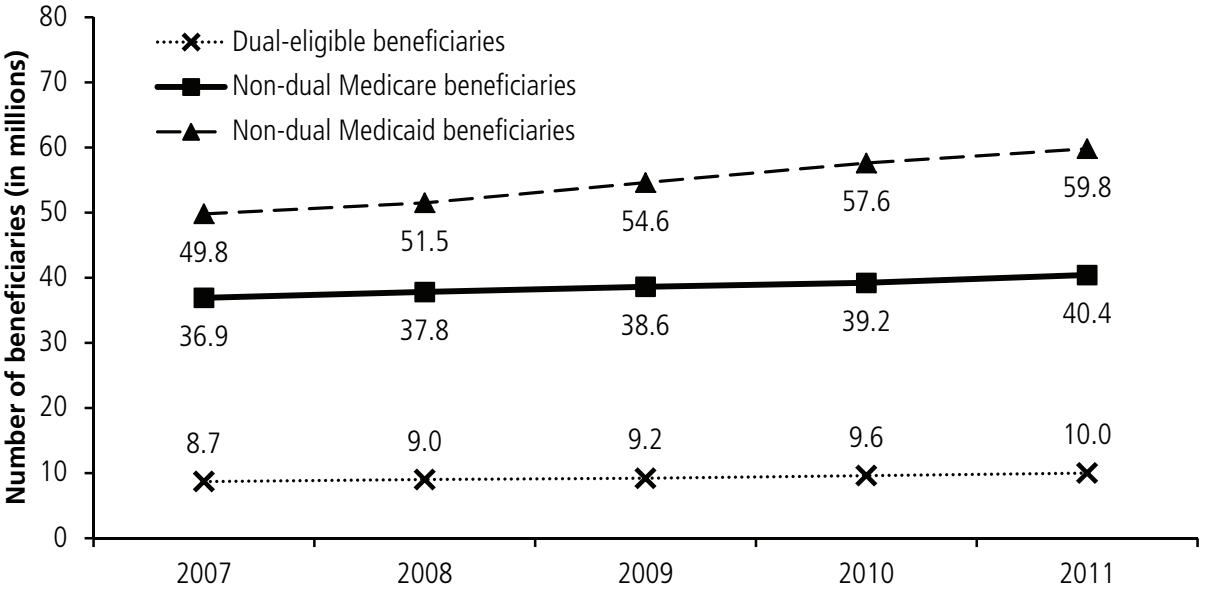


Exhibit 20

Number of dual-eligible and non-dual Medicare and Medicaid beneficiaries, CY 2007–2011



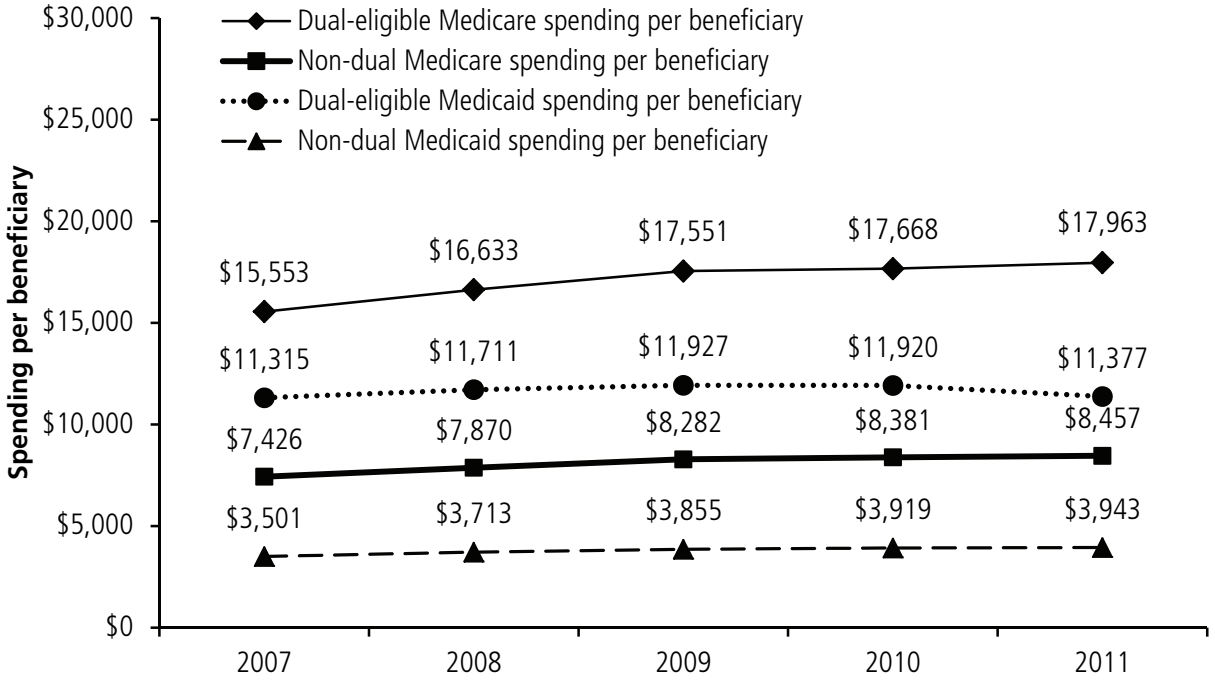
Category	Annual percentage growth in the number of beneficiaries				Cumulative growth	Average annual growth rate
	2008	2009	2010	2011		
Dual-eligible beneficiaries	3.1%	2.7%	4.2%	4.3%	15.1%	3.6%
Non-dual Medicare beneficiaries	2.3	2.0	1.8	2.9	9.3	2.3
Non-dual Medicaid beneficiaries	3.4	6.0	5.5	3.8	20.1	4.7

Note: *CY (calendar year). Exhibit includes all dual-eligible and non-dual beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid beneficiaries include Medicaid-expansion State Children's Health Insurance Program enrollees.*

- The number of individuals dually eligible for Medicare and Medicaid grew from 8.7 million people in 2007 to 10.0 million people in 2011—a cumulative growth of 15.1 percent over the period and an average annual growth rate of 3.6 percent.
- Of the three categories of beneficiaries, the fastest growth was among non-dual Medicaid beneficiaries. Increasing from 49.8 million in 2007 to 59.8 million in 2011, the number of non-dual Medicaid beneficiaries had a cumulative growth of 20.1 percent and an average annual growth rate of 4.7 percent.
- The slowest growth was among the non-dual Medicare beneficiaries. Although the number of non-dual Medicare beneficiaries increased from 36.9 million individuals in 2007 to 40.4 million individuals in 2011, non-dual Medicare beneficiaries had lower cumulative growth (9.3 percent) and lower average annual growth (2.3 percent) than dual-eligible beneficiaries and non-dual Medicaid beneficiaries.
- Although the number of Medicaid beneficiaries increased each year from 2007 to 2011, the rate of growth of non-dual Medicaid beneficiaries slowed in both 2010 and 2011.

Exhibit 21

Medicare and Medicaid spending per dual-eligible and non-dual beneficiary, CY 2007–2011



Category	Annual percentage growth in spending per beneficiary				Cumulative growth	Average annual growth rate
	2008	2009	2010	2011		
Dual-eligible Medicare spending per beneficiary	6.9%	5.5%	0.7%	1.7%	15.5%	3.7%
Non-dual Medicare spending per beneficiary	6.0	5.2	1.2	0.9	13.9	3.3
Dual-eligible Medicaid spending per beneficiary	3.5	1.8	–0.1	–4.6	0.5	0.1
Non-dual Medicaid spending per beneficiary	6.1	3.8	1.7	0.6	12.6	3.0

Note: *CY (calendar year). Exhibit includes all dual-eligible and non-dual beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts include Medicaid-expansion State Children's Health Insurance Program amounts; amounts spent on dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending.*

(Continued next page)

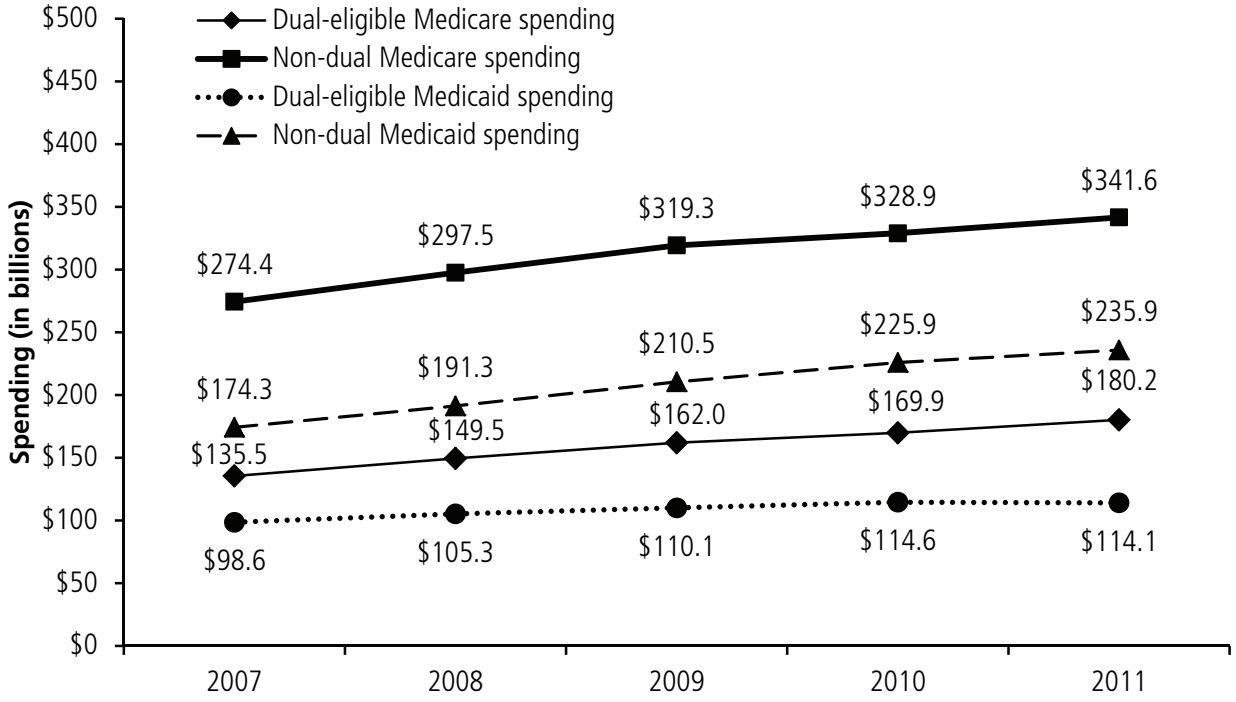
Exhibit 21

Medicare and Medicaid spending per dual-eligible and non-dual beneficiary, CY 2007–2011 (continued)

- Medicare and Medicaid per beneficiary spending grew between 2007 and 2011 for individuals dually eligible for Medicare and Medicaid. Medicare spending per dual-eligible beneficiary grew faster than Medicaid spending per dual-eligible beneficiary over this time period (15.5 percent cumulative growth and 3.7 percent average annual growth for Medicare spending per beneficiary compared with 0.5 percent cumulative growth and 0.1 percent average annual growth for Medicaid spending per beneficiary).
- Comparing Medicare per beneficiary spending on dual-eligible beneficiaries and non-dual beneficiaries, per beneficiary spending on dual-eligible beneficiaries increased faster. Cumulative growth in Medicare per beneficiary spending between 2007 and 2011 was 15.5 percent for dual-eligible beneficiaries and 13.9 percent for non-dual beneficiaries; average annual growth was 3.7 percent for dual-eligible beneficiaries compared with 3.3 percent for non-dual beneficiaries.
- Comparing Medicaid per beneficiary spending on dual-eligible beneficiaries and non-dual Medicaid beneficiaries, per beneficiary spending grew faster for non-dual Medicaid beneficiaries (12.6 percent cumulative growth and 3.0 percent average annual growth for non-dual beneficiaries compared with 0.5 percent cumulative and 0.1 percent average annual growth for dual-eligible beneficiaries).
- Although Medicare and Medicaid spending per beneficiary grew between 2007 and 2011 for dual-eligible beneficiaries and non-dual beneficiaries, the rate of growth for three of the four categories declined each year between 2007 and 2011. Growth slowed to less than 2 percent for each category in 2011, and growth declined by 4.6 percent for Medicaid spending per dual-eligible beneficiary.

Exhibit 22

Medicare and Medicaid spending for dual-eligible and non-dual beneficiaries, CY 2007–2011



Category	Annual percentage growth in spending				Cumulative growth	Average annual growth rate
	2008	2009	2010	2011		
Dual-eligible Medicare spending	10.3%	8.3%	4.9%	6.1%	33.0%	7.4%
Non-dual Medicare spending	8.4	7.3	3.0	3.9	24.5	5.6
Dual-eligible Medicaid spending	6.8	4.6	4.1	–0.4	15.8	3.7
Non-dual Medicaid spending	9.7	10.1	7.3	4.4	35.3	7.9

Note: *CY (calendar year). Exhibit includes all dual-eligible and non-dual beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts include Medicaid-expansion State Children's Health Insurance Program amounts; amounts spent on dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending.*

(Continued next page)

Exhibit 22

Medicare and Medicaid spending for dual-eligible and non-dual beneficiaries, CY 2007–2011 (continued)

- Although Medicare and Medicaid spending on individuals dually eligible for Medicare and Medicaid and non-dual beneficiaries grew between 2007 and 2011, 2008 had the highest rate of growth for Medicare and Medicaid spending on dual-eligible beneficiaries and for Medicare spending on non-dual beneficiaries. The lower growth generally observed for 2009–2011 is a function of the decline in the rate of growth of beneficiaries (Exhibit 20) and per beneficiary spending (Exhibit 21).
- Medicare and Medicaid spending on dual-eligible beneficiaries grew between 2007 and 2011. Medicare spending on dual-eligible beneficiaries increased from $135.5 billion in 2007 to $180.2 billion in 2011—a cumulative growth of 33.0 percent and an average annual growth of 7.4 percent.
- Medicaid spent less than Medicare on dual-eligible beneficiaries between 2007 and 2011—Medicaid spending on dual-eligible beneficiaries was $98.6 billion in 2007 and $114.1 billion in 2011. Compared with the growth in Medicare spending on dual-eligible beneficiaries, both the cumulative growth of Medicaid spending on this population and the average annual growth rate were lower (15.8 percent and 3.7 percent, respectively).
- Non-dual Medicaid spending grew faster than Medicare and Medicaid spending on dual-eligible beneficiaries and faster than Medicare spending on non-dual beneficiaries. Increasing from $174.3 billion in 2007 to $235.9 billion in 2011, Medicaid spending on non-dual beneficiaries had a cumulative growth of 35.3 percent and an average annual growth rate of 7.9 percent.
- Although total Medicare spending was higher for non-dual beneficiaries than for dual-eligible beneficiaries between 2007 and 2011, Medicare spending on dual-eligible beneficiaries grew faster over this period compared with Medicare spending on non-dual beneficiaries. Cumulative growth in Medicare spending on dual-eligible beneficiaries was 33.0 percent compared with 24.5 percent for non-dual beneficiaries; average annual growth was 7.4 percent for dual-eligible beneficiaries compared with 5.6 percent for non-dual beneficiaries.

Exhibit 23

Share of dual-eligible beneficiaries by selected beneficiary characteristics, CY 2007 and CY 2011

Beneficiary characteristic	2007	2011	2007–2011 percentage point change
Age			
65 and older	61.2%	58.8%	–2.3
Under 65	38.8	41.2	2.3
Benefit level			
Full benefit	77.9%	73.2%	–4.7
Partial benefit	22.1	26.8	4.7
Original reason for entitlement to Medicare			
Age	50.2%	47.5%	–2.7
ESRD	1.1	0.9	–0.2
Disability	48.7	51.4	2.7
Medicaid eligibility pathway			
SSI	40.6%	36.2%	–4.4
Poverty related	31.4	36.3	4.9
Medically needy	8.7	8.8	<0.1
Section 1115 waiver	0.6	0.5	–0.1
Special income limit and other	18.7	18.3	–0.5
Medicare FFS and managed care			
FFS only	82.2%	77.9%	–4.2
MA only	12.7	18.1	5.4
Both FFS and MA	5.2	4.0	–1.2
Medicaid FFS and managed care			
FFS only	62.8%	58.4%	–4.5
FFS and limited-benefit managed care only	25.8	27.8	2.0
At least one month of comprehensive managed care	11.4	13.9	2.4

Note: *CY (calendar year), ESRD (end-stage renal disease), SSI (Supplemental Security Income), FFS (fee-for-service), MA (Medicare Advantage). Exhibit includes all dual-eligible beneficiaries (FFS, managed care, and ESRD). Percentages may not sum to 100 due to rounding. Percentage point change is calculated using unrounded numbers.*

(Continued next page)

Exhibit 23

Share of dual-eligible beneficiaries by selected beneficiary characteristics, CY 2007 and CY 2011 (continued)

- The characteristics of individuals dually eligible for Medicare and Medicaid changed between CY 2007 and CY 2011. During this period, there was an increase in the share of dual-eligible beneficiaries who were under age 65 (2.3 percentage point increase), received partial benefits (4.7 percentage point increase), and were enrolled in Medicare or Medicaid managed care (4.2 and 4.5 percentage point increase, respectively). The share of dual-eligible beneficiaries who were under age 65 increased from 38.8 percent of the population in 2007 to 41.2 percent in 2011, while the share of dual-eligible beneficiaries who received partial benefits increased from 22.1 percent of all dual-eligible beneficiaries to more than a quarter (26.8 percent) of the population in 2011.
- The share of dual-eligible beneficiaries who qualified for Medicaid through poverty-related pathways, which often provide partial benefits, increased by 4.9 percentage points, from 31.4 percent of the dual-eligible population in 2007 to 36.3 percent of the population in 2011.
- There was a slight shift in dual-eligible beneficiaries' Medicare eligibility pathways between 2007 and 2011. In 2007, slightly over half (50.2 percent) of all dual-eligible beneficiaries originally qualified for Medicare on the basis of age. However, by 2011, slightly over half (51.4 percent) of dual-eligible beneficiaries originally qualified for Medicare on the basis of disability.
- The share of dual-eligible beneficiaries enrolling in Medicare Advantage plans increased between 2007 and 2011. The share whose only Medicare enrollment was in Medicare Advantage increased by 5.4 percentage points over this period. The share with enrollment in both Medicare FFS and Medicare Advantage decreased by 1.2 percentage points.
- The share of dual-eligible beneficiaries whose only Medicaid enrollment was in Medicaid FFS and a limited-benefit Medicaid managed care plan increased by 2.0 percentage points. The share with at least one month of comprehensive Medicaid managed care enrollment increased by 2.4 percentage points.

Exhibit 24

Use of Medicare services and per user spending for FFS beneficiaries, CY 2007 and CY 2011

Select Medicare services	Full-benefit FFS dual-eligible beneficiaries			FFS non-dual Medicare beneficiaries		
	2007	2011	2007–2011	2007	2011	2007–2011
Share using service in each year and percentage point change during period						
Inpatient hospital	28.9%	27.7%	–1.2	18.5%	17.0%	–1.4
Skilled nursing facility	10.9	10.6	–0.3	4.2	4.3	0.1
Home health	12.1	14.5	2.3	8.4	9.1	0.8
Other outpatient	93.8	94.4	0.6	91.1	91.5	0.4
Part D drugs	91.5	91.5	0.0	33.2	35.6	2.4
Per user FFS spending in each year and average annual growth during period						
Inpatient hospital	$15,942	$18,708	4.1%	$13,575	$15,516	3.4%
Skilled nursing facility	14,123	19,467	8.4	11,102	14,777	7.4
Home health	6,080	5,906	–0.7	4,223	4,672	2.6
Other outpatient	4,904	5,904	4.7	3,622	4,367	4.8
Part D drugs	4,201	4,976	4.3	1,375	1,620	4.3

Note: *FFS (fee-for-service), CY (calendar year). Dual-eligible beneficiaries are limited to full-benefit dual eligibles in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicare "inpatient hospital" includes psychiatric hospital services. Medicare "other outpatient" includes physician services, hospice, durable medical equipment, hospital outpatient, emergency room not preceding an inpatient stay, and other outpatient facilities. "Part D drugs" reflects beneficiaries who filled Part D prescriptions, not the number of beneficiaries enrolled in Part D plans. The percentage of FFS non-dual Medicare beneficiaries using Part D drugs is artificially low because it includes beneficiaries who are not enrolled in Part D. Percentage point change is calculated using unrounded numbers.*

- Medicare per user FFS spending on full-benefit individuals dually eligible for Medicare and Medicaid increased between 2007 and 2011 for inpatient hospital services (4.1 percent average annual growth), skilled nursing facility services (8.4 percent average annual growth), other outpatient services (4.7 percent average annual growth) and Part D prescription fills (4.3 percent average annual growth). Medicare per user FFS spending on full-benefit dual-eligible beneficiaries decreased between 2007 and 2011 for home health services (–0.7 percent average annual growth).
- The share of full-benefit dual-eligible beneficiaries using home health services, other outpatient services, and filling Part D drug prescriptions increased between 2007 and 2011. The share of full-benefit dual-eligible beneficiaries using inpatient hospital services decreased between 2007 and 2011 by 1.2 percentage points, and the share using skilled nursing facility services decreased by 0.3 percentage points.
- Comparing full-benefit dual-eligible beneficiaries with non-dual Medicare beneficiaries, per user FFS spending in 2007 and 2011 was higher for dual-eligible beneficiaries for each type of service. Growth in per user spending was faster for dual-eligible beneficiaries compared with non-dual Medicare beneficiaries for inpatient hospital services and skilled nursing facility services; it was similar or slower for home health services, other outpatient services, and Part D drugs.
- Between 2007 and 2011, a greater share of full-benefit dual-eligible beneficiaries were users of the select Medicare services shown in this exhibit than were non-dual Medicare beneficiaries.

Exhibit 25

Use of Medicaid services and per user spending for FFS beneficiaries, CY 2007 and CY 2011

Select Medicaid services	Full-benefit FFS dual-eligible beneficiaries			Full-benefit FFS non-dual Medicaid beneficiaries (disabled, under age 65)		
	2007	2011	2007–2011	2007	2011	2007–2011
Share using service in each year and percentage point change during period						
Inpatient hospital	14.6%	13.9%	–0.6	17.3%	17.0%	–0.4
Outpatient	85.3	86.6	1.4	85.9	84.4	–1.6
Institutional LTSS	22.7	20.7	–2.0	4.7	4.5	–0.2
HCBS state plan	14.4	14.0	–0.4	11.6	10.7	–0.8
HCBS waiver	13.0	13.6	0.6	7.9	9.1	1.3
Drugs	51.7	49.6	–2.1	76.6	74.3	–2.2
Managed care capitation	39.3	31.8	–7.6	62.1	57.3	–4.8
Per user spending in each year and average annual growth during period						
Inpatient hospital	$1,985	$2,115	1.6%	$19,621	$21,145	1.9%
Outpatient	2,178	2,390	2.3	4,869	5,537	3.3
Institutional LTSS	37,598	41,789	2.7	52,580	58,067	2.5
HCBS state plan	9,459	10,020	1.5	7,854	9,791	5.7
HCBS waiver	25,967	29,511	3.3	27,793	29,556	1.5
Drugs	324	277	–3.8	3,840	4,020	1.2
Managed care capitation	747	2,391	33.8	606	1,518	25.8

Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Dual-eligible beneficiaries are limited to full-benefit dual eligibles in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid "outpatient" includes all Medicaid services that are not inpatient, LTSS (institutional or HCBS), drugs, or managed care capitation (for FFS beneficiaries in limited-benefit plans). The non-dual Medicaid beneficiary category excludes nondisabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries age 65 and older who did not have Medicare coverage. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Percentage point change is calculated using unrounded numbers.*

- Medicaid per user FFS spending on full-benefit individuals dually eligible for Medicare and Medicaid increased between 2007 and 2011 for inpatient hospital services, outpatient services, institutional LTSS, HCBS state plan services, HCBS waiver services, and Medicaid managed care capitation payments (primarily for FFS beneficiaries in limited-benefit plans).
- The share of full-benefit dual-eligible beneficiaries using institutional LTSS declined between 2007 and 2011 by 2.0 percentage points but still remained above 20 percent. The share of dual-eligible beneficiaries using HCBS waiver services increased over this period.
- Medicaid per user spending on managed care had the largest percentage increase between 2007 and 2011 for both dual-eligible beneficiaries and non-dual disabled Medicaid beneficiaries (33.8 percent and 25.8 percent average annual growth, respectively). However, the share of beneficiaries in these groups with managed care capitation payments decreased between 2007 and 2011 by 7.6 percentage points for dual-eligible beneficiaries and 4.8 percentage points for non-dual disabled beneficiaries.

Exhibit 26

Number of and spending for FFS full-benefit dual-eligible beneficiaries by Medicaid LTSS use, CY 2007 and CY 2011

Type of LTSS user	Full-benefit FFS dual-eligible beneficiaries (in millions)			Medicare spending (in billions)			Medicaid spending (in billions)		
	2007	2011	2007–2011 average annual growth	2007	2011	2007–2011 average annual growth	2007	2011	2007–2011 average annual growth
Users of institutional LTSS	1.1	1.0	–2.3%	$27.7	$31.5	3.3%	$43.3	$43.7	0.2%
Users of HCBS waiver services	0.5	0.6	1.9	8.9	11.0	5.3	17.2	20.5	4.4
Users of HCBS state plan services	0.5	0.5	0.4	9.0	10.6	4.0	6.9	7.7	2.9
No Medicaid LTSS use	2.6	2.6	0.5	27.6	34.0	5.4	6.3	8.7	8.6

Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending.*

- Among the categories of LTSS users, Medicaid and Medicare spending on individuals dually eligible for Medicare and Medicaid was highest in both 2007 and 2011 for dual-eligible beneficiaries who used institutional LTSS services compared with dual-eligible beneficiaries who used HCBS waiver or state plan services.
- In 2007 and 2011, Medicare spending was higher than Medicaid spending for users of HCBS state plan services and for dual-eligible beneficiaries who did not use LTSS services, while Medicaid spending was higher for users of institutional LTSS and users of HCBS waiver services. Medicare spending generally grew faster than Medicaid spending between 2007 and 2011 for all users of LTSS services.
- Medicare and Medicaid spending on institutional LTSS users grew each year by an average of 3.3 percent and 0.2 percent, respectively. Although spending increased for each category of LTSS users, the number of full-benefit dual-eligible beneficiaries in each category generally remained constant between 2007 and 2011.

Exhibit 27

Average annual growth in dual-eligible enrollment by state, CY 2007–2011

State	Average annual growth in number of dual-eligible beneficiaries			Number of dual-eligible beneficiaries (in thousands)					
	CY 2007–2011			CY 2007			CY 2011		
	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit
National	3.6%	2.0%	8.7%	8,715	6,793	1,922	10,033	7,349	2,684
Alabama	1.2	–0.5	2.7	201	97	104	211	95	116
Alaska	4.3	3.9	15.9	14	13	0	16	15	1
Arizona	4.4	3.9	6.2	145	114	31	172	133	39
Arkansas	3.1	0.8	6.7	115	72	43	130	74	56
California	2.8	2.7	9.3	1,162	1,135	27	1,300	1,261	39
Colorado	4.3	3.3	7.4	79	61	19	94	69	25
Connecticut	11.6	1.4	33.7	100	77	23	155	82	73
Delaware	4.1	2.6	5.4	23	11	12	27	12	15
District of Columbia	4.1	0.6	20.6	21	18	3	25	19	6
Florida	6.9	3.2	11.8	556	328	228	727	372	355
Georgia	4.4	1.8	7.5	252	142	110	298	152	146
Hawaii	3.8	2.7	14.2	31	29	3	36	32	4
Idaho	4.2	2.1	9.2	31	22	9	36	24	12
Illinois	4.8	5.1	3.1	300	262	38	363	320	43
Indiana	4.2	3.4	5.5	151	99	52	178	113	65
Iowa	2.7	1.5	8.2	78	66	13	87	70	17
Kansas	3.9	0.9	11.3	61	46	15	71	47	24
Kentucky	3.0	0.5	6.9	166	103	63	188	106	82
Louisiana	4.2	1.8	7.8	172	106	67	203	113	90
Maine	4.0	2.2	6.7	88	53	35	103	58	45
Maryland	4.7	3.1	8.1	106	72	33	127	81	45
Massachusetts	–3.1	–4.2	15.9	240	230	10	211	193	18
Michigan	4.3	3.0	14.0	257	229	28	304	258	47
Minnesota	3.1	2.8	5.5	126	113	14	143	126	17
Mississippi	1.5	0.2	3.0	153	84	69	163	85	78
Missouri	2.7	0.8	15.9	170	153	17	189	158	31
Montana	9.0	2.9	30.6	18	15	3	25	17	8
Nebraska	–2.0	–1.3	–10.0	40	36	4	37	34	2
Nevada	6.8	3.3	11.0	38	21	16	49	24	25
New Hampshire	5.8	2.5	13.9	27	20	7	34	22	12
New Jersey	2.1	2.2	1.5	201	174	27	218	190	28
New Mexico	7.9	1.5	20.2	54	39	15	73	41	32
New York	3.5	2.7	8.3	724	630	93	829	701	128
North Carolina	2.2	0.9	7.6	306	249	57	334	258	76
North Dakota	–1.4	2.8	–19.9	15	11	4	14	13	2
Ohio	4.8	3.7	7.2	289	200	89	349	231	118
Oklahoma	2.9	2.0	7.2	109	92	17	122	99	23
Oregon	6.0	3.2	11.8	87	61	26	109	69	41

State	Average annual growth in number of dual-eligible beneficiaries			Number of dual-eligible beneficiaries (in thousands)					
	CY 2007–2011			CY 2007			CY 2011		
	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit
Pennsylvania	4.1	3.3	8.1	376	319	56	441	364	77
Rhode Island	1.2	0.6	4.8	39	34	5	41	34	6
South Carolina	1.7	1.1	5.7	147	130	18	158	136	22
South Dakota	1.9	0.0	5.7	20	14	6	22	14	8
Tennessee	*	–7.6	16.7	278	211	66	277	154	123
Texas	3.7	1.4	7.5	593	381	212	686	403	283
Utah	4.7	3.6	13.3	30	27	3	36	31	5
Vermont	2.7	2.4	3.4	27	19	8	30	21	9
Virginia	3.4	2.0	6.5	167	117	49	190	127	63
Washington	5.5	4.1	9.8	145	111	33	179	130	49
West Virginia	3.3	1.8	5.6	76	48	29	87	51	36
Wisconsin	4.1	3.4	9.3	143	128	15	168	146	22
Wyoming	3.8	1.5	8.4	10	7	3	11	7	4

Note: *Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Beneficiaries are attributed to a state based on their most recent month of enrollment. The sum of the state counts exceeds the unduplicated national count because a small number (less than 1 percent) of beneficiaries were reported in more than one state for their most recent month of enrollment in the Medicaid program.*
** Indicates a decline of less than 0.1 percent.*
Source: *Acumen LLC analysis of Medicare and Medicaid enrollment data for MedPAC and MACPAC.*

- Between CY 2007 and 2011, national average annual growth in total dual-eligible enrollment was 3.6 percent, 2.0 percent for the full-benefit population, and 8.7 percent for the partial-benefit population.
- Average annual growth in total dual-eligible enrollment varied substantially by state. Four states had a negative growth rate (Massachusetts, Nebraska, North Dakota, and Tennessee) and one state had a growth rate in excess of 10 percent (Connecticut).
- Only one state had average annual growth in full-benefit dual-eligible enrollment of more than 5 percent (Illinois). Four states had negative growth rates (Alabama, Massachusetts, Nebraska, and Tennessee).
- In contrast, partial-benefit enrollment growth rates exceeded 5 percent in all but eight states, and exceeded 15 percent in eight states. Partial-benefit enrollment growth rates decreased in two states (Nebraska and North Dakota).

MEDPAC Medicare Payment Advisory Commission

425 I Street NW • Suite 701 • Washington, DC 20001
202-220-3700 (Phone) • 202-220-3759 (Fax) • www.medpac.gov

MACPAC Medicaid and CHIP Payment and Access Commission

1800 M Street NW • Suite 650 South • Washington, DC 20036
202-350-2000 (Phone) • 202-273-2452 (Fax) • www.macpac.gov