Changes in Spending and Use of Services after Becoming Dually Eligible for Medicare and Medicaid

In any given year, about 1 million people become dually eligible for Medicare and Medicaid, based on their age or disability and low incomes. They are a diverse population that includes individuals with multiple chronic conditions as well as those who are relatively healthy. In 2013, the most recent year for which comprehensive data are available, dually eligible beneficiaries accounted for a disproportionate share of spending in both programs. In Medicare, they accounted for 20 percent of enrollment but 34 percent of spending, while in Medicaid, they accounted for 15 percent of enrollment and 32 percent of spending (MACPAC and MedPAC 2018).

Given the high cost and often complex care needs of dually eligible beneficiaries, policymakers continue to be interested in both controlling costs and improving care. In considering targets for program improvement, a key question is how the transition from Medicaid or Medicare to dual eligibility affects spending and use of health care services. We set out to quantify changes in utilization and spending and identify differences in those patterns based on whether beneficiaries were Medicaid or Medicare beneficiaries first and then became dually eligible.

Spending and utilization per person increased in most cases after becoming dually eligible, whether or not an individual started in Medicaid or Medicare, although there were differences in spending for specific services. For example, for individuals coming into dual status from Medicare, spending per person on nursing facility services was high compared to individuals coming from Medicaid. This issue brief presents key findings; detailed data on per person costs and utilization can be found in the Appendix.

Approach

To better understand the spending and utilization changes associated with dually eligible status, we analyzed patterns of care for a cohort of individuals enrolled in fee for service (FFS) using four years of administrative data from 2009 to 2012. Transitions to dual status occurred in 2010 and 2011.[1] This time period represented the most comprehensive data available at the time of our analysis and allowed us to observe trends before and after dual status for all individuals in this cohort.

We focused on individuals eligible for full Medicaid benefits because they represent the vast majority of our cohort and are eligible for services paid for by each program. About 82 percent of the cohort was eligible for full Medicaid benefits. Partial-benefit dually eligible beneficiaries are only eligible for Medicaid

assistance with Medicare premiums and cost sharing and although they appear in our cohort tables (Tables 5A and 5B), we did not include them in our analysis of spending and utilization.

We found largely similar patterns in spending and use of services among full-benefit dually eligible beneficiaries, regardless of whether they came into dual status from Medicare or Medicaid. Where there were differences, we distinguished between individuals eligible based on their low income and others who spent down to become eligible for Medicaid or who required an institutional level of care.

Spending and Utilization Increased After Dual Status

For most beneficiaries becoming dually eligible, spending and utilization increased regardless of whether they were initially covered by Medicare or Medicaid. The exception was dually eligible beneficiaries coming from Medicare who became eligible for Medicaid through spend down or who required an institutional level of care. [2] They used fewer services and had lower per person spending on most services after dual status, but received a significant amount of nursing facility care, a benefit not covered by Medicare.

Findings for beneficiaries coming from Medicaid

For beneficiaries entering dual status from Medicaid, spending per person increased across all service categories, with the largest increases in home health services, physician services, and outpatient services (Table 1A). Spending increases for physician services and outpatient services tended to be larger for people with more institutional use (e.g., those institutionalized for more than 90 days) (Table 2B). Spending on inpatient services increased the most for people with cognitive impairment compared to those with other chronic conditions (Tables 3A and 3B). Utilization per person also increased across most types of services, with some of the largest increases—upwards of 90 percent—occurring in home health and outpatient visits (Table 1B).

These increases may be explained by broader access to providers when Medicare is the primary source of coverage. We found that, compared with people becoming dually eligible from Medicare, people coming from Medicaid had larger increases in physician visits and were somewhat more likely to switch the doctor providing the most visits. This may be in part because more doctors accept new Medicare patients than new Medicaid patients. For example, one study found that the share of doctors accepting new Medicare patients in 2013 was about 20 percent higher than the share accepting new Medicaid patients (Hing et al. 2015).

Findings for beneficiaries coming from Medicare

For beneficiaries entering dual status from Medicare, spending per person increased across almost all types of service, although beneficiaries who qualified for Medicaid through spend down saw some declines in services such as inpatient (-17 percent), home health (-38 percent), and skilled nursing facility (-3 percent) (Table 1A).

Medicare does not cover long-term services and supports (LTSS). Individuals gain access to a new benefit with dual coverage, which, in the case of individuals who qualify for Medicaid by spending down their

incomes, may cause beneficiaries to substitute nursing facility care for other services. Spending on nursing facility services was high for these beneficiaries (Table 1A). Not surprisingly, spending per person on nursing facility care was higher for individuals who were institutionalized for more than 90 days (Table 2A). We also found that spending for people with certain chronic conditions, in particular spending on nursing facility services, was generally higher for beneficiaries who spent down than for other dually eligible beneficiaries (Table 2B).

Utilization increased for most services (Table 1B). Access to Medicaid assistance with Medicare premiums and cost sharing may cause individuals to use more services given that Medicaid covered out-of-pocket costs.[3]

Findings on spending for nursing facility services

Spending on nursing facility services was highest for beneficiaries coming from Medicare, particularly if those beneficiaries became dually eligible through spend down and were age 65 and over (Tables 4A and 4B). Spending for this group was $22,196 per person in the year after the transition to dual status with 180 days of use compared to $4,752 and 37 days per person for those under 65 who became eligible through spend down (Tables 4A and 4B). Spending and utilization declined for some acute care services, including inpatient services (-24 percent) and physician services (-9 percent) (Table 4A).

The pattern of high spending on nursing facility care with declines in acute care services likely reflects movement to an institutionalized setting, substituting nursing facility care for acute and post-acute care. Beneficiaries coming from Medicare would have new access to coverage of LTSS, a benefit not covered by Medicare. They would also have new access to Medicaid assistance with Medicare premiums and cost sharing which may account for some increased utilization.

Beneficiaries coming from Medicaid did not experience a notable change in spending on nursing facility services after becoming dually eligible, but spending on acute care services increased almost across the board (Table 4A). Because new dually eligible beneficiaries coming from Medicaid already had access to nursing facility coverage as Medicaid-only beneficiaries, we would not expect to see much change in their use of these services. Medicare eligibility would presumably provide access to a broader set of providers and may explain the increased use of acute care services. Older beneficiaries typically have more significant health care needs which might explain why we saw the most significant increases among beneficiaries age 65 and older.

Methodology

We analyzed a cohort of individuals transitioning into dually eligible status from either Medicare or Medicaid FFS in 2010 and 2011. Anyone not enrolled in Medicaid for a full year both before and after the transition was excluded. We included beneficiaries in a particular year if they died in that year after their transitions to dually eligible status. Most of the full-benefit dually eligible beneficiaries in our cohort, 62 percent, were coming into dual status from Medicare, although it was a more even split among individuals

eligible based on their low income (Table 5A). We divided our cohort into full-benefit and partial-benefit dually eligible beneficiaries but focused our analysis on the first group.

We further divided the full-benefit dually eligible beneficiaries into Qualified Medicare Beneficiaries Plus (QMB Plus) and other full-benefit dually eligible beneficiaries.[4] QMB Plus beneficiaries are eligible based on their low-income, whereas other full-benefit beneficiaries either have higher incomes but have spent down their income by incurring medical expenses to qualify for Medicaid or qualify under the special income option because they require an institutional level of care.[5] Other dually eligible beneficiaries, such as enrollees in the Specified Low-Income Medicare Beneficiary (SLMB) program and the Qualifying Individual (QI) program, were excluded from the analysis.

Spending and utilization were measured per person and utilization was quantified as number of visits, stays or days of use, depending on the service category. We analyzed patterns of care by tracking changes in per person utilization rates and per person spending from the year before the transition to the year after the transition to dual status. To identify any variations among dually eligible beneficiaries, we compared these metrics for different types of full-benefit dually eligible beneficiaries. After dual status, we focused on services covered by Medicare because it is the primary payer for acute and post-acute care services for someone who is dually eligible.

An analysis of the demographic characteristics of our cohort shows that most of our cohort was female (60 percent), was white, non-Hispanic (66 percent), lived in an urban area (71 percent), and was not institutionalized (72 percent) (Table 5B). We know that many individuals in our cohort had chronic conditions and may have had multiple chronic conditions. Behavioral health conditions were the most prevalent in our cohort (38 percent).

Endnotes

[1] We excluded managed care from our analysis due to incomplete data.

[2] States can choose to cover certain individuals with high medical expenses who may spend down their income to qualify for Medicaid coverage based on incurred medical expenses. For more information on eligibility, see MACPAC's fact sheet on Federal Requirements and State Options: Eligibility.

[3] Although all states cover some portion of deductibles and coinsurance, in 2013, only four states paid providers Medicare's full deductibles and coinsurance. Other states limited payments to the lesser of the full amount of Medicare deductibles and coinsurance, or the difference between the Medicaid rate and the amount already paid by Medicare (MACPAC 2013). Depending on how providers respond to states paying less for dually eligible beneficiaries, access to care could be affected (MACPAC 2015).

[4] QMB Plus beneficiaries are eligible for full Medicaid benefits, in addition to Medicaid assistance with Medicare premiums and cost sharing. QMB Only beneficiaries are only eligible for assistance with premiums and cost sharing.

[5] The special income rule is an optional Medicaid eligibility pathway that most states haven taken up. It covers individuals who need an institutional level of care and have income up to 300 percent of the Supplemental Security Income federal benefit rate. For more information on Medicaid eligibility for individuals over age 65 and those with disabilities, see MACPAC's fact sheet *Federal Requirements and State Options: Eligibility*.

References

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Appendix: Patterns of Spending and Use of Services by Full-Benefit Dually Eligible Beneficiaries

TABLE 1A. Per Person Spending on Selected Services by Full-Benefit Dually Eligible Beneficiaries, 2009–2012

Service	Full-benefit beneficiaries					
	QMB Plus beneficiaries			Other full-benefit beneficiaries		
	Before	After[1]	Percent change	Before	After[1]	Percent change
Beneficiaries from Medicare						
Inpatient	$6,536	$8,438	29%	$12,542	$10,374	-17%
Outpatient	$1,362	$2,573	89%	$2,186	$3,262	49%
Physician	$2,307	$3,506	52%	$4,072	$4,060	0%
Home health	$889	$1,056	19%	$2,088	$1,296	-38%
SNF	$3,133	$4,095	31%	$8,159	$7,936	-3%
Nursing facility	–	$9,011	–	–	$19,886	–
Beneficiaries from Medicaid						
Inpatient	$3,366	$5,505	64%	$4,248	$6,249	47%
Outpatient	$1,399	$2,639	89%	$1,536	$2,894	88%
Physician	$1,747	$3,023	73%	$1,632	$3,079	89%
Home health	$446	$852	91%	$526	$879	67%
SNF	–	$528	–	–	$780	–
Nursing facility	$1,922	$1,855	-3%	$5,156	$4,919	-5%

Notes: The Before columns represent the year before the transition to dual status and the After columns represent the year after the transition. QMB is qualified Medicare beneficiary. QMB Plus beneficiaries are eligible for full Medicaid benefits compared to QMB Only beneficiaries who are only eligible for Medicaid assistance with Medicare premiums and cost sharing. SNF is skilled nursing facility.

[1] This column is the sum of Medicare and Medicaid spending with the exception of nursing facility, which is paid for by Medicaid both before and after the transition.

Source: Acumen, LLC analysis of 2009–2012 Medicare and Medicaid enrollment and claims data.

TABLE 1B. Per Person Use of Selected Services by Full-Benefit Dually Eligible Beneficiaries, 2009–2012

Service	Full-benefit beneficiaries					
	QMB Plus			Other full-benefit beneficiaries		
	Before	After	Percent change	Before	After	Percent change
Beneficiaries from Medicare						
Inpatient days	4	5	14%	9	7	-25%
Outpatient visits	8	15	96%	14	25	85%
Physician visits	18	25	34%	34	32	-4%
Home health days	15	13	-13%	34	15	-56%
SNF	8	11	39%	21	22	5%
Nursing facility days	–	63	–	0	161	–
Beneficiaries from Medicaid						
Inpatient days	3	3	-4%	3	3	-21%
Outpatient visits	6	12	83%	7	13	95%
Physician visits	15	19	25%	15	19	25%
Home health days	5	9	92%	5	8	68%
SNF	–	1	–	–	2	–
Nursing facility days	12	12	3%	32	31	-3%

Notes: The Before columns represent the year before the transition to dual status and the After columns represent the year after the transition. The After columns represent services covered by Medicare because Medicare is the primary payer for acute and post-acute care with the exception of nursing facility days, which are paid for by Medicaid both before and after the transition. QMB is qualified Medicare beneficiary. SNF is skilled nursing facility.

Source: Acumen, LLC analysis of 2009–2012 Medicare and Medicaid enrollment and claims data.

TABLE 2A. Per Person Spending on Selected Services for Beneficiaries Coming from Medicare, by Institutional Status, 2009–2012

Service and institutional status	Full-benefit beneficiaries							
	QMB Plus				Other full-benefit beneficiaries			
	Before Medicare	After Medicare	Percent change	Medicaid after dual status[1]	Before Medicare	After Medicare	Percent change	Medicaid after dual status[1]
Inpatient								
Not institutionalized	$3,580	$5,440	52%	$260	$8,719	$8,133	-7%	$453
90 days or less	$14,429	$19,523	35%	$459	$16,363	$13,633	-17%	$353
More than 90 days	$14,399	$13,662	-5%	$364	$13,939	$10,168	-27%	$228
Outpatient								
Not institutionalized	$1,101	$1,942	76%	$224	$1,957	$2,259	15%	$303
90 days or less	$2,202	$3,124	42%	$177	$2,595	$2,891	11%	$113
More than 90 days	$1,996	$3,675	84%	$123	$2,207	$3,747	70%	$104
Physician								
Not institutionalized	$1,514	$2,479	64%	$283	$3,098	$3,014	-3%	$335
90 days or less	$4,532	$5,691	26%	$257	$5,147	$4,348	-16%	$153
More than 90 days	$4,372	$5,109	17%	$194	$4,392	$4,286	-2%	$125
Home health								
Not institutionalized	$521	$710	36%	$330	$1,739	$1,569	-10%	$835
90 days or less	$1,824	$1,839	1%	$405	$2,438	$1,240	-49%	$393
More than 90 days	$1,892	$527	-72%	$109	$2,215	$342	-85%	$47
SNF								
Not institutionalized	$716	$702	-2%	–	$3,104	$2,118	-32%	–
90 days or less	$7,992	$11,841	48%	–	$10,574	$9,970	-6%	–
More than 90 days	$10,205	$13,649	34%	–	$10,920	$11,372	4%	–

TABLE 2A. (continued)

Service and institutional status	Full-benefit beneficiaries							
	QMB Plus				Other full-benefit beneficiaries			
	Before Medicare	After Medicare	Percent change	Medicaid after dual status[1]	Before Medicare	After Medicare	Percent change	Medicaid after dual status[1]
Prescription drugs								
Not institutionalized	$1,205	$2,525	110%	$127	$1,434	$2,763	93%	$202
90 days or less	$1,328	$2,683	102%	$113	$1,115	$2,286	105%	$101
More than 90 days	$1,279	$3,843	200%	$193	$1,030	$3,597	249%	$177
Nursing facility								
Not institutionalized	–	–	–	$673	–	–	–	$2,474
90 days or less	–	–	–	$15,327	–	–	–	$16,476
More than 90 days	–	–	–	$37,594	–	–	–	$33,462

Notes: This table includes only beneficiaries coming into dual status from Medicare. The Before columns represent the year before the transition to dual status and the After columns represent the year after the transition. QMB is qualified Medicare beneficiary. SNF is skilled nursing facility.

[1] Medicaid spending after dual status when Medicaid is secondary payer.

Source: Acumen, LLC analysis of 2009–2012 Medicare and Medicaid enrollment and claims data.

TABLE 2B. Per Person Spending on Selected Services for Beneficiaries Coming from Medicaid, by Institutional Status, 2009–2012

Service and institutional status	Full-benefit beneficiaries							
	QMB Plus				Other full-benefit beneficiaries			
	Before Medicaid	After Medicare	Percent change	Medicaid after dual status[1]	Before Medicaid	After Medicare	Percent change	Medicaid after dual status[1]
Inpatient								
Not institutionalized	$2,829	$4,017	42%	$418	$3,296	$3,942	20%	$801
90 days or less	$13,645	$26,518	94%	$3,071	$14,343	$20,156	41%	$4,767
More than 90 days	$11,469	$16,948	48%	$2,526	$10,141	$11,413	13%	$3,114
Outpatient								
Not institutionalized	$1,376	$2,126	55%	$344	$1,549	$2,252	45%	$444
90 days or less	$2,357	$4,933	109%	$533	$2,251	$4,779	112%	$435
More than 90 days	$1,449	$5,075	250%	$370	$1,124	$3,718	231%	$324
Physician								
Not institutionalized	$1,639	$2,279	39%	$477	$1,531	$2,294	50%	$420
90 days or less	$4,125	$7,447	81%	$765	$3,200	$6,291	97%	$660
More than 90 days	$3,176	$6,346	100%	$664	$2,063	$4,808	133%	$530
Home health								
Not institutionalized	$436	$468	7%	$342	$523	$425	-19%	$441
90 days or less	$982	$2,046	108%	$759	$1,100	$1,550	41%	$855
More than 90 days	$389	$590	51%	$164	$332	$297	-11%	$124
SNF								
Not institutionalized	–	$102	–	–	–	$113	–	–
90 days or less	–	$7,234	–	–	–	$5,483	–	–
More than 90 days	–	$7,856	–	–	–	$5,825	–	–

TABLE 2B. (continued)

Service and institutional status	Full-benefit beneficiaries							
	QMB Plus				Other full-benefit beneficiaries			
	Before Medicaid	After Medicare	Percent change	Medicaid after dual status[1]	Before Medicaid	After Medicare	Percent change	Medicaid after dual status[1]
Prescription drugs								
Not institutionalized	$4,060	$3,775	-7%	$566	$4,407	$3,865	-12%	$772
90 days or less	$6,346	$4,888	-23%	$782	$6,328	$4,778	-25%	$1,154
More than 90 days	$7,218	$6,406	-11%	$1,243	$4,984	$5,803	16%	$861
Nursing facility								
Not institutionalized	$188	–	–	$83	$394	–	–	$201
90 days or less	$14,624	–	–	$11,594	$23,906	–	–	$19,447
More than 90 days	$40,732	–	–	$43,535	$46,898	–	–	$47,833

Notes: This table includes only beneficiaries coming into dual status from Medicaid. To track spending on service use based on the primary source of coverage for beneficiaries coming from Medicaid, we calculate the percent change from Medicaid spending before dual status, when Medicaid was primary, to Medicare spending after dual status, when Medicare is primary. The Before columns represent the year before the transition to dual status and the After columns represent the year after the transition. QMB is qualified Medicare beneficiary. SNF is skilled nursing facility.

[1] Medicaid spending after dual status when Medicaid is secondary payer.

Source: Acumen, LLC analysis of 2009–2012 Medicare and Medicaid enrollment and claims data.

TABLE 3A. Per Person Spending by Full-Benefit Dually Eligible Beneficiaries on Selected Services, by Selected Chronic Conditions, 2009–2012

Chronic condition	Full-benefit beneficiaries							
	QMB Plus				Other full-benefit beneficiaries			
	Before	After Medicare	Percent change	Medicaid after dual status[1]	Before	After Medicare	Percent change	Medicaid after dual status[1]
Beneficiaries from Medicare								
Inpatient services								
Arthritis	$10,707	$10,875	2%	$267	$14,979	$10,908	-27%	$234
Behavioral health conditions	$10,898	$11,427	5%	$352	$15,535	$11,506	-26%	$325
Cognitive impairment	$11,957	$11,182	-6%	$277	$12,613	$9,373	-26%	$211
Diabetes	$11,972	$13,726	15%	$448	$18,744	$14,481	-23%	$437
Ischemic heart disease	$14,192	$15,215	7%	$417	$18,096	$13,510	-25%	$354
None or other chronic conditions	$756	$2,524	234%	$199	$2,038	$3,919	92%	$474
Nursing facility services								
Arthritis	–	–	–	$15,118	–	–	–	$22,627
Behavioral health conditions	–	–	–	$14,440	–	–	–	$22,884
Cognitive impairment	–	–	–	$24,966	–	–	–	$25,399
Diabetes	–	–	–	$11,956	–	–	–	$20,661
Ischemic heart disease	–	–	–	$15,455	–	–	–	$21,818
None or other chronic conditions	–	–	–	$926	–	–	–	$4,254
Beneficiaries from Medicaid								
Inpatient services								
Arthritis	$3,993	$7,424	86%	$770	$4,471	$7,111	59%	$1,555
Behavioral health conditions	$4,795	$8,416	76%	$763	$6,267	$9,188	47%	$1,613
Cognitive impairment	$5,196	$9,995	92%	$1,599	$5,780	$8,416	46%	$2,579

TABLE 3A. (continued)

Chronic condition	Full-benefit beneficiaries							
	QMB Plus				Other full-benefit beneficiaries			
	Before	After Medicare	Percent change	Medicaid after dual status[1]	Before	After Medicare	Percent change	Medicaid after dual status[1]
Beneficiaries from Medicaid								
Inpatient services								
Diabetes	$6,418	$9,983	56%	$1,082	$7,518	$10,478	39%	$2,085
Ischemic heart disease	$7,677	$13,420	75%	$1,448	$9,177	$12,662	38%	$3,127
None or other chronic conditions	$2,004	$2,301	15%	$308	$2,622	$2,378	-9%	$647
Nursing facility services								
Arthritis	$1,899	–	–	$1,996	$5,917	–	–	$5,663
Behavioral health conditions	$3,051	–	–	$3,017	$8,483	–	–	$8,211
Cognitive impairment	$10,942	–	–	$11,424	$21,573	–	–	$20,899
Diabetes	$3,548	–	–	$3,466	$8,610	–	–	$8,233
Ischemic heart disease	$3,169	–	–	$3,170	$8,931	–	–	$8,488
None or other chronic conditions	$1,078	–	–	$992	$2,916	–	–	$2,740

Notes: Categories are not mutually exclusive as individuals may have multiple chronic conditions. To track spending on service use based on the primary source of coverage for beneficiaries coming from Medicaid, we calculate the percent change from Medicaid spending before dual status, when Medicaid was primary, to Medicare spending after dual status, when Medicare is primary. The Before columns represent the year before the transition to dual status and the After columns represent the year after the transition. QMB is qualified Medicare beneficiary.

[1] Medicaid spending after dual status when Medicaid is secondary payer.

Source: Acumen, LLC analysis of 2009–2012 Medicare and Medicaid enrollment and claims data.

TABLE 3B. Per Person Use of Selected Services by Full-Benefit Dually Eligible Beneficiaries, by Selected Chronic Conditions, 2009–2012

Chronic condition	Full-benefit beneficiaries							
	QMB Plus				Other full-benefit beneficiaries			
	Before	After Medicare	Percent change	Medicaid after dual status[1]	Before	After Medicare	Percent change	Medicaid after dual status[1]
Beneficiaries from Medicare								
Inpatient services—days of use								
Arthritis	7	7	-8%	3	11	7	-32%	3
Behavioral health conditions	8	8	-2%	3	11	8	-30%	3
Cognitive impairment	8	8	-11%	3	9	7	-30%	2
Diabetes	8	8	5%	3	13	9	-28%	4
Ischemic heart disease	9	9	-2%	3	12	9	-30%	3
None or other chronic conditions	0	1	222%	1	1	2	70%	2
Nursing facility services—days of use								
Arthritis	–	–	–	105	–	–	–	185
Behavioral health conditions	–	–	–	101	–	–	–	187
Cognitive impairment	–	–	–	173	–	–	–	206
Diabetes	–	–	–	84	–	–	–	168
Ischemic heart disease	–	–	–	107	–	–	–	175
None or other chronic conditions	–	–	–	6	–	–	–	33
Beneficiaries from Medicaid								
Inpatient services—days of use								
Arthritis	3	4	16%	3	4	4	-4%	3
Behavioral health conditions	4	5	18%	4	6	6	-1%	4
Cognitive impairment	5	6	25%	5	5	5	1%	5

TABLE 3B. (continued)

Chronic condition	Full-benefit beneficiaries							
	QMB Plus				Other full-benefit beneficiaries			
	Before	After Medicare	Percent change	Medicaid after dual status[1]	Before	After Medicare	Percent change	Medicaid after dual status[1]
Beneficiaries from Medicaid								
Inpatient services—days of use								
Diabetes	5	5	-6%	5	6	5	-14%	4
Ischemic heart disease	6	6	4%	6	7	6	-14%	6
None or other chronic conditions	2	1	-24%	1	2	1	-42%	1
Nursing facility services—days of use								
Arthritis	13	–	–	14	44	–	–	43
Behavioral health conditions	20	–	–	21	57	–	–	56
Cognitive impairment	70	–	–	76	152	–	–	146
Diabetes	22	–	–	23	56	–	–	54
Ischemic heart disease	20	–	–	21	59	–	–	57
None or other chronic conditions	6	–	–	6	15	–	–	15

Notes: Categories are not mutually exclusive as individuals may have multiple chronic conditions. To track utilization based on the primary source of coverage for beneficiaries coming from Medicaid, we calculate the percent change from Medicaid before dual status, when Medicaid was primary, to Medicare after dual status, when Medicare is primary. The Before columns represent the year before the transition to dual status and the After columns represent the year after the transition. QMB is qualified Medicare beneficiary.

[1] Medicaid utilization after dual status when Medicaid is secondary payer.

Source: Acumen, LLC analysis of 2009–2012 Medicare and Medicaid enrollment and claims data.

TABLE 4A. Per Person Spending by Full-Benefit Dually Eligible Beneficiaries on Selected Acute Care Services Compared with Nursing Facility Services, by Age, 2009–2012

Service	Full-benefit beneficiaries							
	QMB Plus				Other full-benefit beneficiaries			
	Before	After Medicare	Percent change	Medicaid after dual status[1]	Before	After Medicare	Percent change	Medicaid after dual status[1]
Beneficiaries from Medicare								
Under 65								
Inpatient	$4,088	$6,905	69%	$352	$10,323	$11,529	12%	$852
Outpatient	$1,330	$2,405	81%	$299	$2,387	$3,300	38%	$539
Physician	$1,405	$2,631	87%	$328	$2,797	$3,660	31%	$466
Nursing facility	–	–	–	$1,324	–	–	–	$4,752
65 and over								
Inpatient	$7,757	$8,759	13%	$268	$12,880	$9,821	-24%	$247
Outpatient	$1,378	$2,355	71%	$152	$2,155	$3,056	42%	$119
Physician	$2,756	$3,547	29%	$232	$4,266	$3,887	-9%	$162
Nursing facility	–	–	–	$12,844	–	–	–	$22,196
Beneficiaries from Medicaid								
Under 65								
Inpatient	$3,576	$5,356	50%	$337	$4,850	$6,465	33%	$487
Outpatient	$1,608	$2,502	56%	$413	$1,881	$2,684	43%	$524
Physician	$1,840	$2,382	29%	$584	$1,816	$2,577	42%	$513
Nursing facility	$1,092	–	–	$946	$3,475	–	–	$3,120
65 and over								
Inpatient	$3,066	$4,389	43%	$851	$3,494	$3,430	-2%	$1,937
Outpatient	$1,103	$1,989	80%	$257	$1,103	$2,181	98%	$319
Physician	$1,614	$2,749	70%	$356	$1,401	$2,724	94%	$343
Nursing facility	$3,100	–	–	$3,147	$7,265	–	–	$7,174

Notes: The Before columns represent the year before the transition to dual status and the After columns represent the year after the transition. QMB is qualified Medicare beneficiary.

[1] Medicaid spending after dual status when Medicaid is the secondary payer.

Source: Acumen, LLC analysis of 2009–2012 Medicare and Medicaid enrollment and claims data.

TABLE 4B. Per Person Use by Full-Benefit Dually Eligible Beneficiaries of Selected Acute Care Services Compared with Nursing Facility Services, by Age, 2009–2012

Service	Full-benefit beneficiaries							
	QMB Plus				Other full-benefit beneficiaries			
	Before	After Medicare	Percent change	Medicaid after dual status[1]	Before	After Medicare	Percent change	Medicaid after dual status[1]
Beneficiaries from Medicare								
Under 65								
Inpatient days of use	2.9	4.3	48%	2.4	6.8	7.0	2%	4.2
Outpatient visits	6.8	12.1	77%	5.3	12.0	18.2	52%	7.0
Physician visits[2]	11.5	20.2	75%	9.3	21.8	26.9	23%	12.9
Nursing facility days of use	–	–	–	9.5	–	–	–	37.3
65 and over								
Inpatient days of use	5.1	5.2	3%	2.1	9.1	6.5	-29%	2.4
Outpatient visits	7.8	16.0	105%	3.2	13.8	26.3	90%	3.1
Physician visits[2]	21.8	26.8	23%	7.6	35.3	33.2	-6%	7.6
Nursing facility days of use	–	–	–	89.7	–	–	–	180.2
Beneficiaries from Medicaid								
Under 65								
Inpatient days of use	3.1	3.0	-3%	2.3	3.9	3.4	-12%	2.2
Outpatient visits	7.3	12.7	75%	7.3	7.9	13.5	72%	7.2
Physician visits[2]	14.6	17.9	23%	13.3	15.4	18.3	19%	11.8
Nursing facility days of use	6.5	–	–	6.3	20.2	–	–	19.0
65 and over								
Inpatient days of use	2.5	2.3	-6%	2.3	2.8	1.8	-35%	2.5
Outpatient visits	5.2	10.3	99%	4.7	5.0	12.1	141%	4.0
Physician visits[2]	15.1	19.3	28%	14.5	14.5	19.2	32%	11.4
Nursing facility days of use	19.5	–	–	20.4	46.5	–	–	45.7

Notes: The Before columns represent the year before the transition to dual status and the After columns represent the year after the transition. QMB is qualified Medicare beneficiary.

[1] Medicaid spending after dual status when Medicaid is the secondary payer.

[2] Includes visits with primary physicians, specialty physicians, or both.

Source: Acumen, LLC analysis of 2009–2012 Medicare and Medicaid enrollment and claims data.

TABLE 5A. Cohort Distribution of Full-Benefit and Partial-Benefit Dually Eligible Beneficiaries, 2009–2012

Benefit category	Beneficiaries	Share of cohort	Under 65	Share of cohort	Over 65	Share of cohort
Coming from Medicare						
QMB Plus	142,273	22%	47,342	20%	94,931	23%
Other full-benefit dually eligible	192,825	29%	25,528	11%	167,297	40%
QMB Only (partial benefit)	106,574	16%	40,644	17%	65,930	16%
Subtotal	**441,672**	**67%**	**113,514**	**48%**	**328,158**	**79%**
Coming from Medicaid						
QMB Plus	128,768	20%	75,574	32%	53,194	13%
Other full-benefit dually eligible	75,700	12%	42,118	18%	33,582	8%
QMB Only (partial benefit)	9,796	1%	7,503	3%	2,293	1%
Subtotal	**214,264**	**33%**	**125,195**	**52%**	**89,069**	**21%**
All						
QMB Plus	271,041	41%	122,916	51%	148,125	36%
Other full-benefit dually eligible	268,525	41%	67,646	28%	200,879	48%
QMB Only (partial benefit)	116,370	18%	48,147	20%	68,223	16%
Total	**655,936**	**100%**	**238,709**	**100%**	**417,227**	**100%**

Notes: This table includes partial-benefit dually eligible beneficiaries. QMB is qualified Medicare beneficiary. QMB Only are eligible for partial Medicaid benefits.

Source: Acumen, LLC analysis of 2009–2012 Medicare and Medicaid enrollment and claims data.

TABLE 5B. Cohort Characteristics of Full-Benefit and Partial-Benefit Dually Eligible Beneficiaries, 2009–2012

Characteristic	Beneficiaries	Share of cohort
Gender		
Male	264,227	40%
Female	391,706	60%
Unknown	3	0%
Race/Ethnicity		
White, non-Hispanic	433,919	66%
Black, non-Hispanic	114,706	17%
Hispanic	65,382	10%
Other	34,035	5%
Unknown	7,894	1%
Residence		
Urban	465,379	71%
Rural	189,497	29%
Unknown	1,060	0%
Chronic Conditions		
Arthritis	179,399	27%
Behavioral health conditions	249,909	38%
Cognitive impairment	175,242	27%
Diabetes	186,300	28%
Ischemic heart disease	189,542	29%
None or other condition	202,370	31%
Institutional Status		
90 days or less	52,125	8%
More than 90 days	133,405	20%
Not institutionalized	470,406	72%

Note: This table includes partial-benefit dually eligible beneficiaries.
Source: Acumen, LLC analysis of 2009–2012 Medicare and Medicaid enrollment and claims data.