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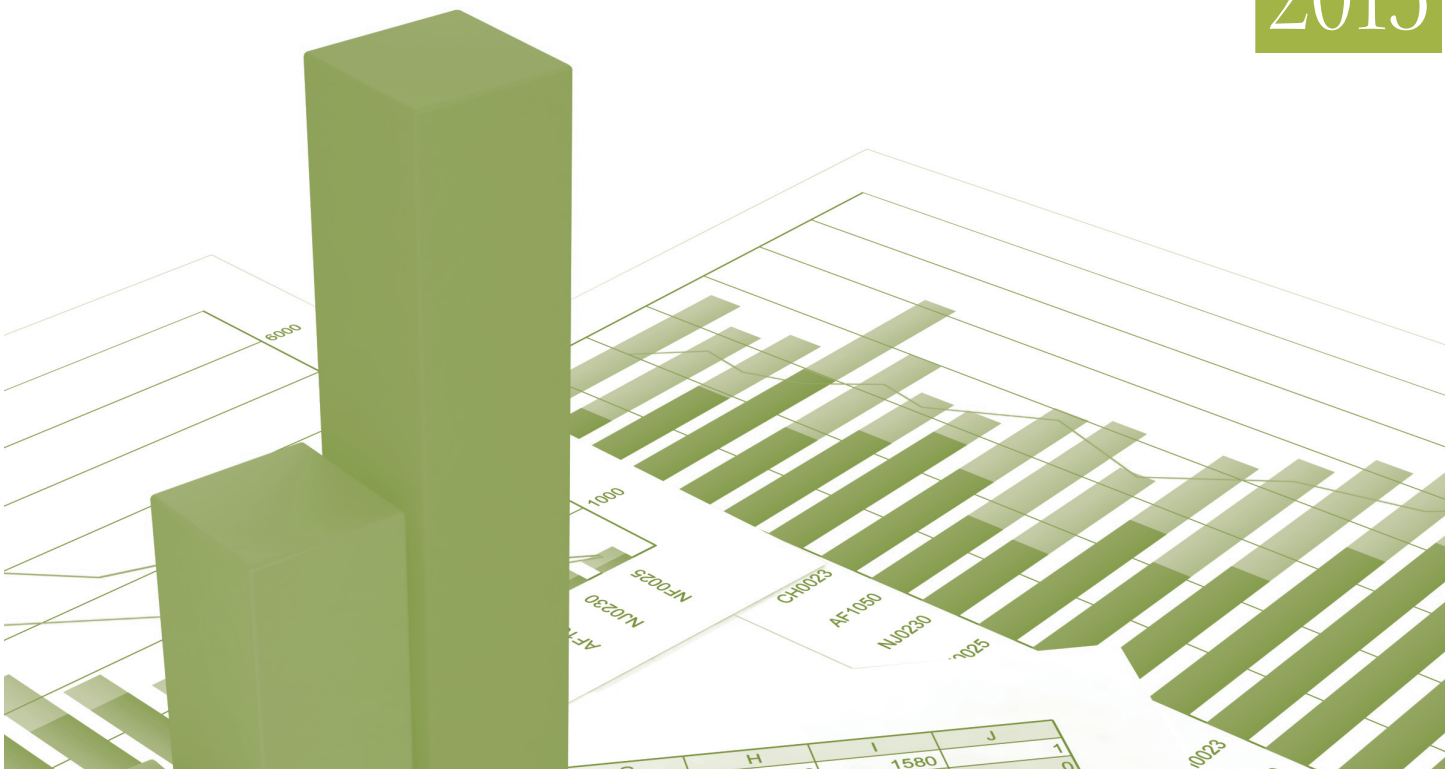

DATA BOOK

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

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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 (CMS), 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 non-partisan, federal agency charged with providing policy and data analysis to the Congress on Medicaid and CHIP, and for making recommendations to the Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on a wide range of issues affecting these programs. Appointed by the U.S. Comptroller General, the 17 commissioners have diverse backgrounds, offer broad perspectives on Medicaid and CHIP, and represent different regions across the United States. The Commission conducts independent policy analysis and health services research on key Medicaid and CHIP topics, including but not limited to:

- eligibility, enrollment, and benefits;
- payment;
- access to care;
- quality of care;
- interactions of Medicaid and CHIP with Medicare and the health care system generally; and
- data development to support policy analysis and program accountability.

As required in its statutory charge, the Commission submits reports to the Congress by March 15 and June 15 of each year. The statute requires that each member of the Commission vote on recommendations contained in the reports. The Commission's reports are intended to provide the Congress with a better understanding of the Medicaid and CHIP programs, their roles in the U.S. health care system, and key policy and data issues.

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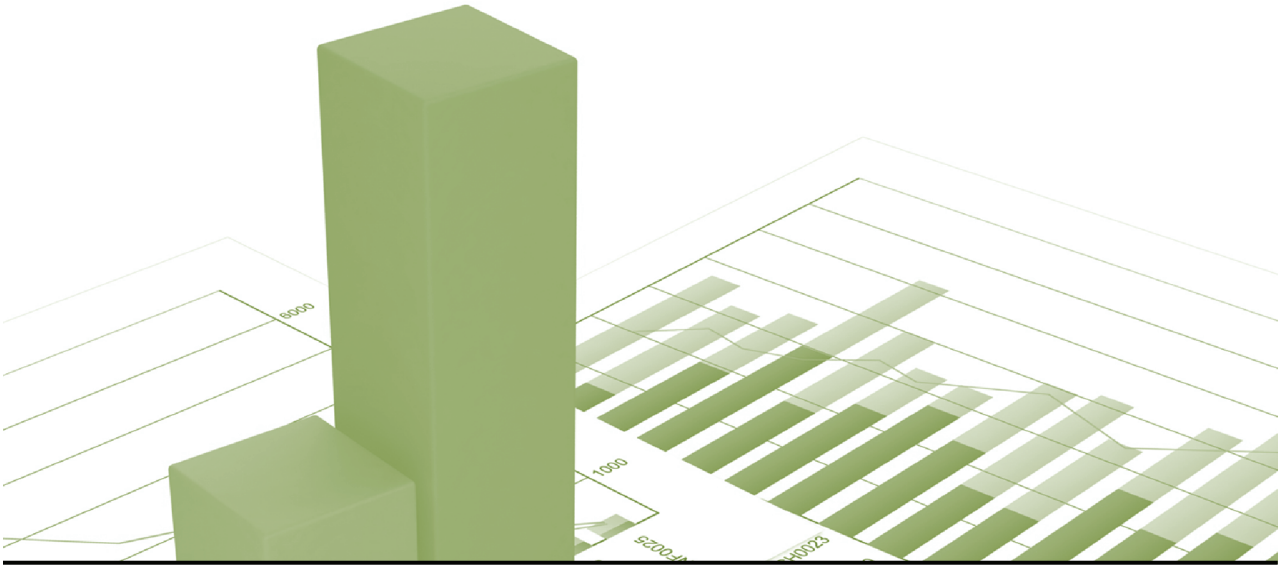
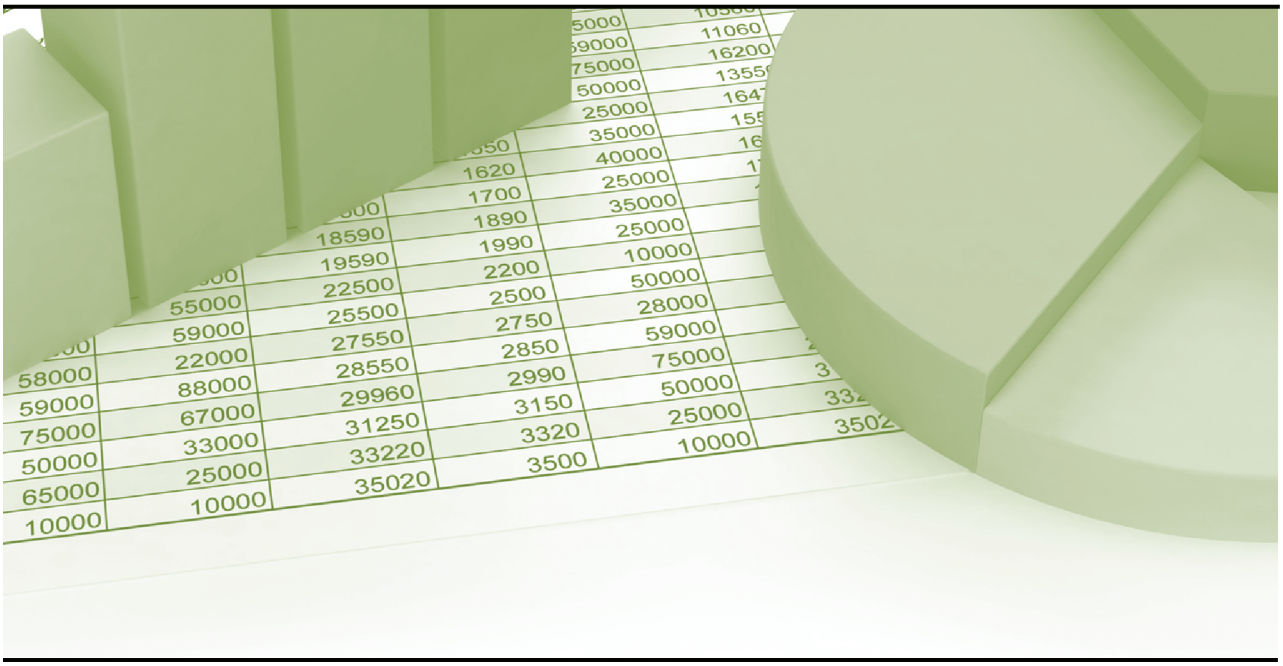


Introduction



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, cognitive impairments such as dementia, developmental disabilities, mental illness, and difficulties with activities of daily living. It also includes some individuals who are relatively healthy.

For dual-eligible beneficiaries, Medicare is the primary payer of primary, 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, also provides services not covered by Medicare, 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 due to 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 is a result of a yearlong effort to create a common understanding of the characteristics of dual-eligible beneficiaries and their use of services that would be useful to the Congress as well inform each commission's own discussions of the policy issues associated with this population.

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 Medicare and Medicaid services
- characteristics of high-cost dual-eligible beneficiaries
- Medicare and Medicaid spending on selected dual-eligible populations: LTSS and Alzheimer's or related dementia

In each section we compare subgroups of dual-eligible beneficiaries, including those with full versus partial benefits and those under age 65 versus those age 65 and older. We also compare dual-eligible beneficiaries to non-dual Medicare and Medicaid beneficiaries. In the case of Medicaid, we 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 non-disabled 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.

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 primary and specialty care, 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 benefits not included in the Medicare program. 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 that include premiums, payroll taxes, general revenues, and state contributions toward drug coverage for dual-eligible beneficiaries. Most Medicaid costs are shared by states and the federal government according to the federal medical assistance percentage, 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).

Categories of dual-eligible beneficiaries

Different types of dual-eligible beneficiaries receive varying levels of Medicaid assistance (Table 1). Under mandatory Medicaid eligibility pathways referred to as Medicare Savings Programs (MSPs), dual-eligible beneficiaries qualify for assistance with payment of Medicare premiums only or with Medicare premiums and cost sharing. Individuals who only receive assistance with premiums or cost sharing through the MSPs are referred to as partial-benefit dual-eligible beneficiaries. Among people with MSP coverage, some also qualify for the full range of services offered by state Medicaid programs. Additionally, individuals may qualify for full Medicaid benefits under separate non-MSP pathways. All individuals who qualify for full Medicaid benefits 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 2013	Benefits
Medicare Savings Program (MSP) beneficiaries			
Qualified Medicare beneficiaries (QMB)	Partial: QMB only	▪ At or below 100% FPL ▪ $7,080 / $10,620	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 beneficiaries (SLMB)	Partial: SLMB only	▪ 101%–120% FPL ▪ $7,080 / $10,620	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
Qualified individuals (QI)	Partial	▪ 121%–135% FPL ▪ $7,080 / $10,620	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 due to 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 (SSI) 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). Medicaid benefits for dual-eligible beneficiaries are jointly financed by the federal government and states. Although certain categories of dual-eligible beneficiaries are eligible for Medicaid coverage of their Medicare cost sharing, the Balanced Budget Act of 1997 permitted states to pay less than the full amount of cost sharing if the Medicare rate minus the cost-sharing amount is higher than the Medicaid rate for those services. Resource limits for QMB, SLMB, and QI are adjusted annually for inflation. Not all income and resources (e.g., the value of a house, vehicle, etc.) 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 2012; Centers for Medicare & Medicaid Services 2011, 2013a, and 2013b; and 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 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 of 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.)

Medicaid. Depending on the type of dual-eligible beneficiary, the Medicaid benefit package varies (Table 1). For many, Medicaid pays Medicare premiums and is the secondary payer of Medicare-covered services. For full-benefit dual-eligible beneficiaries, states must cover certain Medicaid services, such as Medicare cost sharing, 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, and vision and hearing services and supplies. There is considerable variation across states in the optional Medicaid services covered. This results in different benefits for dual-eligible beneficiaries depending on where they live.

As with Medicare, Medicaid benefits may be provided by managed care plans, 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, 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 age 65 and older
	SNF, long-term care hospital, and inpatient rehabilitation facility services (all limited to post-acute care); SNF coverage has 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 regular federal match for those expenditures (with the exception of the qualified 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 2013a). In cases where Medicaid payment rates are lower than Medicare, these lesser-of policies result in states paying less than the full amount of 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, 2013 and 2009

Part A	
Premium	Premium-free for insured individuals and their dependents and survivors; for uninsured individuals "buying in," $441 per month or $243 for individuals with at least 30 quarters of coverage ($443 and $244 in 2009), plus the Part B premium (Part A cannot be purchased by itself)
Hospital stays	$1,184 deductible for days 1–60 of each benefit period ($1,068 in 2009)
	$296 per day for days 61–90 of each benefit period (1/4 of hospital deductible each year) ($267 in 2009)
	$592 per "lifetime reserve day" (1/2 of hospital deductible each year) after day 90 each benefit period (up to 60 days over lifetime) ($534 in 2009)
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
	$148 per day (1/8 of hospital deductible each year) ($133.50 in 2009) for days 21–100 of each benefit period
	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 3 pints (unless donated to replace what is used)
Part B	
Premium	$104.90 per month ($96.40 in 2009); higher for higher income individuals beginning in 2007
Deductible	The first $147 of Part B–covered services or items ($135 in 2009)
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 21.6% in 2013 (was 23% in 2009), to be phased down to 20% over time; no copayment for a single service can be more than the Part A hospital deductible
Mental health services	35% (50% in 2009) of the Medicare-approved amount for outpatient mental health care (to be phased down to 20% by 2014)
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 3 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 2013 is $31.17 (was $30.36 in 2009); 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	$325 ($295 in 2009); not applied to dual-eligible beneficiaries; dual-eligible beneficiaries pay only nominal copayments
Initial coverage limit	$2,970 ($2,700 in 2009); dual-eligible beneficiaries pay only nominal copayments
Out-of-pocket threshold (catastrophic cap)	$4,750 ($4,350 in 2009); 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: $1.15 for generic or preferred multisource drugs and $3.50 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 may not exceed Medicare levels or may not exceed 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). 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 2008, 2009, 2012*

Additional information on Medicare and Medicaid 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, presence of end-stage renal disease (ESRD), or disability. Individuals qualify for Medicare based on age if they are age 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 age 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 individuals under the SSI program and can receive Medicaid coverage.

In this data book we distinguish between individuals under age 65 who qualified for Medicare on the basis of disability based on their own employment record or another person's employment record. Those who qualified for Medicare on the basis of disability through their own employment record have worked enough quarters to qualify for Medicare benefits. Those who qualified for Medicare on the basis of disability through another's employment record do not have their own qualifying work history. These individuals are often disabled widow(er)s and surviving divorced spouses, age 50 or older, or adult children age 18 or 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 age 65 or 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 age 65 and older. For most eligibility pathways that apply to individuals with disabilities and those age 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 age 65 and older include but are not limited to:

- **Poverty level.** States may opt to cover individuals with disabilities and those age 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 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.

Partly due to differences in states' use of optional eligibility pathways, the extent to which eligible individuals are enrolled, and states' underlying demographic profiles, 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 age 65 and older.

Methods

Sources of data

The data presented are for calendar year (CY) 2009, the most recent year for which complete claims data were available for the Medicare and Medicaid programs when the analytic work for this data book began. 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.

The analytic files used for this data book were created by Acumen, LLC, from these sources and are similar to files created for research purposes by the Centers for Medicare & Medicaid Services (CMS), such as the recently released 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 slightly different estimates of enrollment and spending relative to 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. In order for a beneficiary to be considered 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 record from those with entitlement based on another individual's record. 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 record include disabled adult children who receive benefits through a disabled, retired, or deceased parent and disabled individuals age 50 and older who receive benefits through a deceased spouse or deceased former (divorced) spouse.

- *Medicaid long-term services and supports (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 age 65 and older or under age 21), home- and community-based services (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 2009 (between 100,000 and 400,000 (Saucier et al. 2012)) was relatively small compared to the number of Medicaid FFS LTSS users identified in this data book (4.2 million).

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 to obtain federal matching funds in a data source referred to as the CMS-64, 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 nearly 40 percent of Medicaid FFS spending on inpatient and outpatient hospital services (MACPAC 2013a). The MSIS data also exclude Medicaid payments for Medicare premiums—$11 billion in 2009, of which $8 billion was the federal share and $3 billion was the state share (MACPAC 2013b)—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 that is updated by CMS on an ongoing basis (Mathematica 2013). A disconnect between managed care enrollment and payment data was one example of a potential 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 2009

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	**$2.6**	**$0.3**	**$1.7**	**$0.3**	**$0.3**	**$9.2**
Hospital deductible	1.3	0.1	0.5	0.2	0.2	6.0
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	2.8
Part B total	**5.5**	**0.4**	**2.0**	**1.0**	**0.9**	**27.3**
Deductible	0.5	<0.1	0.2	0.1	0.1	3.2
Coinsurance	5.0	0.3	1.9	0.9	0.8	24.1
Part A and Part B total	**8.2**	**0.7**	**3.7**	**1.3**	**1.2**	**36.5**

Note: *QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualified individual), QDWI (qualified disabled and 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

Given that an individual's enrollment in Medicare and Medicaid may vary over the course of a year and that 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. This 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 81 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 89 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 2009

	Number of beneficiaries (millions)		Average monthly as a percent of ever enrolled
	Ever enrolled	Average monthly	
Dual-eligible beneficiaries	**9.2**	**8.2**	**89%**
Medicare beneficiaries with no dual-eligible enrollment	**38.6**	**37.3**	**97**
Under age 65	4.2	4.2	99
Age 65 and older	34.4	33.2	97
Medicaid beneficiaries with no dual-eligible enrollment	**54.8**	**44.0**	**80**
Nondisabled under age 65	48.6	38.3	79
Disabled under age 65	5.6	5.1	91
Age 65 and older	0.6	0.5	91
All Medicare beneficiaries	**47.8**	**45.5**	**95**
All Medicaid beneficiaries	**64.1**	**52.2**	**81**

Note: *Medicaid beneficiaries include Medicaid-expansion State Children's Health Insurance Program enrollees.*
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. In order to avoid double-counting spending and utilization, we attribute all spending and utilization an individual incurred in a year to that individual's category. That is, if an individual is identified as a dual-eligible beneficiary, 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 is attributed to that individual and counted as spending for a dual-eligible beneficiary. The benefit 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 CY 2009 (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 2009, 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 20 percent of the dual-eligible population were enrolled in an MA plan in 2009 (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 2 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 (12 percent versus 37 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). Except as otherwise indicated, the tables in this data book showing utilization and expenditure statistics exclude beneficiaries with ESRD. Although 41 percent of beneficiaries with ESRD are dual-eligible beneficiaries, we exclude ESRD beneficiaries 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 2009

	All beneficiaries	Non-ESRD	ESRD	ESRD as percent of total
Population				
All Medicare beneficiaries (in millions)	47.8	47.2	0.5	1.1%
Dual-eligible beneficiaries (in millions)	9.2	9.0	0.2	2.4
Dual-eligible beneficiaries as percent of category	19%	19%	41%	
Medicare expenditures				
Total spending (in billions)	$481.4	$448.9	$32.5	6.7
Per person per year	10,075	9,504	59,604	
Spending on dual-eligible beneficiaries (in billions)	162.1	145.0	17.1	10.5
Per person per year	17,566	16,108	76,248	
Spending on non-dual beneficiaries (in billions)	319.3	303.9	15.4	4.8
Per person per year	8,282	7,949	48,003	
Medicaid expenditures				
Spending on dual-eligible beneficiaries (in billions)	$109.9	$106.1	$3.8	3.5
Per person per year	11,916	11,786	17,121	

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. With the ESRD population included, annual per capita Medicare spending for dual-eligible beneficiaries averaged $17,566 in 2009; excluding ESRD beneficiaries, per capita Medicare spending on dual-eligible beneficiaries averaged $16,108 for the year. In comparison, Medicaid spending on dual-eligible beneficiaries including the ESRD population was $11,916; excluding these individuals, the amount was $11,786.

Table 7. Dual-eligible, Medicare, and Medicaid beneficiaries as a percent of population by state, CY 2009 (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	306,772	9,227	3%	7,022	76%	2,206	24%	47,781	16%	64,065	21%
Alabama	4,758	201	4	95	47	106	53	870	18	949	20
Alaska	699	14	2	14	98	0.3	2	67	10	130	19
Arizona	6,343	161	3	125	78	36	22	940	15	1,737	27
Arkansas	2,897	122	4	72	59	50	41	547	19	745	26
California	36,961	1,226	3	1,195	97	31	3	4,907	13	11,363	31
Colorado	4,972	84	2	63	75	21	25	632	13	633	13
Connecticut	3,562	109	3	79	73	29	27	586	16	590	17
Delaware	892	25	3	12	47	13	53	152	17	207	23
District of Columbia	592	22	4	18	82	4	18	82	14	175	29
Florida	18,653	626	3	352	56	274	44	3,445	18	3,425	18
Georgia	9,621	267	3	143	54	123	46	1,259	13	1,786	19
Hawaii	1,347	34	2	30	90	3	10	210	16	271	20
Idaho	1,554	33	2	22	69	10	31	233	15	236	15
Illinois	12,797	331	3	287	87	45	13	1,905	15	2,796	22
Indiana	6,459	159	2	105	66	54	34	1,034	16	1,124	17
Iowa	3,033	82	3	68	83	14	17	537	18	529	17
Kansas	2,833	64	2	46	72	18	28	448	16	365	13
Kentucky	4,317	176	4	105	60	71	40	783	18	924	21
Louisiana	4,492	186	4	109	59	77	41	709	16	1,280	28
Maine	1,330	99	7	53	54	46	46	274	21	364	27
Maryland	5,730	113	2	76	67	37	33	807	14	979	17
Massachusetts	6,518	222	3	205	92	17	8	1,054	16	1,278	20
Michigan	9,902	273	3	239	88	34	12	1,701	17	2,152	22
Minnesota	5,281	133	3	118	88	15	12	807	15	883	17
Mississippi	2,959	153	5	83	54	70	46	513	17	737	25
Missouri	5,961	176	3	155	88	21	12	1,027	17	1,089	18

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	984	22	2%	15	69%	7	31%	173	18%	119	12%
Nebraska	1,813	42	2	37	90	4	10	289	16	258	14
Nevada	2,685	39	1	22	57	17	43	360	13	304	11
New Hampshire	1,316	30	2	21	70	9	30	226	17	158	12
New Jersey	8,756	208	2	181	87	27	13	1,370	16	1,206	14
New Mexico	2,037	66	3	39	60	26	40	319	16	625	31
New York	19,307	764	4	664	87	100	13	3,089	16	5,283	27
North Carolina	9,450	314	3	248	79	66	21	1,521	16	1,842	19
North Dakota	665	15	2	12	78	3	22	113	17	78	12
Ohio	11,529	318	3	219	69	99	31	1,968	17	2,314	20
Oklahoma	3,718	115	3	95	83	20	17	624	17	847	23
Oregon	3,809	95	2	64	67	31	33	634	17	561	15
Pennsylvania	12,667	399	3	338	85	61	15	2,368	19	2,294	18
Rhode Island	1,054	40	4	34	85	6	15	189	18	222	21
South Carolina	4,590	148	3	130	88	17	12	785	17	933	20
South Dakota	807	21	3	14	66	7	34	141	17	134	17
Tennessee	6,306	283	4	185	65	98	35	1,090	17	1,497	24
Texas	24,802	627	3	390	62	237	38	3,057	12	4,591	19
Utah	2,723	31	1	28	89	3	11	287	11	328	12
Vermont	625	29	5	20	72	8	28	114	18	185	30
Virginia	7,926	175	2	120	69	55	31	1,167	15	992	13
Washington	6,667	158	2	120	76	38	24	990	15	1,283	19
West Virginia	1,848	81	4	49	61	32	39	397	21	413	22
Wisconsin	5,669	152	3	134	88	18	12	937	17	1,221	22
Wyoming	560	10	2	7	68	3	32	82	15	80	14

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 "Intercensal Estimates of the Resident Population by Single Year of Age and Sex for States and the United States: April 1, 2000 to July 1, 2010" and Medicare and Medicaid enrollment data for MedPAC and MACPAC.*

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Section

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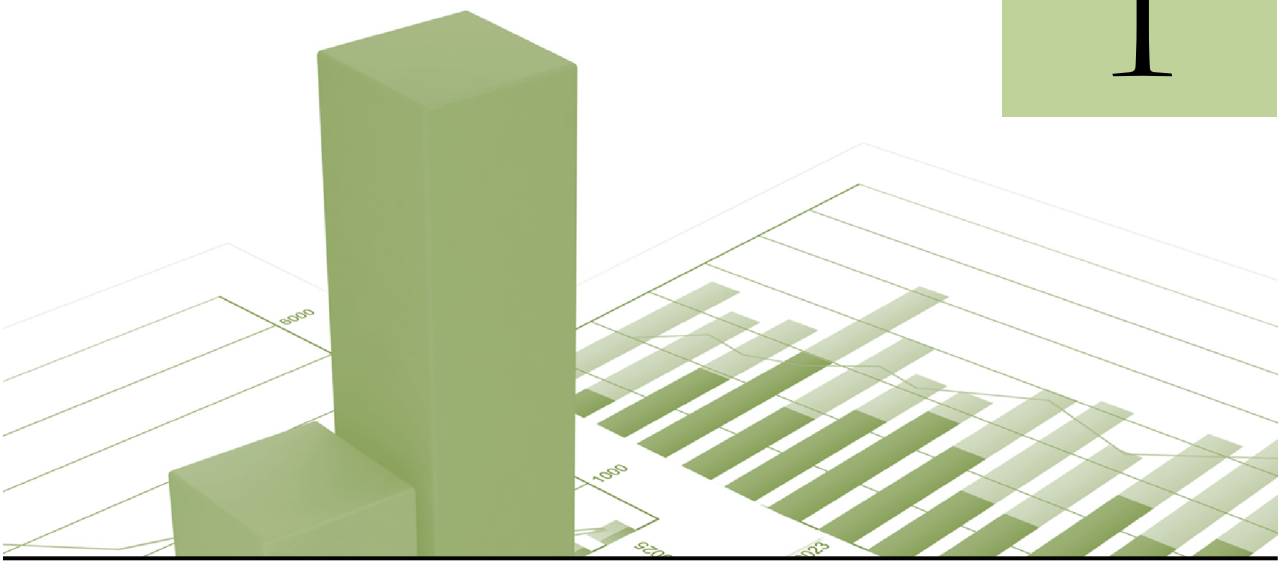


Overview of dual-eligible beneficiaries

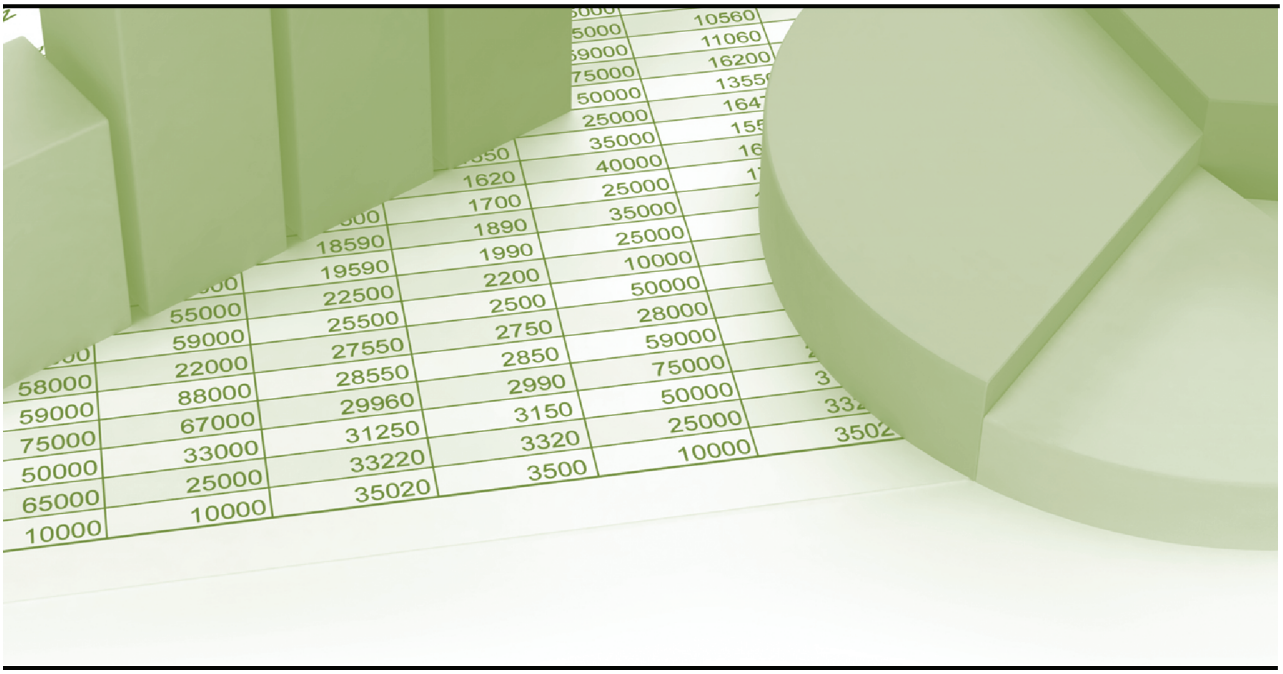
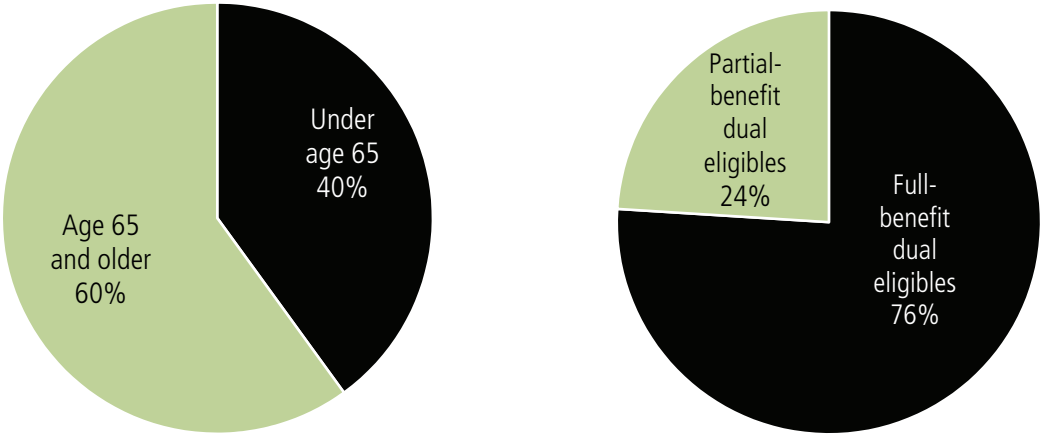


Exhibit 1

Snapshot of dual-eligible beneficiaries by type of benefit, CY 2009

9.2 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 9.2 million individuals were dually eligible for Medicare and Medicaid benefits in at least one month of CY 2009. The majority (60 percent) of dual-eligible beneficiaries were age 65 and older.
- Most dual-eligible beneficiaries (76 percent) were eligible for full Medicaid benefits.

Exhibit 2

Dual-eligible beneficiary enrollment in full- and partial-benefit categories, CY 2009

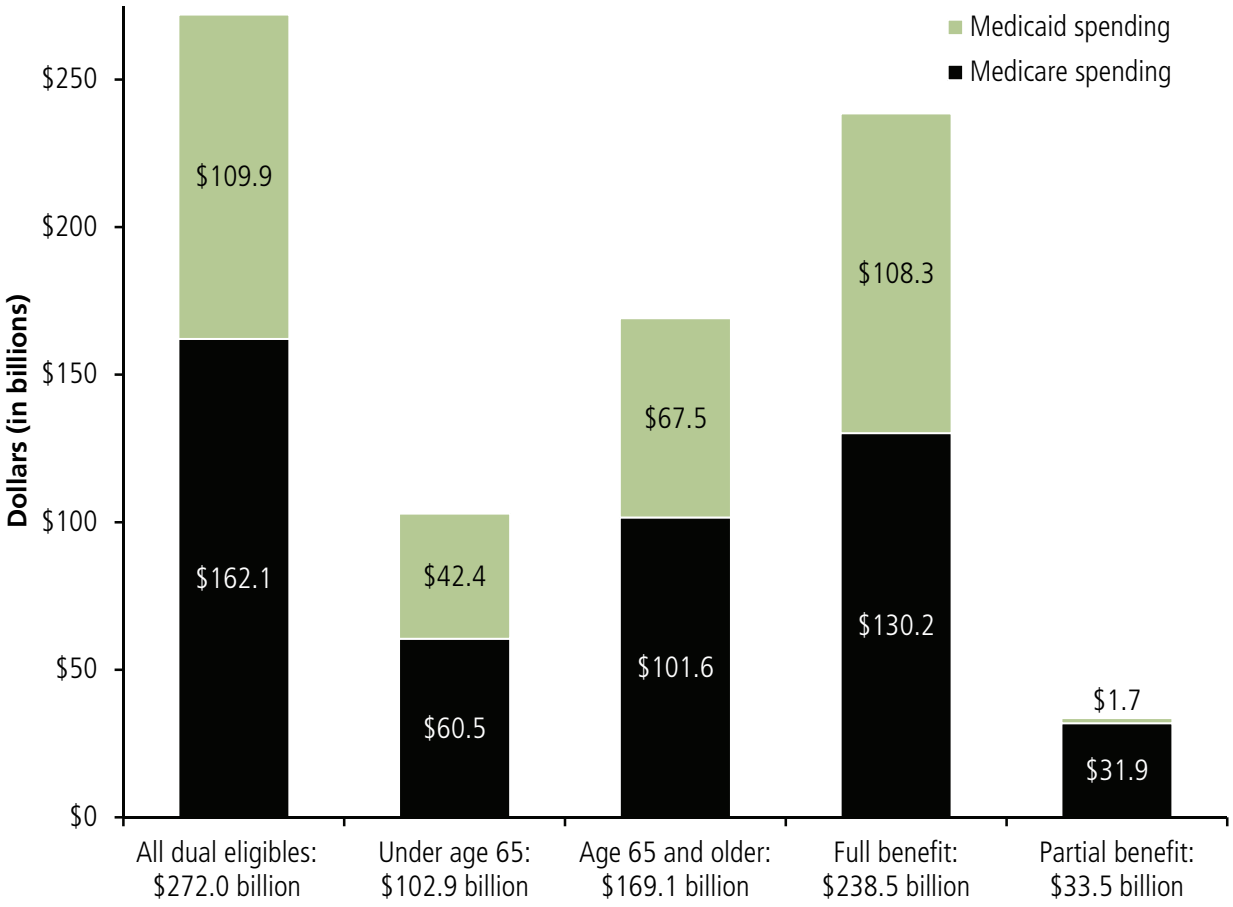
Benefit categories	Dual-eligible beneficiaries		
	All	Under age 65	Age 65 and older
Full-benefit dual-eligible beneficiaries	**76%**	**76%**	**76%**
QMB plus	53	56	52
SLMB plus	3	3	3
Other full-benefit	20	18	22
Partial-benefit dual-eligible beneficiaries	**24**	**24**	**24**
QMB only	11	12	10
SLMB only	8	8	9
QI	5	4	5
QDWI	<1	<1	<1

Note: *CY (calendar year), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualified 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 due to rounding.*

- In CY 2009 over 50 percent of individuals who were dually eligible for both Medicare and Medicaid were QMB-plus beneficiaries with full Medicaid benefits.
- Among the partial-benefit dual-eligible beneficiary categories, the greatest enrollment (11 percent) was in the QMB-only category.

Exhibit 3

Medicare and Medicaid spending on dual-eligible beneficiaries by age and type of benefit, CY 2009

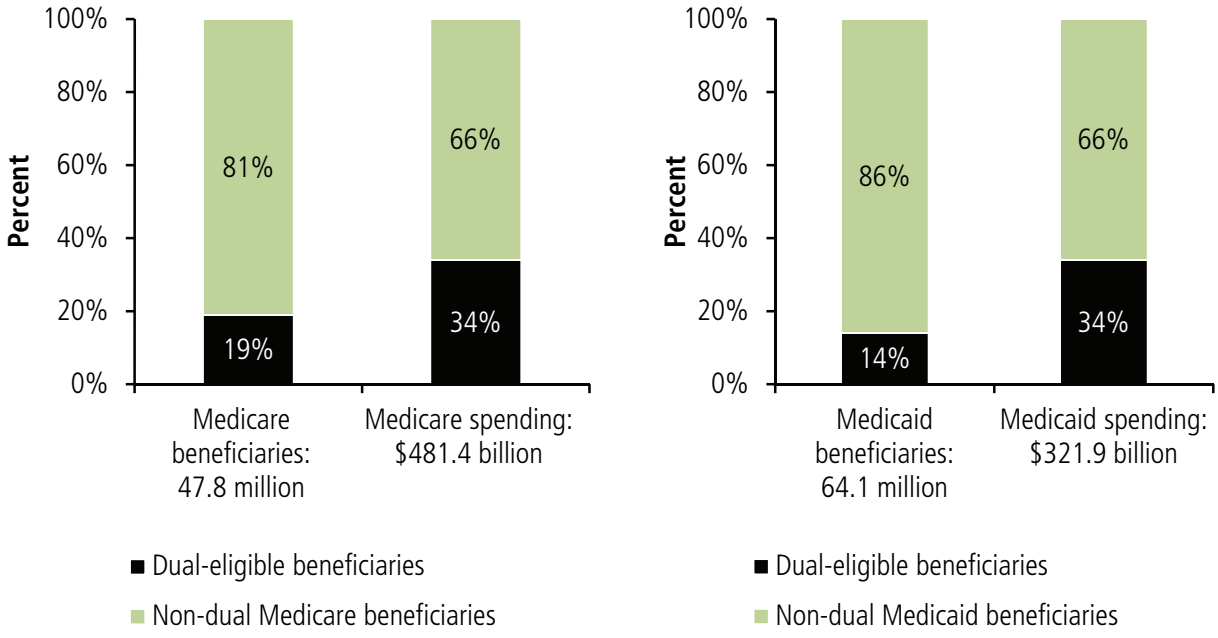


Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Totals may not sum due to rounding. Exhibit excludes administrative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

- Combined Medicare and Medicaid spending on individuals who were dually eligible for both Medicare and Medicaid was $272 billion in CY 2009. Medicare accounted for more than half of combined spending ($162.1 billion).
- By age group, most Medicare and Medicaid spending on dual-eligible beneficiaries was accounted for by beneficiaries age 65 and older ($169.1 billion combined spending).
- Full-benefit dual-eligible beneficiaries represented a higher share of combined spending than partial-benefit dual-eligible beneficiaries ($238.5 billion compared with $33.5 billion, respectively).

Exhibit 4

Dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2009



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 includes enrollment and spending for Medicaid-expansion State Children's Health Insurance Program (CHIP) beneficiaries. Exhibit excludes administrative spending.*

- Individuals dually eligible for Medicare and Medicaid benefits accounted for disproportionate shares of Medicare and Medicaid spending in CY 2009.
- Dual-eligible beneficiaries totaled 19 percent of the Medicare population in 2009 but accounted for 34 percent of Medicare spending.
- Similarly, dual-eligible beneficiaries comprised 14 percent of all Medicaid beneficiaries but accounted for 34 percent of Medicaid spending.

Exhibit 5

Selected subgroups of dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2009

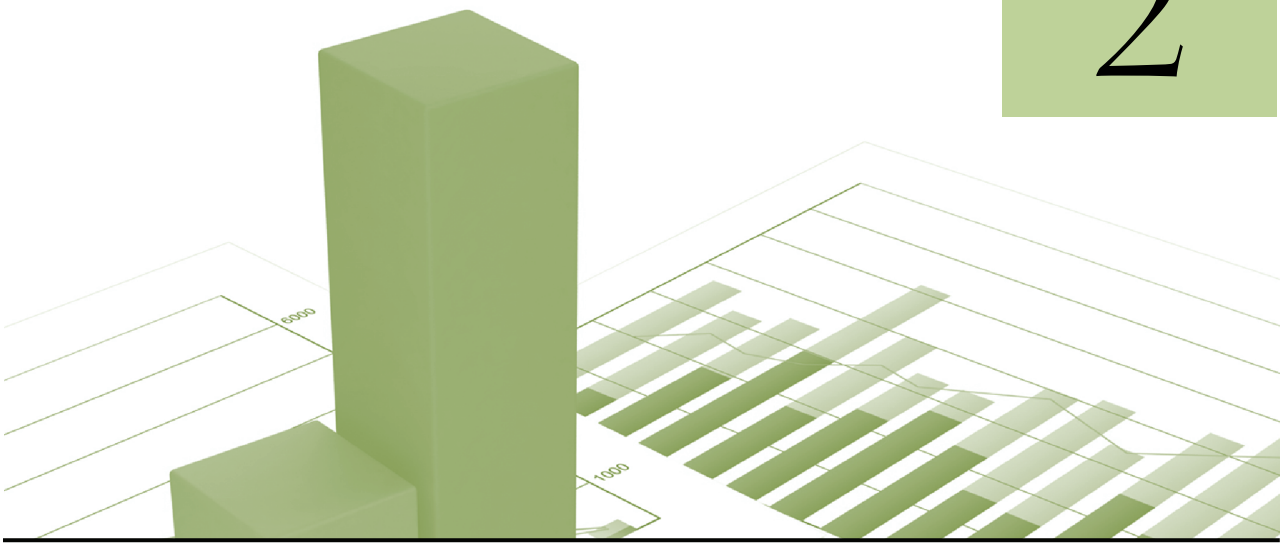
Dual-eligible beneficiary subgroup	Percent of all Medicare beneficiaries	Percent of all Medicare spending	Percent of all Medicaid beneficiaries	Percent of all Medicaid spending
Age				
Under age 65	8%	13%	6%	13%
Age 65 and older	12	21	9	21
Type of benefit				
Full benefit	15%	27%	11%	34%
Partial benefit	5	7	3	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 age 65 and older were 12 percent of the Medicare population in CY 2009 but accounted for 21 percent of Medicare spending. These beneficiaries also accounted for 9 percent of the Medicaid population but 21 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 34 percent of all Medicaid spending.

Section

2



Characteristics of dual-eligible beneficiaries

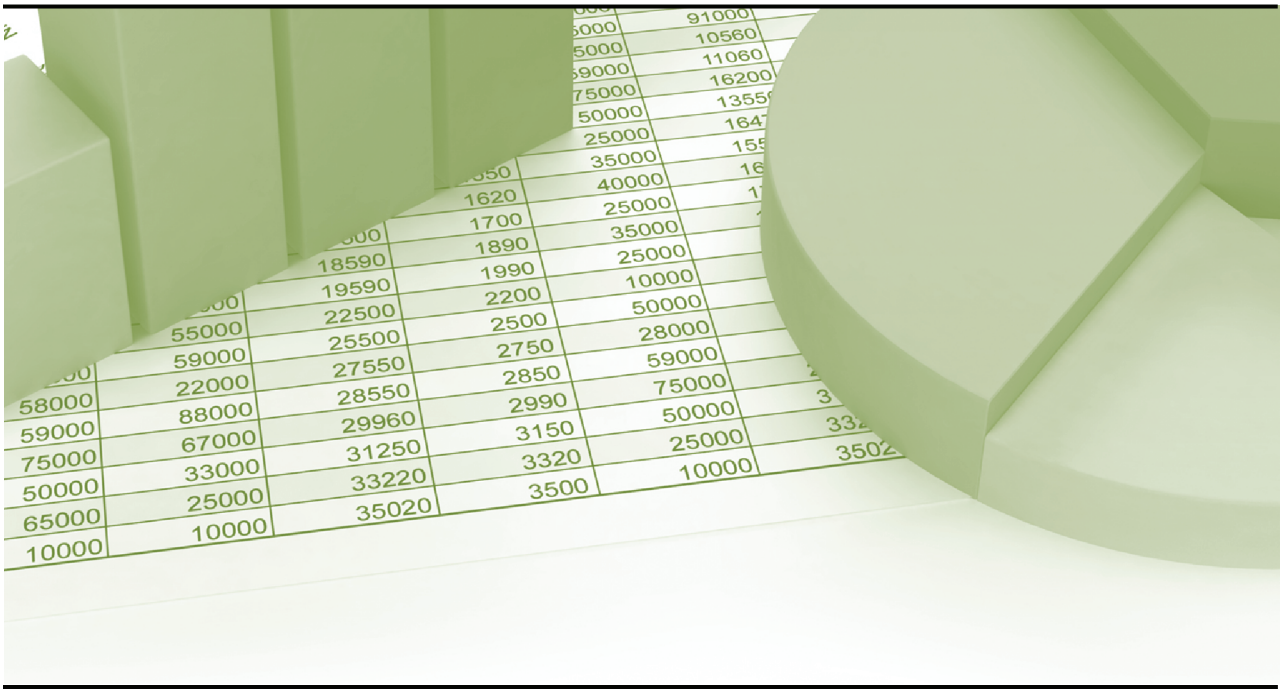


Exhibit 6

Demographic characteristics of dual-eligible and non-dual Medicare and Medicaid beneficiaries, CY 2009

Demographic characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries	Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Age 65 and older	Full benefit	Partial benefit		
Gender							
Male	38%	49%	31%	38%	39%	46%	52%
Female	62	51	69	62	61	54	48
Race/Ethnicity							
White/non-Hispanic	58%	63%	55%	56%	64%	85%	52%
African American/non-Hispanic	20	24	18	20	22	8	31
Hispanic	15	11	18	16	12	5	13
Other	7	3	9	8	2	2	4
Residence							
Urban	75%	73%	76%	77%	68%	76%	76%
Rural	25	27	24	23	32	24	23

Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease) with non-missing demographic characteristics (the share of beneficiaries with missing information was 2 percent or less in all cases with the exception of race/ethnicity for non-dual disabled Medicaid beneficiaries, where the share was 14 percent). The non-dual Medicaid beneficiary category excludes nondisabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries age 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 2009 were female (62 percent), White (58 percent), and lived in an urban area (75 percent).
- Dual-eligible beneficiaries were proportionately more likely to be White (58 percent) than non-dual disabled Medicaid beneficiaries (52 percent) but less likely than non-dual Medicare beneficiaries (85 percent). There were more African American (20 percent) and Hispanic (15 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 age 65 and older to be male (49 percent vs. 31 percent), White (63 percent vs. 55 percent), or African-American (24 percent vs. 18 percent). More of the age 65 and older dual-eligible beneficiaries were Hispanic (18 percent vs. 11 percent).
- Comparing full-benefit and partial-benefit dual-eligible beneficiaries, more of the full-benefit beneficiaries were Hispanic (16 percent vs. 12 percent) or lived in an urban area (77 percent vs. 68 percent).

Exhibit 7

Additional characteristics of dual-eligible beneficiaries, CY 2009

Characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Age 65 and older	Full benefit	Partial benefit	
Limitations in ADLs						
None	46%	50%	44%	38%	66%	75%
1–2 ADL limitations	24	30	20	25	21	17
3–6 ADL limitations	31	20	37	37	13	8
Self-reported health status						
Excellent or very good	19%	17%	20%	17%	24%	46%
Good or fair	62	58	64	62	62	48
Poor	17	22	15	18	15	6
Unknown	2	2	2	3	0	1
Living arrangement						
Institution	22%	12%	27%	28%	4%	5%
Alone	30	30	31	26	41	28
Spouse	16	12	18	14	20	53
Children, nonrelatives, others	32	46	24	31	35	14
Education						
No high school diploma	50%	39%	57%	51%	47%	18%
High school diploma only	27	34	23	25	33	32
Some college	20	26	17	21	19	49
Other	2	2	3	3	0	1

Note: *CY (calendar year), ADL (activity of daily living). Exhibit includes all dual-eligible 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: *2009 Medicare Current Beneficiary Survey.*

- More than half (55 percent) of individuals dually eligible for Medicare and Medicaid benefits in CY 2009 had at least one limitation with an ADL. Half of the dual-eligible population did not graduate from high school.
- Compared to 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 (22 percent vs. 5 percent).
- Dual-eligible beneficiaries age 65 and older had more ADL limitations than those under age 65 (37 percent with 3 to 6 ADL limitations vs. 20 percent with 3 to 6 ADL limitations). Dual-eligible beneficiaries age 65 and older were also more likely than the younger dual-eligible beneficiaries to live in an institution (27 percent vs. 12 percent). More of the under age 65 dual-eligible beneficiaries reported being in poor health (22 percent vs. 15 percent).
- Between full-benefit and partial-benefit dual-eligible beneficiaries, more of the partial-benefit beneficiaries had no ADL limitations (66 percent vs. 38 percent). More than one-quarter (28 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 dual-eligible beneficiaries under age 65 and age 65 and older, CY 2009

Condition	FFS dual-eligible beneficiaries	
	Under age 65	Age 65 and older
Cognitive impairment		
Alzheimer's disease or related dementia	4%	23%
Intellectual disabilities and related conditions	8	1
Medical conditions		
Diabetes	22%	34%
Heart failure	8	24
Hypertension	38	66
Ischemic heart disease	14	35
Behavioral health conditions		
Anxiety disorders	18%	10%
Bipolar disorder	13	2
Depression	29	19
Schizophrenia and other psychotic disorders	14	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 fee-for-service claims are not available for these 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 among those under age 65 versus those age 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. 4 percent). More of the under age 65 population had an intellectual disability (8 percent vs. 1 percent).
- Compared to the under age 65 population, the age 65 and older population generally had higher rates of medical conditions, including diabetes, hypertension, heart failure, and ischemic heart disease.
- Behavioral health conditions—anxiety disorders, bipolar disorder, depression, and schizophrenia and other psychotic disorders—were consistently more common among the under age 65 dual-eligible population than among dual-eligible beneficiaries age 65 and older.

Section

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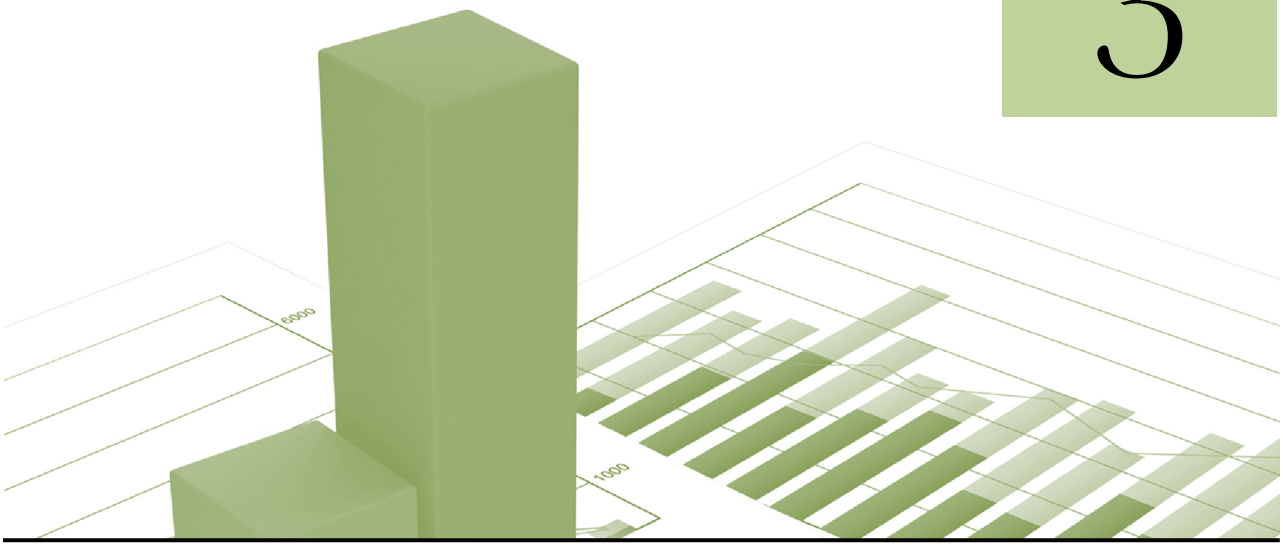

Eligibility pathways, managed care enrollment, and continuity of enrollment

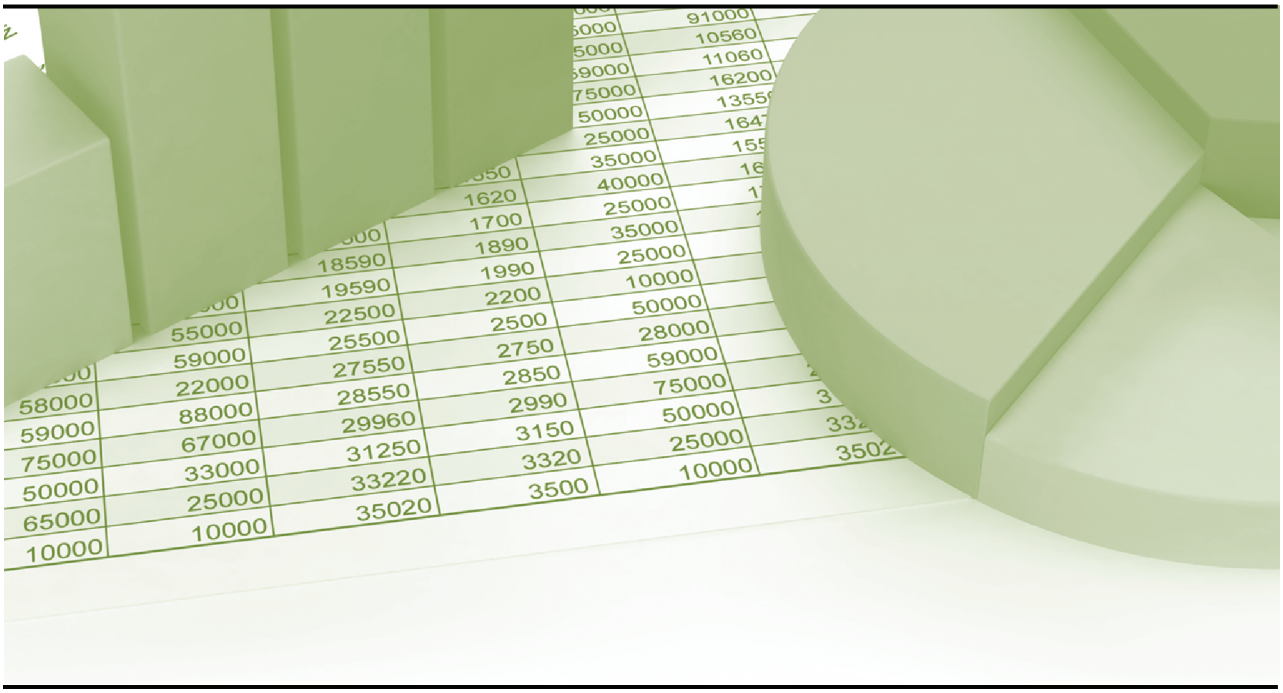

Exhibit 9

Medicare eligibility pathways, CY 2009

Original reason for entitlement to Medicare	Dual-eligible beneficiaries			Non-dual Medicare beneficiaries
	All	Full benefit	Partial benefit	
Age	49%	50%	46%	83%
ESRD	1	1	1	<1
Disability	50	49	53	17
Based on own record	77	73	88	93
Based on another's record	23	27	12	7

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

- Overall, individuals dually eligible for Medicare and Medicaid benefits in CY 2009 were nearly split between those who originally qualified for Medicare benefits based on age (49 percent) and those who qualified for Medicare benefits based on disability (50 percent).
- In contrast to dual-eligible beneficiaries, most non-dual Medicare beneficiaries (83 percent) originally qualified for Medicare benefits based on their age.
- Most (73 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 (88 percent) of partial-benefit dual-eligible beneficiaries who originally qualified for Medicare benefits due to disability did so based on their own record.
- The remaining dual-eligible beneficiaries (27 percent among those with full benefits and 12 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 age 18 or older who have been disabled since childhood.

Exhibit 10

Medicaid eligibility pathways, CY 2009

Medicaid eligibility group	Dual-eligible beneficiaries			Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Age 65 and older	
SSI	39%	40%	37%	82%
Poverty-related	33	36	32	4
Medically needy	8	6	10	5
Section 1115 waiver	1	1	<1	1
Special income limit and other	19	17	21	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 age 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 2009 qualified for Medicaid benefits through the SSI program (39 percent) or through poverty-related eligibility pathways (33 percent).
- In contrast to dual-eligible beneficiaries, most non-dual disabled Medicaid beneficiaries (82 percent) qualified for Medicaid benefits through the SSI program.
- Compared to those under age 65, dual-eligible beneficiaries age 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 2009

Type of Medicare enrollment	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Age 65 and older	Full benefit	Partial benefit	
FFS only	79%	85%	76%	83%	69%	75%
MA only	16	11	20	13	26	23
Both FFS and MA	4	4	4	4	5	2

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

- In CY 2009 most (79 percent) of individuals dually eligible for Medicare and Medicaid services were enrolled only in Medicare FFS.
- Non-dual Medicare beneficiaries had higher enrollment in only the MA program than dual-eligible beneficiaries (16 percent vs. 23 percent).
- Dual-eligible beneficiaries age 65 and older were more likely to be enrolled in only an MA plan compared with those under age 65 (20 percent vs. 11 percent).
- Partial-benefit dual-eligible beneficiaries were more likely to be enrolled in only an MA plan than full-benefit beneficiaries (26 percent vs. 13 percent), while full-benefit beneficiaries were more likely to be only in FFS (83 percent vs. 69 percent).

Exhibit 12

Medicaid fee-for-service and managed care enrollment, CY 2009

Type of Medicaid enrollment	Dual-eligible beneficiaries					Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Age 65 and older	Full benefit	Partial benefit	
FFS only	58%	57%	59%	47%	92%	27%
FFS and limited-benefit managed care only	30	30	31	38	4	35
At least one month of comprehensive managed care	12	13	11	14	4	37

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 age 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 2009 were either enrolled only in Medicaid FFS (58 percent) or only in Medicaid FFS and a limited-benefit Medicaid managed care plan (30 percent).
- Non-dual disabled Medicaid beneficiaries were more likely than dual-eligible beneficiaries to have at least one month of enrollment in a comprehensive managed care plan (37 percent vs. 12 percent) and less likely to be enrolled in only Medicaid FFS (27 percent vs. 58 percent).
- Dual-eligible beneficiaries under age 65 and age 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 2009

Enrollment status	Dual-eligible beneficiaries				
	All	Under age 65	Age 65 and older	Full benefit	Partial benefit
Had dual-eligible status for all 12 months of the year					
	77%	77%	76%	78%	73%
Switched between full and partial status during the year					
	5	6	4	3	11
Became dually eligible during the year					
	12	12	11	11	13
Of those who became dually eligible during the year, percent of:					
Medicare beneficiaries who gained Medicaid coverage	58	35	75	53	73
Medicaid beneficiaries who gained Medicare coverage	38	63	21	45	21
Individuals who gained Medicare and Medicaid coverage simultaneously	3	2	4	2	6

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 (77 percent) were dual-eligible beneficiaries during every month of CY 2009.
- Only 5 percent of all dual-eligible beneficiaries in 2009 switched between full-benefit and partial-benefit dual-eligible status.
- Twelve percent of dual-eligible beneficiaries first became dually eligible during 2009. Among these individuals, more than half (58 percent) were non-dual Medicare beneficiaries who subsequently gained Medicaid coverage.
- Among beneficiaries who became dually eligible during 2009, those under age 65 were more likely to have been non-dual Medicaid beneficiaries before they became dual-eligible beneficiaries (63 percent). Those age 65 and older were more likely to have been non-dual Medicare beneficiaries before becoming dual-eligible beneficiaries (75 percent).
- Full-benefit beneficiaries who became dually eligible during the year were almost equally split between those who were non-dual Medicare beneficiaries first (53 percent) and those who were non-dual disabled Medicaid beneficiaries first (45 percent).

Section

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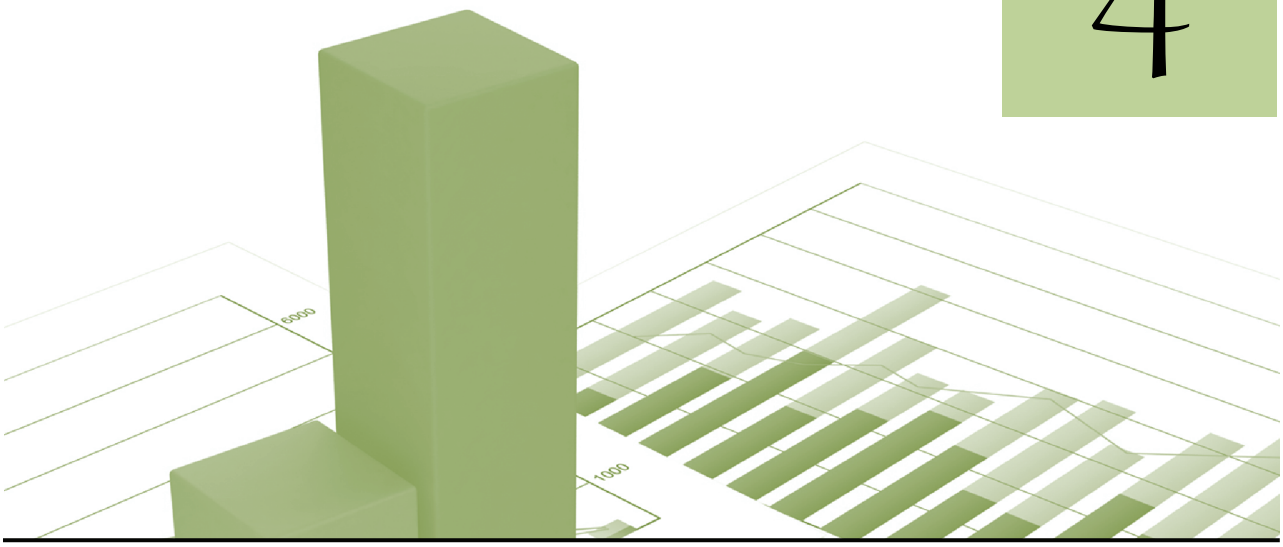

Dual-eligible beneficiaries' utilization of Medicare and Medicaid services

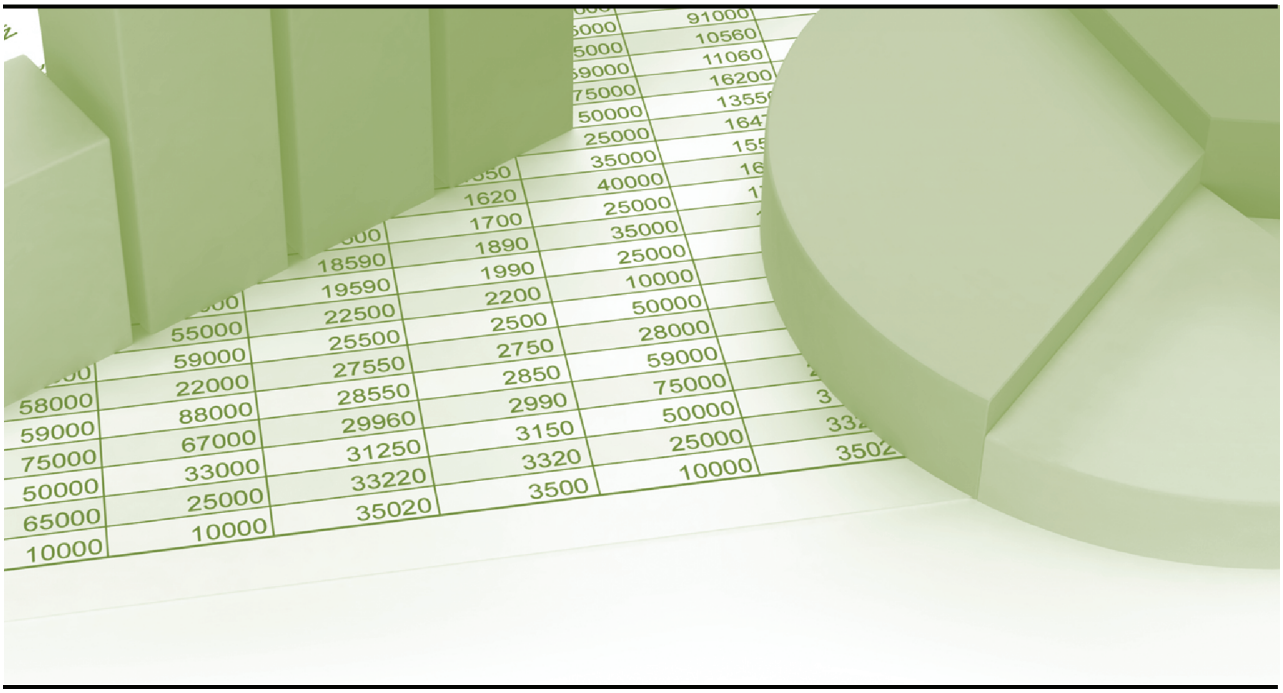

Exhibit 14

Use of Medicare services and per user spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2009

Selected FFS Medicare services	Full-benefit FFS dual-eligible beneficiaries			Full-benefit 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%	$18,134	29%	18%	$15,049	33%
Skilled nursing facility	11	16,594	10	4	12,899	7
Home health	14	6,631	5	9	4,883	5
Other outpatient	94	5,588	30	92	4,048	45

Note: *FFS (fee-for-service), CY (calendar year). 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. The "percent of total spending" columns do not sum to 100 because spending is shown only for selected services. Exhibit excludes administrative spending.*

- Individuals dually eligible for Medicare and Medicaid services in CY 2009 had higher use of certain FFS Medicare services (inpatient hospital, skilled nursing facility, home health, and other outpatient services) than non-dual Medicare beneficiaries.
- The greatest percentage point difference in FFS utilization was for inpatient hospital services. Twenty-eight percent of dual-eligible beneficiaries used FFS inpatient hospital services in 2009 compared with 18 percent of 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 (10 percent vs. 7 percent).

Exhibit 15

Use of Medicaid services and per user spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2009

Selected FFS 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%	$2,187	2%	18%	$21,538	21%
Outpatient	87	2,418	12	87	5,372	25
Institutional LTSS	22	40,449	51	5	55,245	14
HCBS state plan	15	10,078	9	11	9,282	6
HCBS waiver	13	28,510	22	9	29,775	14

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 "outpatient" includes all Medicaid services that are not inpatient, LTSS (institutional or HCBS), drugs, or managed care (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. The "percent of total spending" columns do not sum to 100 because spending is shown only for selected services. Exhibit excludes administrative spending.*

- Compared to non-dual disabled Medicaid beneficiaries, individuals dually eligible for Medicare and Medicaid had higher use of FFS Medicaid-covered institutional LTSS (22 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 (51 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 ($55,245 for non-dual disabled Medicaid beneficiaries vs. $40,449 for dual-eligible beneficiaries).
- A higher portion of FFS dual-eligible beneficiaries used Medicaid HCBS services through a state plan than through an HCBS waiver (15 percent vs. 13 percent). However, Medicaid FFS per user spending was higher for HCBS waiver services than for state plan HCBS services ($28,510 vs. $10,078), and HCBS waiver services accounted for a higher portion of Medicaid FFS spending on dual-eligible beneficiaries than state plan HCBS services (22 percent vs. 9 percent).

Exhibit 16

Use of Medicare and Medicaid services and per user spending for FFS dual-eligible beneficiaries under/over age 65, CY 2009

Selected FFS services	Full-benefit FFS dual-eligible beneficiaries under age 65			Full-benefit FFS dual-eligible beneficiaries age 65 and older		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
Medicare services						
Inpatient hospital	23%	$18,570	28%	32%	$17,909	29%
Skilled nursing facility	4	15,644	4	16	16,749	13
Home health	8	5,802	3	18	6,908	6
Other outpatient	92	4,738	29	96	6,186	30
Medicaid services						
Inpatient hospital	13%	$2,875	2%	14%	$1,730	1%
Outpatient	90	2,762	15	85	2,152	11
Institutional LTSS	8	65,064	33	31	35,622	64
HCBS state plan	12	8,053	6	17	11,095	11
HCBS waiver	16	41,284	39	11	15,274	10

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 (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.*

- Individuals dually eligible for Medicare and Medicaid services who were age 65 and older in CY 2009 had higher use of Medicare FFS services—inpatient hospital, skilled nursing facility, home health, and other outpatient 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. Sixteen percent of dual-eligible beneficiaries age 65 and older used FFS skilled nursing facility services compared with 4 percent of those under age 65. Per user FFS Medicare spending was also higher for the age 65 and older dual-eligible population compared to those under age 65 for all Medicare services except inpatient hospital.
- Compared with those age 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 the 65 and older FFS dual-eligible beneficiaries compared with those under the age of 65 (64 percent vs. 33 percent).

Section

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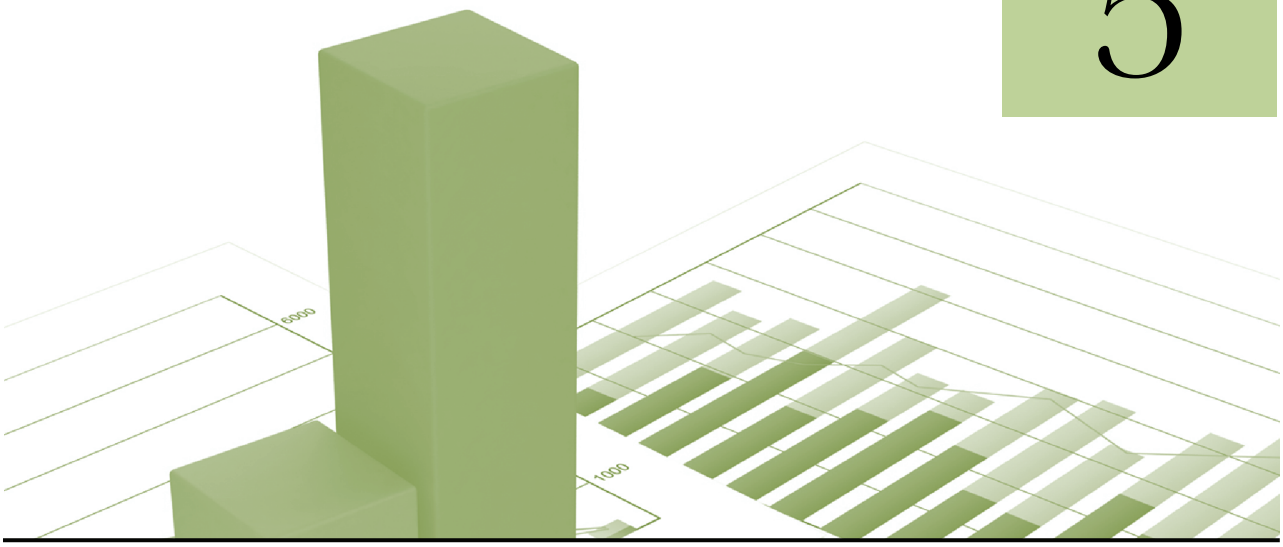


Characteristics of high-cost dual-eligible beneficiaries

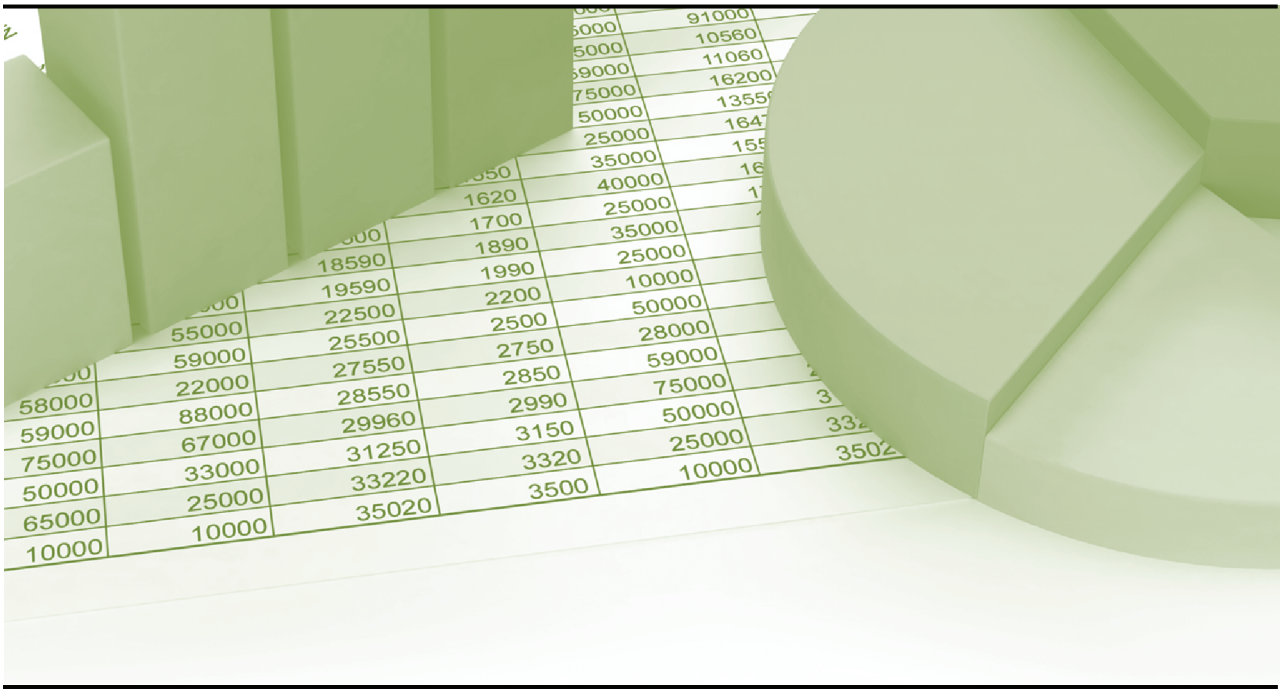
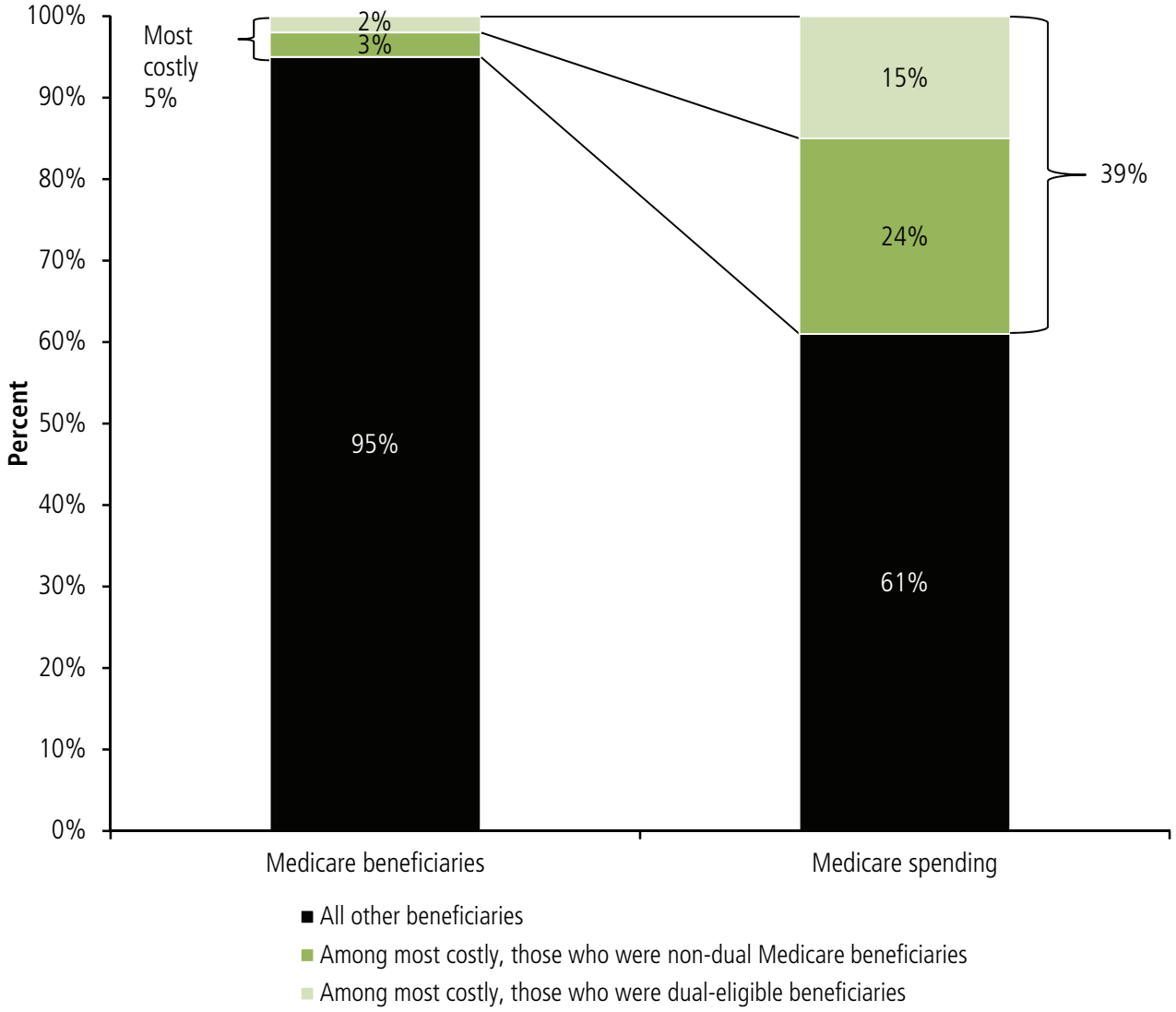


Exhibit 17

High-cost FFS Medicare beneficiaries, CY 2009

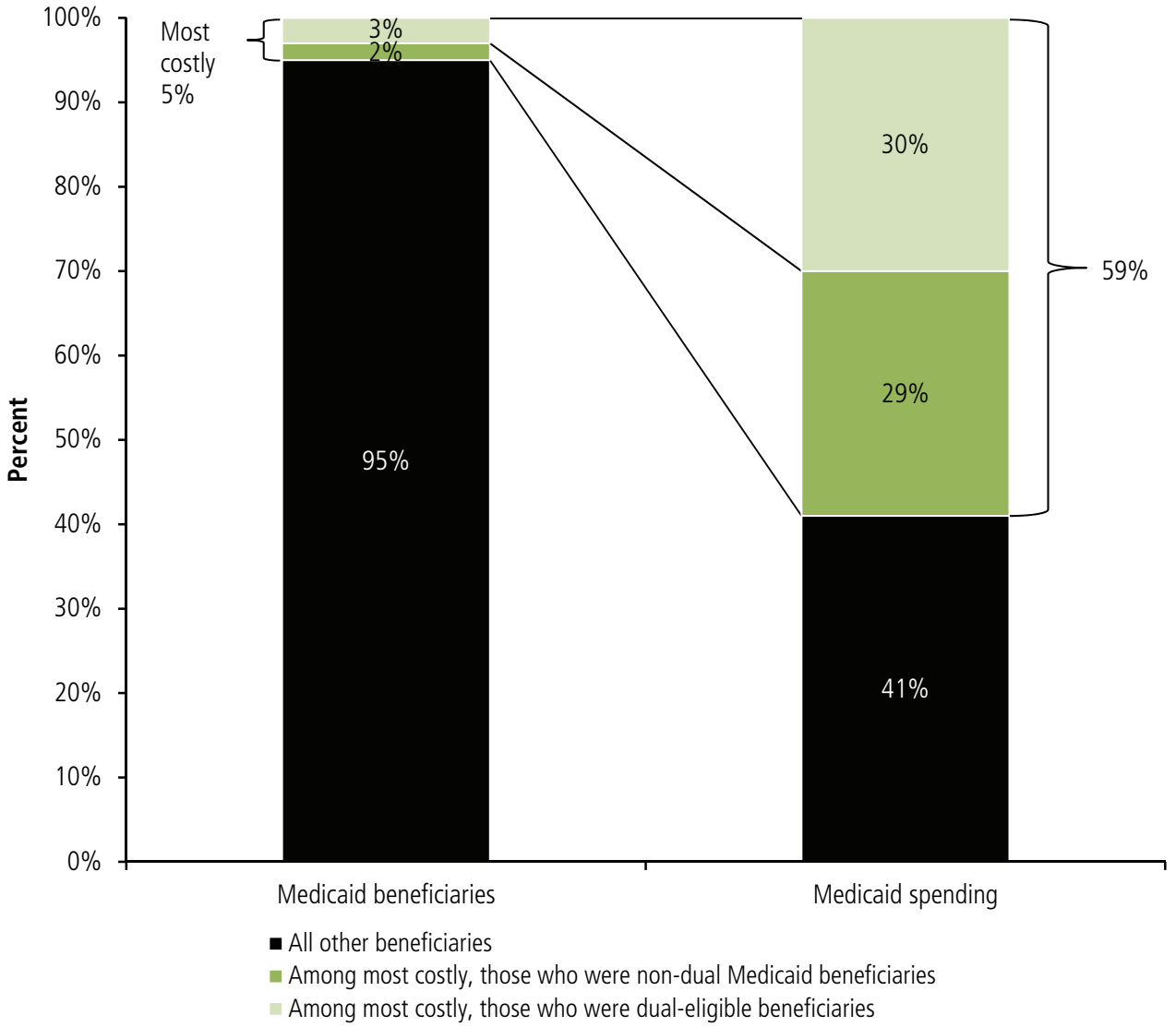


Note: *FFS (fee-for-service), CY (calendar year). Exhibit is limited to beneficiaries in Medicare fee-for-service. End-stage renal disease is excluded. Exhibit excludes administrative spending.*

- In CY 2009, Medicare beneficiaries in the top 5 percent of Medicare FFS spending accounted for 39 percent of Medicare spending on FFS beneficiaries.
- Medicare beneficiaries in the top 5 percent of Medicare FFS spending consisted of dual-eligible beneficiaries and non-dual Medicare beneficiaries. Nearly half of the most costly 5 percent were dual-eligible beneficiaries. These individuals accounted for 15 percent of Medicare spending on FFS beneficiaries in 2009.

Exhibit 18

High-cost FFS Medicaid beneficiaries, CY 2009



Note: *FFS (fee-for-service), CY (calendar year). Exhibit is limited to beneficiaries in 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.*

- In CY 2009 Medicaid FFS beneficiaries in the top 5 percent of spending accounted for almost 60 percent of Medicaid spending on FFS beneficiaries for that year.
- Slightly more than half of the Medicaid FFS beneficiaries in the top 5 percent of spending were dual-eligible beneficiaries; these individuals accounted for 30 percent of all Medicaid spending on FFS beneficiaries.

Exhibit 19

Most costly FFS dual-eligible beneficiaries for Medicare and Medicaid, CY 2009

Most costly FFS dual-eligible beneficiaries for:	Number of beneficiaries	Percent of all Medicare spending on FFS dual-eligible beneficiaries	Percent of all Medicaid spending on FFS dual-eligible beneficiaries	Per capita Medicare spending	Per capita Medicaid spending
Medicare	303,857	31%	8%	$102,935	$20,705
Medicaid	303,857	6	39	20,466	103,291
Both Medicare and Medicaid	17,759	2	2	123,323	101,657

Note: *FFS (fee-for-service), CY (calendar year). Exhibit is limited to dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. "Most costly FFS dual-eligible beneficiaries" is defined as the top 5 percent of Medicare or Medicaid costs. The "both Medicare and Medicaid" group consists of individuals who were in the group of most costly FFS dual-eligible beneficiaries for Medicare and in the group of most costly dual-eligible beneficiaries for Medicaid. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending.*

- The most costly FFS dual-eligible beneficiaries for Medicare (top 5 percent) accounted for a disproportionate share of all Medicare spending on FFS dual-eligible beneficiaries in CY 2009 (31 percent) but not of Medicaid spending (8 percent).
- The inverse is true for the FFS dual-eligible beneficiaries who were most costly to the Medicaid program. These individuals accounted for 39 percent of all Medicaid spending on FFS dual-eligible beneficiaries in 2009 but only 6 percent of Medicare spending.
- Few FFS dual-eligible beneficiaries (17,759) were costly to both Medicare and Medicaid in 2009. These individuals accounted for 2 percent of all Medicare spending and 2 percent of all Medicaid spending on FFS dual-eligible beneficiaries. They also had high Medicare and Medicaid per capita spending ($123,323 and $101,657, respectively).

Exhibit 20

Selected conditions for most costly FFS dual-eligible beneficiaries for Medicare and Medicaid, CY 2009

Condition	Most costly FFS dual-eligible beneficiaries for:		
	Medicare	Medicaid	Both Medicare and Medicaid
Cognitive impairment			
Alzheimer's disease or related dementia	29%	38%	45%
Intellectual disabilities and related conditions	3	31	15
Medical conditions			
Anemia	62%	39%	69%
Diabetes	45	28	48
Heart failure	45	23	50
Hypertension	72	48	71
Ischemic heart disease	50	27	52
Behavioral health conditions			
Anxiety disorders	23%	15%	21%
Bipolar disorder	12	10	14
Depression	45	29	44
Schizophrenia and other psychotic disorders	18	18	24

Note: *FFS (fee-for-service), CY (calendar year). Chronic conditions are identified using Medicare FFS claims. Exhibit is limited to dual-eligible beneficiaries in Medicare and Medicaid FFS. Beneficiaries with end-stage renal disease are excluded. The most costly dual-eligible beneficiaries are defined as the top 5 percent of Medicare or Medicaid costs. The "both Medicare and Medicaid" group consists of individuals who were in the group of most costly dual-eligible beneficiaries for Medicare and in the group of most costly dual-eligible beneficiaries for Medicaid. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums.*

- Individuals dually eligible for Medicare and Medicaid who were high cost to the Medicare program in 2009 had high proportions of medical conditions, including hypertension (72 percent), anemia (62 percent), and ischemic heart disease (50 percent), that generally require Medicare-covered acute-care services.
- Dual-eligible beneficiaries who were costly to Medicaid had high proportions of cognitive impairment—38 percent had Alzheimer's disease or related dementia and 31 percent had intellectual disabilities and related conditions. These conditions generally require Medicaid-covered LTSS services.
- The presence of Alzheimer's disease or related dementia is associated with increased Medicare and Medicaid spending (Exhibit 25 and Exhibit 26). Almost half (45 percent) of dual-eligible beneficiaries who were costly to both programs had these conditions.
- Dual-eligible beneficiaries who were costly to Medicare had higher proportions of behavioral health conditions than dual-eligible beneficiaries who were costly to Medicaid.

Exhibit 21

Use of services and per user spending for most costly FFS dual-eligible beneficiaries for Medicare and Medicaid, CY 2009

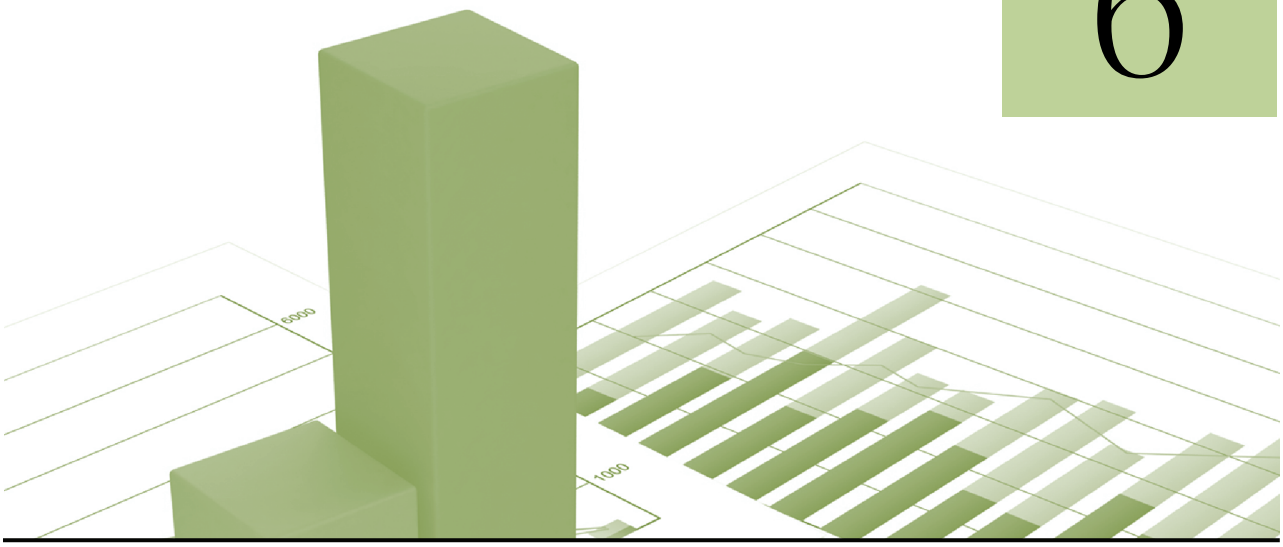
Selected services	Most costly FFS dual-eligible beneficiaries for Medicare			Most costly FFS dual-eligible beneficiaries for Medicaid			Dual-eligible beneficiaries costly for Medicare and Medicaid		
	Percent using services	Per user spending	Percent of total spending	Percent using services	Per user spending	Percent of total spending	Percent using services	Per user spending	Percent of total spending
Medicare services									
Inpatient hospital	94%	$48,425	44%	25%	$22,447	28%	93%	$62,855	48%
Skilled nursing facility	57	24,254	13	10	14,766	7	52	23,752	10
Home health	53	10,335	5	6	6,549	2	27	9,775	2
Other outpatient	100	21,806	21	99	6,445	31	100	31,458	26
Medicaid services									
Inpatient hospital	41%	$3,869	8%	18%	$9,366	2%	69%	$18,214	12%
Outpatient	85	4,278	18	94	6,403	6	98	14,182	14
Institutional LTSS	44	23,985	50	60	94,019	54	69	70,980	48
HCBS state plan	21	10,272	10	16	37,210	6	33	37,888	12
HCBS waiver	15	13,815	10	33	97,503	31	17	67,568	11

Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Exhibit is limited to dual-eligible beneficiaries in Medicare and Medicaid FFS. Beneficiaries with end-stage renal disease are excluded. Most costly dual-eligible beneficiaries are defined as the top 5 percent of Medicare or Medicaid costs. 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 (for FFS beneficiaries in limited-benefit plans). The group of dual-eligible beneficiaries costly to Medicare and Medicaid consists of individuals who were in the group of most costly dual-eligible beneficiaries for Medicare and the group of most costly dual-eligible beneficiaries for Medicaid group. 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.*

- Individuals dually eligible for Medicare and Medicaid benefits who were high cost to the Medicare program in CY 2009 incurred high utilization (over 50 percent) of Medicare-covered inpatient hospital, skilled nursing facility, home health, and outpatient services.
- More than half (60 percent) of dual-eligible beneficiaries who were most costly to the Medicaid program used Medicaid-covered institutional LTSS services at a per user cost of $94,019. About one-third (33 percent) used Medicaid HCBS waiver services at a per user Medicaid cost of $97,503.

Section

6



Medicare and Medicaid spending on selected dual-eligible populations: LTSS and Alzheimer's disease or related dementia

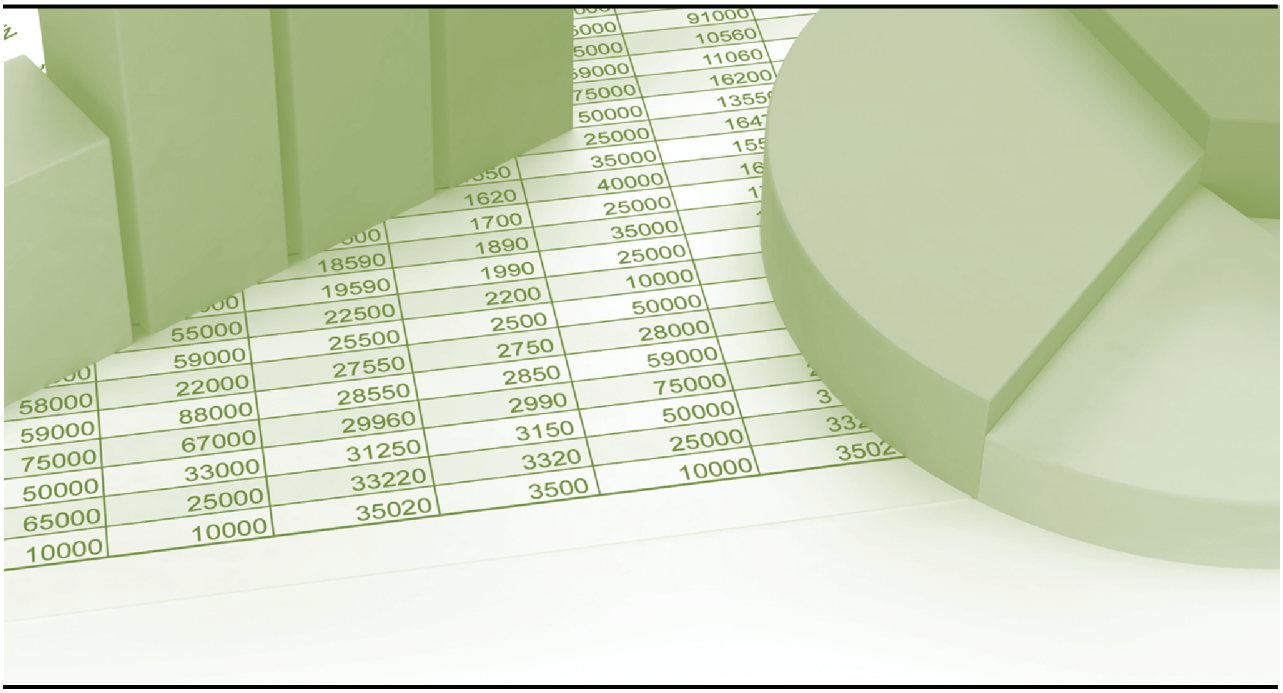
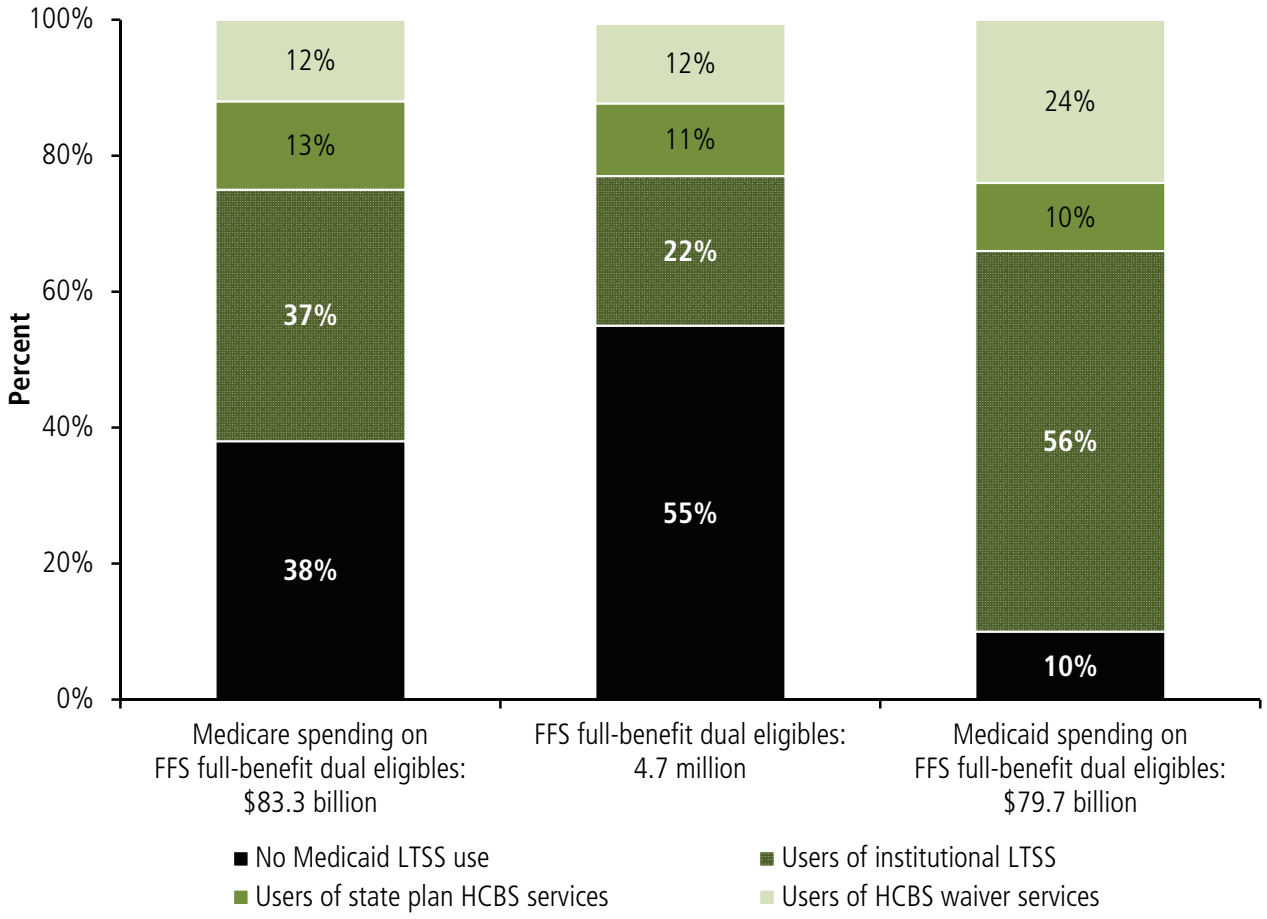


Exhibit 22

Medicare and Medicaid spending on FFS full-benefit dual-eligible users of Medicaid LTSS services, CY 2009

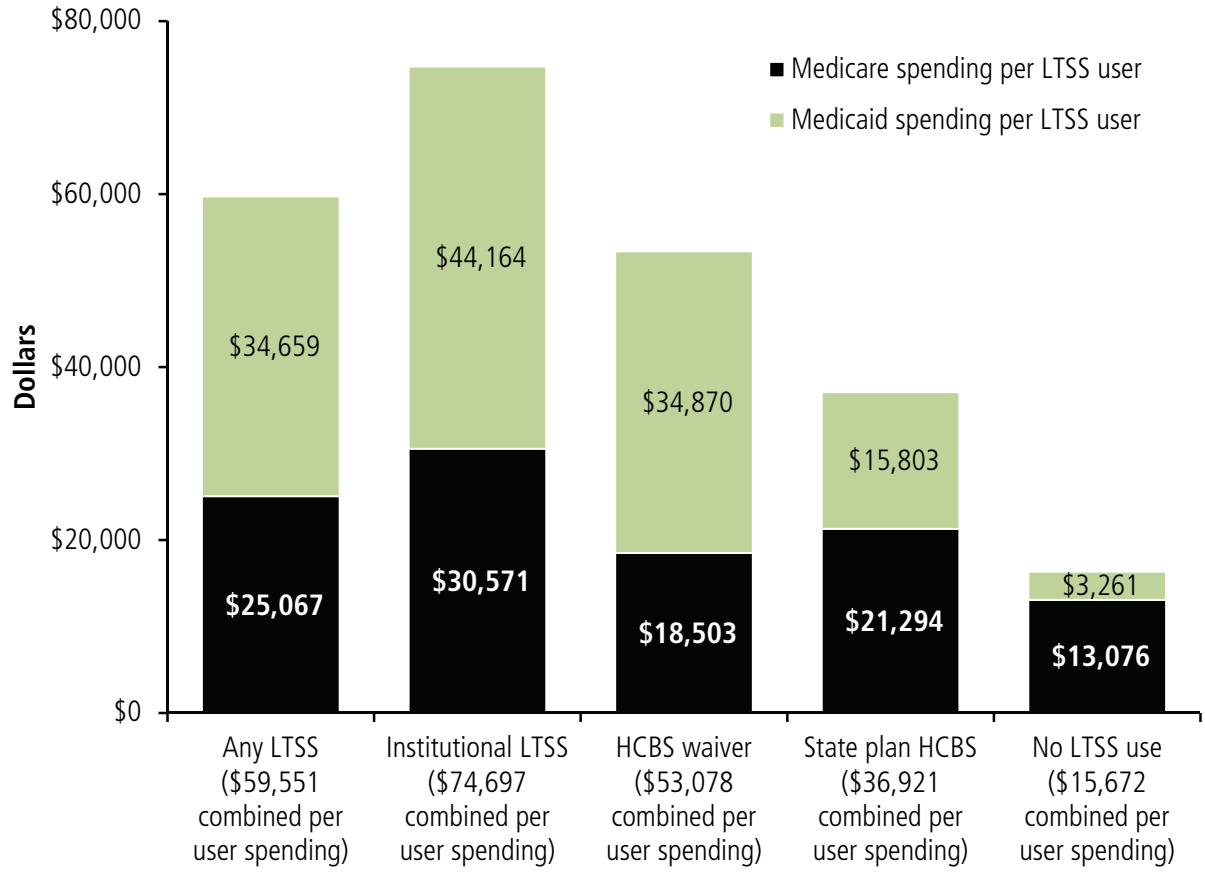


Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible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

- 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 2009, the majority (55 percent) of FFS full-benefit dual-eligible beneficiaries did not use Medicaid LTSS services. However, nearly a quarter (22 percent) of FFS full-benefit dual-eligible beneficiaries used Medicaid-covered institutional LTSS care.
- The 22 percent of FFS full-benefit dual-eligible beneficiaries who used Medicaid-covered institutional LTSS services accounted for 37 percent of Medicare spending on FFS full-benefit dual-eligible beneficiaries and more than half (56 percent) of Medicaid spending on FFS full-benefit dual-eligible beneficiaries.

Exhibit 23

Per user Medicare and Medicaid spending on FFS full-benefit dual-eligible Medicaid LTSS users and non-users, CY 2009

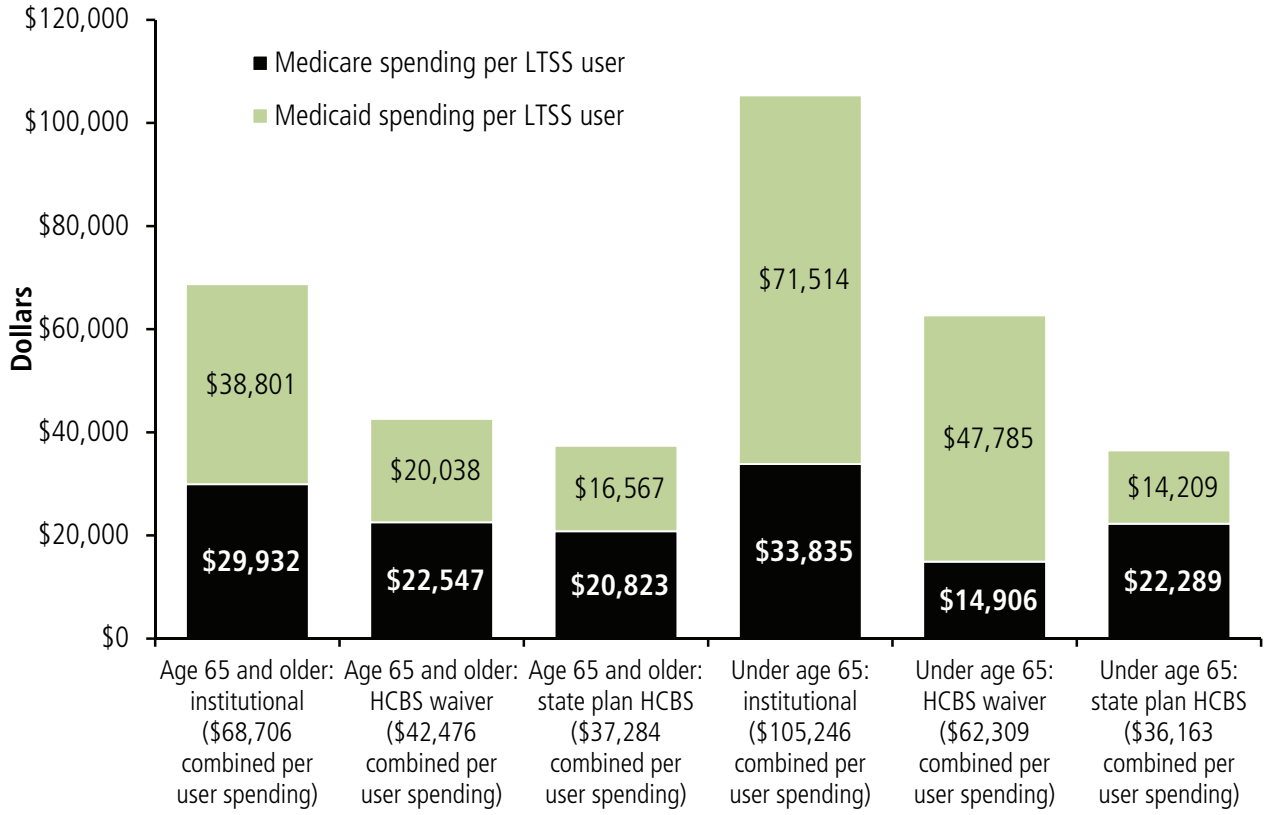


Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible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

- Users of Medicaid-covered institutional LTSS services (22 percent of full-benefit dual-eligible beneficiaries, see Exhibit 22) had the highest Medicare and Medicaid per LTSS user spending in CY 2009 ($30,571 and $44,164 respectively) compared to users of other types of Medicaid LTSS services and non-LTSS users.
- Medicare and Medicaid per LTSS user spending on any type of Medicaid LTSS use (institutional, HCBS waiver, or state plan HCBS services) was higher than per user spending on non-LTSS users.
- Medicaid per LTSS user spending was generally higher than Medicare per LTSS user spending for Medicaid LTSS users (with the exception of users of state plan HCBS). However, Medicare per LTSS user spending exceeded Medicaid per LTSS user spending for non-LTSS users.

Exhibit 24

Per user Medicare and Medicaid spending on FFS full-benefit dual-eligible Medicaid LTSS users by age, CY 2009

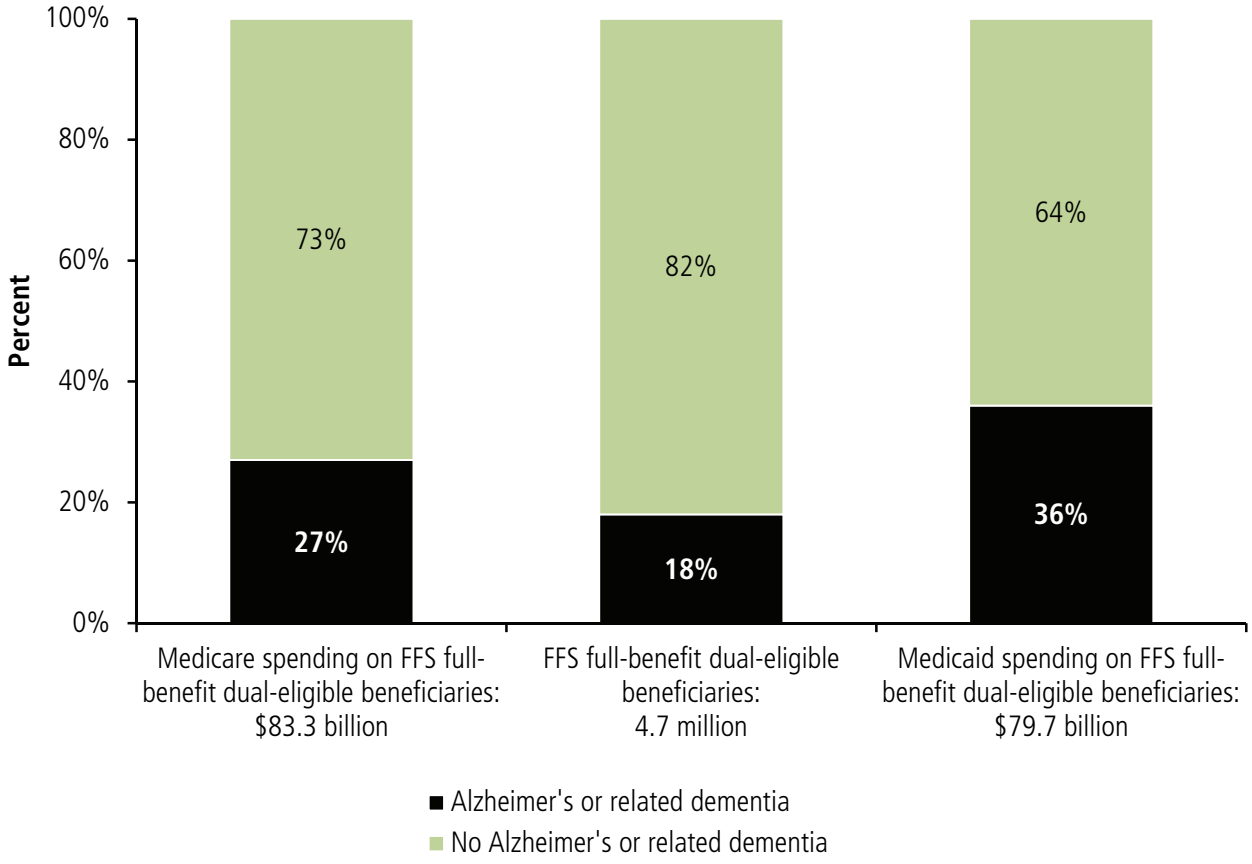


Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible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

- Among Medicaid LTSS users who were age 65 and older, Medicare and Medicaid per LTSS user spending was higher for those who received Medicaid-covered LTSS in an institution ($29,932 vs. $38,801) than for those who received Medicaid LTSS in the community through HCBS waivers ($22,547 vs. $20,038) or through state plan HCBS services ($20,823 vs. $16,567).
- Among Medicaid LTSS users under age 65, Medicare per LTSS user spending was higher for those who received Medicaid-covered institutional LTSS compared with those receiving home- and community-based Medicaid LTSS.
- Medicaid per LTSS user spending on Medicaid-covered institutional LTSS users under age 65 ($71,514) was higher than per LTSS user spending on any other subgroup of Medicaid LTSS users. It was also almost twice as high as per LTSS user spending on Medicaid-covered institutional LTSS users who were age 65 and older ($38,801).

Exhibit 25

Medicare and Medicaid spending on FFS full-benefit dual-eligible beneficiaries with and without Alzheimer's disease or related dementia, CY 2009

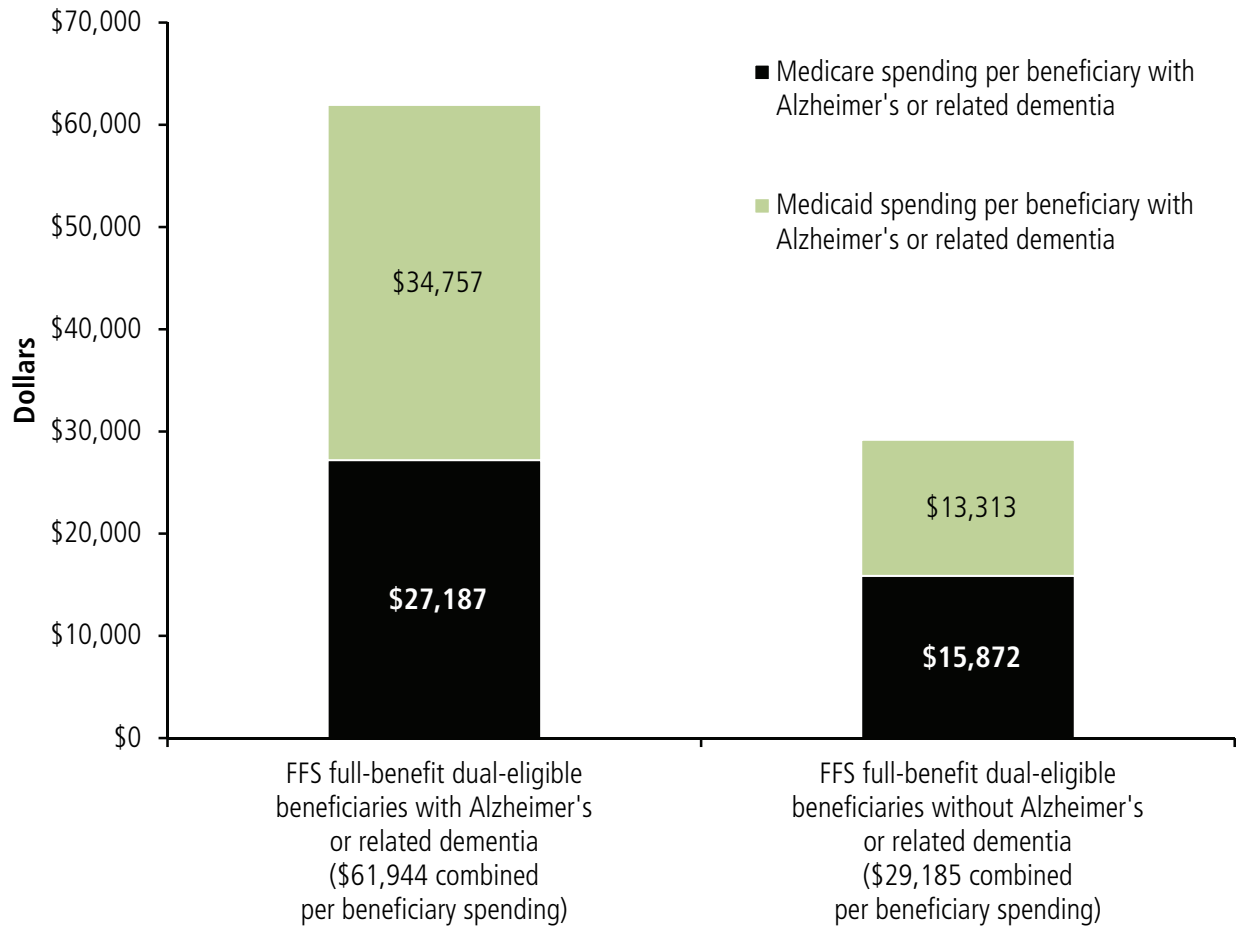


Note: *FFS (fee-for-service), CY (calendar year). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes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

- The presence of Alzheimer's disease or related dementia accounted for disproportionately high Medicare and Medicaid spending on individuals dually eligible for Medicare and Medicaid.
- In CY 2009, 18 percent of full-benefit dual-eligible beneficiaries had Alzheimer's disease or related dementia. These individuals accounted for 27 percent of all Medicare spending and 36 percent of all Medicaid spending on full-benefit dual-eligible beneficiaries.

Exhibit 26

Per beneficiary Medicare and Medicaid spending on FFS full-benefit dual-eligible beneficiaries with and without Alzheimer's disease or related dementia, CY 2009



Note: *CY (calendar year), FFS (fee-for-service). 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 on FFS individuals dually eligible for Medicare and Medicaid who had Alzheimer's disease or related dementia was higher than spending on dual-eligible beneficiaries without this condition.
- Medicaid spending exceeded Medicare spending for FFS full-benefit dual-eligible beneficiaries with Alzheimer's disease or related dementia ($34,757 Medicaid per capita spending vs. $27,187 Medicare per capita spending).

Exhibit 27

Use of services and per user spending for FFS full-benefit dual-eligible beneficiaries with and without Alzheimer's disease or related dementia, CY 2009

Selected services	Full-benefit FFS dual-eligible beneficiaries with Alzheimer's or related dementia			Full-benefit FFS dual-eligible beneficiaries without Alzheimer's or related dementia		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
Medicare services						
Inpatient hospital	41%	$17,324	26%	26%	$18,411	30%
Skilled nursing facility	27	18,430	18	7	15,118	7
Home health	19	7,434	5	12	6,362	5
Other outpatient	100	7,641	28	93	5,119	30
Medicaid services						
Inpatient hospital	17%	$1,777	1%	13%	$2,299	2%
Outpatient	85	3,023	7	88	2,292	15
Institutional LTSS	63	41,283	74	13	39,568	38
HCBS state plan	15	14,878	7	15	9,003	10
HCBS waiver	14	21,692	8	13	30,027	30

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 (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.*

- Among FFS individuals dually eligible for Medicare and Medicaid services with Alzheimer's disease or related dementia, there were more users of certain Medicare and Medicaid services such as inpatient hospital, skilled nursing facility services, and institutional LTSS compared with their dual-eligible counterparts without this condition.
- On a per user basis, Medicare and Medicaid spending for most services for FFS full-benefit dual-eligible beneficiaries with Alzheimer's disease or related dementia was generally similar to or higher than for those without this condition.

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