

# DATA BOOK

# BENEFICIARIES DUALY 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





## Acknowledgments

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## About MedPAC

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

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

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

## About MACPAC

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

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

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

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

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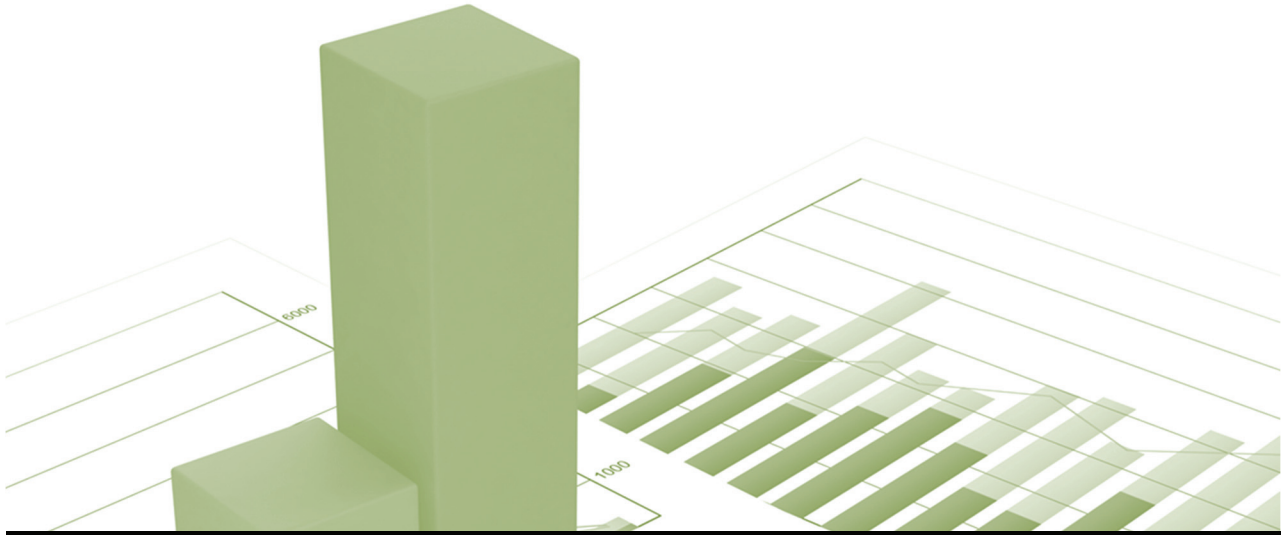
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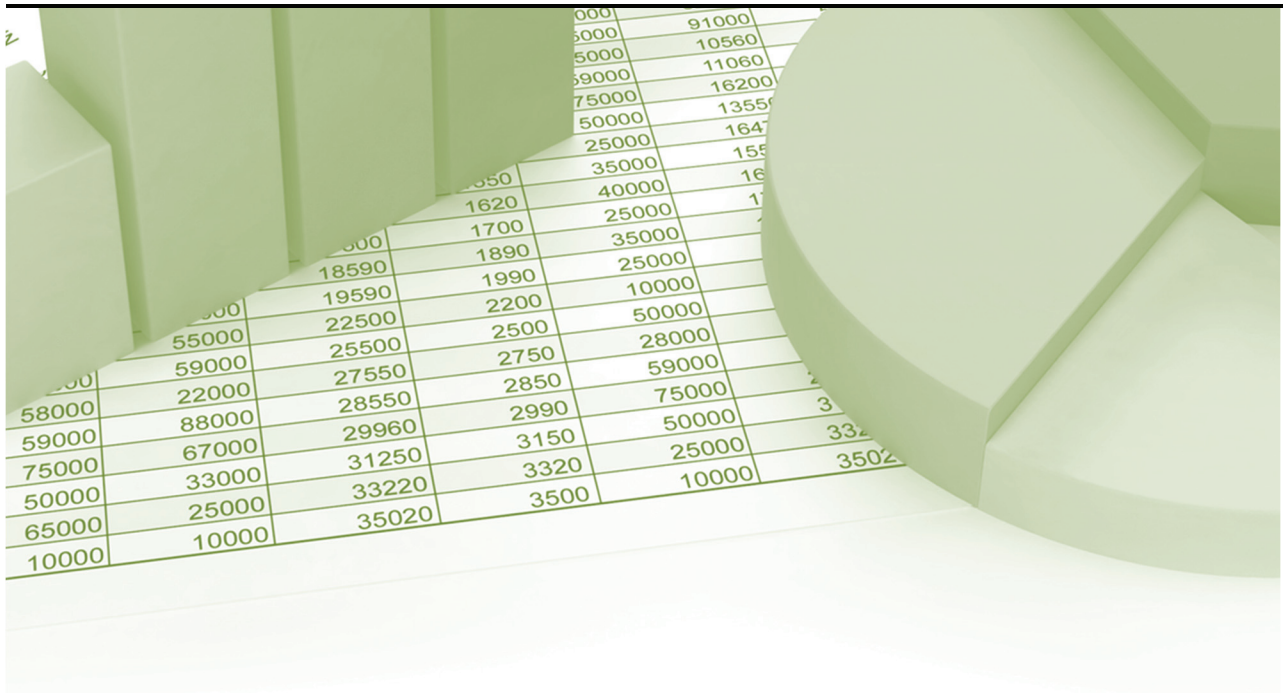
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# Introduction







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

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

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

This data book is organized into the following sections:

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

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

In addition to presenting data for calendar year (CY) 2012, the most recent year for which complete Medicare and Medicaid claims data were available when the analytic work for this data book began, we include information on trends in the dual-eligible population between CY 2008 and CY 2012.

## The role of Medicare and Medicaid for dual-eligible beneficiaries

Medicare is the primary payer for dual-eligible beneficiaries and mainly covers medical services such as professional (e.g., physician) services, inpatient and outpatient acute care, and post-acute skilled-level care. Dual-eligible beneficiaries are eligible for the same Medicare benefits as other Medicare beneficiaries but have low incomes that make it difficult to afford the premiums and cost sharing required by Medicare, as well as the cost of services not covered by the Medicare program.

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

Medicare is a federal program with uniform eligibility rules and a standard benefit package, whereas Medicaid is a joint federal–state program with eligibility rules and benefits that vary by state. Unlike the Medicaid program, where provider payment methodologies and payments are set at the state level, most Medicare payments are governed by formulas that allow for geographic variation but are determined at the national level. The programs also differ in their financing. Medicare is funded from sources such as premiums, payroll taxes, general revenues, and state contributions toward drug coverage for dual-eligible beneficiaries. Federal and state governments share most Medicaid costs according to the federal medical assistance percentage (FMAP), which is based on a formula that provides for a larger federal share in states with lower per capita incomes relative to the national average (and vice versa). For fiscal year 2017, the FMAP ranges from 50 percent to about 75 percent (Office of the Assistant Secretary for Planning and Evaluation 2015).

### Categories of dual-eligible beneficiaries

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

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

Type	Full or partial Medicaid benefits	Federal income and asset (individual / couple) limits for eligibility in 2016	Benefits
<b>Medicare Savings Program (MSP) beneficiaries</b>			
Qualified Medicare beneficiary (QMB)	Partial: QMB only	<ul style="list-style-type: none"> <li>▪ At or below 100% FPL</li> <li>▪ \$7,280 / \$10,930</li> </ul>	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: <ul style="list-style-type: none"> <li>▪ Medicare Part A premiums (if needed)</li> <li>▪ Medicare Part B premiums</li> <li>▪ At state option, certain premiums charged by Medicare Advantage plans</li> <li>▪ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program)</li> </ul>

	Full: QMB plus	<ul style="list-style-type: none"> <li>At or below 100% FPL</li> <li>\$2,000 / \$3,000</li> </ul>	<p>Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of:</p> <ul style="list-style-type: none"> <li>Medicare Part A premiums (if needed)</li> <li>Medicare Part B premiums</li> <li>At state option, certain premiums charged by Medicare Advantage plans</li> <li>Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D)</li> <li>All Medicaid-covered services</li> </ul>
Specified low-income Medicare beneficiary (SLMB)	Partial: SLMB only	<ul style="list-style-type: none"> <li>101%–120% FPL</li> <li>\$7,280 / \$10,930</li> </ul>	<p>Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of:</p> <ul style="list-style-type: none"> <li>Medicare Part B premiums</li> </ul>
	Full: SLMB plus	<ul style="list-style-type: none"> <li>101%–120% FPL</li> <li>\$2,000 / \$3,000</li> </ul>	<p>Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of:</p> <ul style="list-style-type: none"> <li>Medicare Part B premiums</li> <li>At state option, certain premiums charged by Medicare Advantage plans</li> <li>Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid</li> <li>All Medicaid-covered services</li> </ul>
Qualifying individual (QI)	Partial	<ul style="list-style-type: none"> <li>121%–135% FPL</li> <li>\$7,280 / \$10,930</li> </ul>	<p>Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of:</p> <ul style="list-style-type: none"> <li>Medicare Part B premiums</li> </ul>
Qualified disabled and working individuals (QDWI)	Partial	<ul style="list-style-type: none"> <li>At or below 200% FPL</li> <li>\$4,000 / \$6,000</li> </ul>	<p>Lost Medicare Part A benefits because of their return to work but eligible to purchase Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of:</p> <ul style="list-style-type: none"> <li>Medicare Part A premiums</li> </ul>
<b>Non-MSP beneficiaries</b>			
Other full-benefit dual-eligible beneficiaries	Full	<ul style="list-style-type: none"> <li>Income limit varies, but generally at or below 300% of the federal Supplemental Security Income benefit rate (about 225% FPL for an individual)</li> <li>\$2,000 / \$3,000</li> </ul>	<p>Eligible under a mandatory or optional Medicaid pathway, not eligible for MSP, and qualify for Medicaid payment of:</p> <ul style="list-style-type: none"> <li>At state option, certain premiums charged by Medicare Advantage plans</li> <li>Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid</li> <li>All Medicaid-covered services</li> </ul>

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

**Source:** Centers for Medicare & Medicaid Services 2011e, 2013a, and 2013b; MACPAC 2015a; Office of Inspector General, Department of Health and Human Services 2012; Social Security Act; Social Security Administration 2015.

In addition, states have the authority to expand eligibility for MSP benefits by using less restrictive methodologies for counting income and assets. As of October 2016, eight states and the District of Columbia have removed asset levels and four have expanded income levels (Table 2).

**Table 2. States with expanded Medicare Savings Program (MSP) income and asset levels, as of October 2016**

State	QMB monthly income (percent of FPL)	QMB assets		SLMB monthly income (percent of FPL)	SLMB assets		QI monthly income (percent of FPL)	QI assets	
		Single	Couple		Single	Couple		Single	Couple
<b>Federal standard</b>	<b>100%</b>	<b>\$7,280</b>	<b>\$10,930</b>	<b>120%</b>	<b>\$7,280</b>	<b>\$10,930</b>	<b>135%</b>	<b>\$7,280</b>	<b>\$10,930</b>
Alabama	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
Arizona	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
Connecticut <sup>1</sup>	211	No limit	No limit	231	No limit	No limit	246	No limit	No limit
Delaware	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
District of Columbia <sup>2</sup>	300	No limit	No limit	N/A	N/A	N/A	N/A	N/A	N/A
Indiana	150	\$7,280	\$10,930	170	\$7,280	\$10,930	185	\$7,280	\$10,930
Maine <sup>3</sup>	140	\$50,000 in liquid assets	\$75,000 in liquid assets	160	\$50,000 in liquid assets	\$75,000 in liquid assets	175	\$50,000 in liquid assets	\$75,000 in liquid assets
Maryland <sup>4</sup>	100	\$8,780	\$13,930	135	\$8,780	\$13,930	N/A	N/A	N/A
Minnesota	100	\$10,000	\$18,000	120	\$10,000	\$18,000	135	\$10,000	\$18,000
Mississippi	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
New York	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
Oregon	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
Vermont	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit

**Note:** FPL (federal poverty level), N/A (not applicable), QI (qualifying individual) QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary). States may have different names for the QMB, SLMB, and QI programs. Income and asset disregards are not included in this table. All states have at least a \$20 disregard for unearned income. Other income and asset disregards vary by state. This table does not include income and assets for the Qualified Disabled and Working Individuals program. The states that are not included in the table all follow the federal standards.

<sup>1</sup>In Connecticut, QMB, SLMB, and QI income levels are calculations and are rounded.

<sup>2</sup>The District of Columbia does not have a SLMB or QI program because it has expanded eligibility for the QMB program to 300 percent of FPL.

<sup>3</sup>"Liquid assets" refers to cash or other resources that can be converted into cash on demand.

<sup>4</sup>Maryland does not have a QI program because it has expanded eligibility for the SLMB program to 135 percent of FPL.

**Source:** Alabama Medicaid Agency 2015; Baltimore County Government 2016; Baltimore County SHIP 2016; Connecticut State Department of Social Services 2016; Delaware Health and Social Services 2012; District of Columbia Department of Health Care Finance 2016; District of Columbia Department of Health Care Finance 2013; Indiana Family and Social Services Administration 2016; Maine Department of Health and Human Services 2015; Minnesota Department of Human Services 2016; Mississippi Division of Medicaid 2016; New York State Department of Health 2016; Oregon Department of Human Services 2016; State of Vermont Agency of Human Services 2005; Vermont General Assembly 2014.

## Medicare and Medicaid benefits for dual-eligible beneficiaries

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

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 differ from that of traditional fee-for-service (FFS) Medicare. Enrollees in MA plans who have Part D coverage must receive their Part D benefits through the MA plan (referred to as MA prescription drug, or MA-PD, plans), with certain exceptions (see Table 3 and Table 4 for more detailed information about the Medicare benefit). Dual-eligible special needs plans (D-SNPs) are a type of MA plan that enrolls only dual-eligible beneficiaries. D-SNPs are required to contract with states to cover certain Medicaid benefits for dual-eligible beneficiaries, such as cost-sharing assistance, wraparound services (e.g., vision and dental services), behavioral health services, or LTSS.

*Medicaid.* The Medicaid benefit package varies depending on the type of dual-eligible beneficiary (Table 1). For many beneficiaries, Medicaid pays Medicare premiums and is the secondary payer of Medicare-covered services. For full-benefit dual-eligible beneficiaries, states must cover certain Medicaid benefits, such as Medicare cost sharing (discussed below), inpatient hospital and nursing facility services when Medicare limits on covered days are reached, nursing home care not covered by Medicare, and transportation to medical appointments (Table 3). However, with certain exceptions (e.g., for children under age 21), states may place limits on both mandatory and optional benefits by defining medical necessity and the amount, duration, and scope of covered services. States have the option to cover additional benefits, including personal care and a wide range of other home- and community-based services (HCBS), dental care, vision and hearing services, and supplies. There is considerable variation across states in the optional Medicaid services covered. This variation results in different benefits for dual-eligible beneficiaries depending on where they live.

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

**Table 3. 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 4)	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 4)	Optional: Inpatient psychiatric services for individuals under age 21 and mental health facility services for individuals ages 65 and older
	SNF, long-term care hospital, and inpatient rehabilitation facility services (all limited to post-acute care); SNF coverage has a limit on covered days (see Table 4), 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 4 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 4). For Medicare premiums paid on behalf of dual-eligible beneficiaries, state Medicaid programs must pay the full amount (the standard premium), and they receive federal matching funds at the regular Medicaid match rate for those expenditures (except for qualifying individuals (QI) 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 2015b). In cases where Medicaid payment rates are lower than Medicare, these lesser-of policies result in states paying less than the full amount of the Medicare cost-sharing liability. If a state pays less than the full amount, providers are barred from billing qualified Medicare beneficiaries (QMBs) for any remaining cost sharing. Unlike Medicare Part A and Part B services, Medicaid does not pay for cost sharing associated with drugs under Part D, which has its own subsidies for dual-eligible and other low-income beneficiaries.

**Table 4. Medicare premiums and cost-sharing amounts, 2016 and 2012**

<b>Part A</b>	
Premium	Premium-free for insured individuals and their dependents and survivors; for uninsured individuals “buying in,” \$411 per month in 2016 or \$226 for individuals with at least 30 quarters of coverage (\$451 and \$248 in 2012), plus the Part B premium (Part A cannot be purchased by itself)
Hospital stays	\$1,288 deductible in 2016 for days 1–60 of each benefit period (\$1,156 in 2012)
	\$322 per day in 2016 for days 61–90 of each benefit period (1/4 of hospital deductible each year) (\$289 in 2012)
	\$644 per “lifetime reserve day” in 2016 (1/2 of hospital deductible each year) after day 90 of each benefit period (up to 60 days over lifetime) (\$578 in 2012)
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
	\$161 per day in 2016 (1/8 of hospital deductible each year) for days 21–100 of each benefit period (\$144.50 in 2012)
	All costs for each day after day 100 of each benefit period
Hospice care	\$0 for hospice visits; up to a \$5 copay for outpatient prescription drugs
	5% of the Medicare-approved amount for inpatient respite care
Blood	All costs for the first three pints (unless donated to replace what is used)
<b>Part B</b>	
Premium	\$121.80 per month (the standard premium) in 2016 (\$99.90 in 2012), except for beneficiaries who pay the previous year’s premium of \$104.90 because the hold-harmless provision kept their premium from increasing because there was no cost-of-living increase in Social Security benefits in 2016; Part B premiums are higher for higher income individuals as of 2007
Deductible	The first \$166 of Part B–covered services or items in 2016 (\$140 in 2012)
Physician and other medical services	20% of the Medicare-approved amount for physician services, outpatient therapy (subject to limits), and most preventive services
Outpatient hospital services	A coinsurance or copayment amount that varies by service, projected to average 20% in 2016 (21.8% in 2012); no copayment for a single service can be more than the Part A hospital deductible

Mental health services	20% of the Medicare-approved amount for outpatient mental health care in 2016 (40% in 2012)
Clinical laboratory services	\$0 for Medicare-approved services
Home health care	\$0 for home health care services
Durable medical equipment	20% of the Medicare-approved amount
Blood	All costs for the first three pints, then 20% of the Medicare-approved amount for any additional pints (unless donated to replace what is used)
<b>Part D, standard benefit</b>	
Premium	Premiums vary 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 2016 is \$34.10 (\$31.08 in 2012); 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	\$400 in 2016 (\$320 in 2012); not applied to dual-eligible beneficiaries; dual-eligible beneficiaries pay only nominal copayments
Initial coverage limit	\$3,310 in 2016 (\$2,930 in 2012); dual-eligible beneficiaries pay only nominal copayments
Out-of-pocket threshold (catastrophic cap)	\$4,850 in 2016 (\$4,700 in 2012); after this amount, 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: ranging, in 2016, from \$1.20 for generic or preferred multisource drugs up to \$7.40 for other drugs, depending on the person's subsidy category (a range of \$1.10 to \$6.50 in 2012).
<b>Rules for Medicare Advantage plans</b>	
Part A and Part B premiums and cost sharing	Plans can vary the services for which cost sharing is charged and the level of cost sharing, but for certain services, the cost sharing cannot exceed Medicare levels or other limits as specified in Medicare rules. In addition, the overall cost sharing in the plan for Part A and Part B services may not exceed, on average, the actuarial value of the cost sharing of traditional FFS Medicare. In lieu of cost sharing at the point of service, plans may obtain cost-sharing revenue through a monthly premium that all enrollees would pay.  MA plans are prohibited from billing QMBs and full-benefit dual-eligible beneficiaries for Medicare cost sharing if the state has financial responsibility for the cost sharing, but the plan can require beneficiaries to pay cost sharing at levels permitted under the Medicaid program of a given state. The MA plan or its providers can bill the state for any cost sharing that is payable by the state.

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

**Source:** Medicare Payment Advisory Commission 2013 and Centers for Medicare & Medicaid Services 2011a, 2011b, 2011c, 2011d, 2014, 2015a, 2015b.



## Additional information on program eligibility

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

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

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

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

- **Poverty level.** States may opt to cover individuals with disabilities and those ages 65 and older with incomes up to 100 percent of the FPL.
- **Medically needy.** Under this option, individuals with higher incomes can “spend down” to a state-specified medically needy income level by incurring medical expenses.

- **Special income level.** States can cover individuals with incomes up to 300 percent of the SSI benefit rate (about 225 percent of the FPL for an individual) who are receiving LTSS in an institution. States may also extend this eligibility to individuals who use home- and community-based waiver services as an alternative to institutionalization.

The share of each state’s population that is covered by Medicaid varies greatly as a result of differences in states’ use of optional eligibility pathways, the extent to which eligible individuals are enrolled, and differences in demography at the state level (Table 8). Given that Medicare eligibility criteria do not vary by state, differences in the share of the population covered by that program are largely driven by demographics, such as the share of the population ages 65 and older.

## Methods

### Sources of data

The data presented are for 2008 through 2012. When the analytic work for this data book began, CY 2012 was the most recent year for which complete claims data were available for the Medicare and Medicaid programs. The sources of data include:

- Medicare enrollment data from Enrollment Database and Common Medicare Environment (CME) files,
- Medicare Part A, Part B, and Part D claims from Common Working File and Part D Prescription Drug Event data,
- Medicare Part C payment data from Medicare Advantage Prescription Drug files,
- Medicaid enrollment and claims data from Medicaid Statistical Information System (MSIS) files, and
- other data sources noted in specific exhibits as warranted.

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

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

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

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

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

- *Medicare entitlement based on disability.* In this data book, primary claimant information contained in an individual’s Medicare HIC number was used to separate disabled beneficiaries with entitlement to Medicare based on their own work history from those with entitlement based on another individual’s work history. We separated these groups because the latter includes a large number of individuals whose disabilities began in childhood and whose characteristics may therefore differ from those of individuals who became disabled as working-age adults. As discussed previously, disabled beneficiaries entitled to Medicare based on another individual’s work history include disabled adult children who receive benefits through a disabled, retired, or deceased parent as well as disabled individuals ages 50 and older who receive benefits through a deceased spouse or deceased former (divorced) spouse.
- *Medicaid LTSS.* Medicaid LTSS are defined by FFS use of the following Medicaid services: institutional (nursing facility, intermediate care facility for persons with intellectual disabilities, and mental health facility for individuals ages 65 and older or age 21 and under), HCBS under a waiver (including any type of service provided under such a waiver), or HCBS under a state plan (nonwaiver home health and personal care services). We separate these groups because HCBS waiver users are required to meet an institutional level of care and may receive a wide array of services, whereas HCBS state-plan users are not required to meet an institutional level of care and often use fewer services. Beneficiaries whose only Medicaid LTSS use was through a managed care entity are not captured in this definition. However, the number of Medicaid managed care LTSS users in 2011–2012 (389,000 individuals, according to Saucier et al. (2012)) was relatively small compared with the total number of dually eligible and non-dual-eligible Medicaid FFS LTSS users in 2012 identified through analyses completed for this data book (4.2 million). More recent state-reported figures show that more than 1.6 million individuals were using and enrolled in Medicaid managed care plans covering LTSS as of July 1, 2014 (Centers for Medicare & Medicaid Services 2016).

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

- *Reporting of Medicaid data by states.* MSIS data are known to undercount total Medicaid spending at the national level relative to data submitted by states in a data source referred to as the CMS-64 to obtain federal matching funds, with variation by state and type of service. For example, MSIS data generally exclude lump-sum supplemental payments to hospitals that are made in addition to rate-based payments for services used by individual beneficiaries. Such supplemental payments account for more than 40 percent of Medicaid FFS spending on inpatient and outpatient hospital services (MACPAC 2015a). The MSIS data also exclude Medicaid payments for Medicare premiums—\$13.3 billion in 2012, of which \$7.8 billion was the federal share and \$5.4 billion was the state share (MACPAC 2016)—that finance a portion of Medicare spending. Other known issues with state reporting of MSIS data, such as errors in coding individuals in the proper eligibility group, are documented in an anomalies report updated by CMS on an ongoing basis (Mathematica 2015). A disconnect between managed care enrollment and payment data is one example of a possible reporting error that we observed in the Medicaid data. For some individuals, enrollment data indicated that an individual was in one type of managed care plan (e.g., limited benefit) while payment data indicated another plan type (e.g., comprehensive). We did not attempt to correct for such reporting errors in our analysis.

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

- *Identification of Medicaid payments for Medicare cost sharing.* States are instructed to report Medicaid payments for Medicare deductibles and coinsurance in MSIS. The completeness of this reporting may vary by state and type of service. Moreover, payments for Medicare-covered services (such as coinsurance for inpatient hospital or skilled nursing facility stays) cannot always be separated from payments for Medicaid-covered services (such as hospital days in excess of Medicare limits or nursing facility stays that do not meet Medicare's coverage requirements). As a result, to the extent that Medicaid payments for Medicare deductibles and coinsurance are reported, they are embedded in the spending for each Medicaid service type shown. Although the amount of Medicare cost sharing *paid* by Medicaid cannot be separated in MSIS data, the cost-sharing obligations *incurred* by dual-eligible and non-dual beneficiaries are available in Medicare claims data (Table 5). 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 5. Fee-for-service Medicare Part A and Part B cost sharing incurred by dual-eligible and non-dual Medicare beneficiaries (dollars in billions), CY 2012**

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	
<b>Part A total</b>	<b>\$2.8</b>	<b>\$0.3</b>	<b>\$1.7</b>	<b>\$0.4</b>	<b>\$0.4</b>	<b>\$9.5</b>
Hospital deductible	1.4	0.1	0.5	0.3	0.3	6.1
Hospital-day copayments	0.3	<0.1	0.2	<0.1	<0.1	0.5
SNF-day copayments	1.1	0.2	1.0	0.1	0.1	3.0
<b>Part B total</b>	<b>6.1</b>	<b>0.4</b>	<b>2.2</b>	<b>1.3</b>	<b>1.1</b>	<b>30.1</b>
Deductible	0.5	<0.1	0.2	0.1	0.1	3.4
Coinsurance	5.6	0.4	2.1	1.1	1.0	26.7
<b>Part A and Part B total</b>	<b>8.9</b>	<b>0.7</b>	<b>4.0</b>	<b>1.7</b>	<b>1.5</b>	<b>39.7</b>

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

## Population definitions

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

- *Enrollment and residence.* In this data book, Medicare beneficiaries are individuals with at least one month of enrollment in Part A or Part B of that program. Medicaid beneficiaries are individuals with at least one month of regular Medicaid or Medicaid-expansion Children’s Health Insurance Program (CHIP) enrollment. Individuals residing outside of the 50 states and the District of Columbia are excluded from the analysis.
- *Counting and categorizing dual-eligible beneficiaries.* For most Medicare beneficiaries, including dual-eligible beneficiaries, Medicare entitlement status does not change from month to month. By contrast, Medicaid eligibility is less stable, with some beneficiaries losing and regaining eligibility over the course of a year or changing the nature of their eligibility. For dual-eligible beneficiaries, the status change can be from partial-benefit to full-benefit Medicaid coverage.



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

The choice of whether to count beneficiaries using an ever-enrolled or an average monthly measure makes a much larger difference for the Medicaid population (where average monthly beneficiary counts were 83 percent of ever-enrolled counts) than the Medicare population (where average monthly counts were 95 percent of ever-enrolled counts) (Table 6). For dual-eligible beneficiaries, average monthly counts were 89 percent of ever-enrolled counts.

**Table 6. Comparison of dual-eligible and non-dual Medicare and Medicaid beneficiary counts using ever-enrolled and average monthly measures, CY 2012**

	Number of beneficiaries (millions)		Average monthly as a percent of ever enrolled
	Ever enrolled	Average monthly	
<b>Dual-eligible beneficiaries</b>	<b>10.4</b>	<b>9.2</b>	<b>89%</b>
Under age 65	4.3	3.8	89
Ages 65 and older	6.1	5.4	88
<b>Medicare beneficiaries with no dual-eligible enrollment</b>	<b>41.9</b>	<b>40.4</b>	<b>96</b>
Under age 65	4.4	4.4	99
Ages 65 and older	37.5	36.0	96
<b>Medicaid beneficiaries with no dual-eligible enrollment</b>	<b>61.3</b>	<b>50.6</b>	<b>83</b>
Nondisabled under age 65	54.4	44.3	81
Disabled under age 65	6.2	5.7	91
Ages 65 and older	0.6	0.6	96
<b>All Medicare beneficiaries</b>	<b>52.3</b>	<b>49.6</b>	<b>95</b>
<b>All Medicaid beneficiaries</b>	<b>71.8</b>	<b>59.9</b>	<b>83</b>

**Note:** Medicaid beneficiaries include Medicaid-expansion Children’s Health Insurance Program enrollees. Figures may not sum to subtotals due to rounding.

**Source:** Acumen LLC analysis of Medicare and Medicaid enrollment files for MedPAC and MACPAC.

- *Attributing spending and utilization.* Beneficiaries’ spending and utilization are attributed to them after they are counted and categorized as dual-eligible beneficiaries, non-dual Medicare beneficiaries, or non-dual Medicaid beneficiaries. To avoid double-counting spending and utilization, we attribute all spending and utilization an individual incurs in a year to that individual’s category. That is, for individuals identified as dual-eligible beneficiaries, their dual type (full or partial) is assigned based on their most recent month of dual-eligible enrollment, and their spending and utilization for the entire year are attributed to that individual and counted as spending for a dual-eligible beneficiary. The advantage of this methodology is that spending and

utilization are not double-counted. However, some dual-eligible beneficiaries switched between non-dual and dual-eligible status during the year or between subgroups of dual-eligible beneficiaries.

A limitation of this methodology is that we are at times attributing spending and utilization to a category (e.g., dual-eligible beneficiary, non-dual beneficiary) when in fact that spending and utilization were incurred while the individual was in a different category. Most dual-eligible beneficiaries did not switch between dual and non-dual or full-benefit and partial-benefit categories in 2012 (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 2012, 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 one quarter of the dual-eligible population was enrolled in an MA plan for all or part of the year in 2012 (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 (5 percent versus 1 percent). This difference reflects the ability of dual-eligible beneficiaries to enroll in or disenroll from MA on a month-by-month basis (whereas non-dual Medicare beneficiaries generally can only make changes during a limited open enrollment period each year). Dual-eligible beneficiaries were less likely to have been in comprehensive Medicaid managed care plans than non-dual disabled Medicaid beneficiaries under age 65 (16 percent versus 54 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 7). Unless otherwise indicated, the tables in this data book showing utilization and expenditure statistics exclude beneficiaries with ESRD 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 7. Beneficiaries with end-stage renal disease and their expenditures, CY 2012**

	All beneficiaries	Non-ESRD	ESRD	ESRD as percent of total
<b>Population</b>				
All Medicare beneficiaries (in millions)	52.3	51.7	0.6	1.1%
Dual-eligible beneficiaries (in millions)	10.4	10.2	0.3	2.4
Dual-eligible beneficiaries as percent of category	20%	20%	42%	
<b>Medicare expenditures</b>				
Total spending (in billions)	\$543.0	\$506.3	\$36.7	6.8
<i>Per person per year</i>	10,381	9,790	61,973	
Spending on dual-eligible beneficiaries (in billions)	187.0	167.5	19.6	10.5
<i>Per person per year</i>	17,973	16,489	78,165	
Spending on non-dual beneficiaries (in billions)	355.9	338.8	17.1	4.8
<i>Per person per year</i>	8,495	8,152	50,121	
<b>Medicaid expenditures</b>				
Spending on dual-eligible beneficiaries (in billions)	\$118.8	\$115.1	\$3.7	3.1
<i>Per person per year</i>	11,419	11,338	14,680	

**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 (ESRD and non-ESRD beneficiaries) are greater for Medicare expenditures than for Medicaid expenditures in the case of dual-eligible beneficiaries. In 2012, annual per capita Medicare spending for dual-eligible ESRD beneficiaries was \$78,165; per capita Medicaid spending was \$14,680. With the ESRD population included, annual per capita Medicare spending for dual-eligible beneficiaries averaged \$17,973 in 2012; excluding ESRD beneficiaries, per capita Medicare spending on dual-eligible beneficiaries averaged \$16,489 for the year. In comparison, Medicaid per capita



spending on dual-eligible beneficiaries including the ESRD population was \$11,419; excluding these individuals, the amount was \$11,338.

Table 8. Dual-eligible, Medicare, and Medicaid beneficiaries as a percent of population by state, CY 2012 (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 total population
		Number (thousands)	Percent of total population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of dual-eligible population				
National	313,914	10,406	3%	7,542	72%	2,864	28%	52,307	17%	71,755	23%
Alabama	4,822	215	4	95	44	120	56	944	20	1,086	23
Alaska	731	17	2	16	96	1	4	77	11	150	20
Arizona	6,553	183	3	139	76	44	24	1,058	16	1,690	26
Arkansas	2,949	134	5	74	55	60	45	587	20	772	26
California	38,041	1,333	4	1,291	97	42	3	5,432	14	12,275	32
Colorado	5,188	99	2	72	73	27	27	725	14	822	16
Connecticut	3,590	165	5	82	50	83	50	627	17	820	23
Delaware	917	28	3	13	45	15	55	170	19	251	27
District of Columbia	632	29	5	20	72	8	28	88	14	246	39
Florida	19,318	768	4	382	50	386	50	3,794	20	4,135	21
Georgia	9,920	297	3	146	49	151	51	1,412	14	1,748	18
Hawaii	1,392	38	3	33	87	5	13	233	17	324	23
Idaho	1,596	39	2	25	64	14	36	261	16	273	17
Illinois	12,875	375	3	328	87	47	13	2,042	16	3,089	24
Indiana	6,537	186	3	121	65	65	35	1,124	17	1,276	20
Iowa	3,074	89	3	71	79	19	21	566	18	633	21
Kansas	2,886	72	3	47	64	26	36	480	17	422	15
Kentucky	4,380	190	4	105	55	86	45	846	19	963	22
Louisiana	4,602	209	5	115	55	95	45	773	17	1,390	30
Maine	1,329	103	8	57	56	46	44	297	22	433	33
Maryland	5,885	134	2	85	63	49	37	894	15	1,205	20
Massachusetts	6,646	282	4	258	91	24	9	1,178	18	1,709	26
Michigan	9,883	313	3	263	84	50	16	1,849	19	2,255	23
Minnesota	5,379	146	3	128	87	18	13	881	16	1,130	21
Mississippi	2,985	165	6	84	51	81	49	551	18	766	26
Missouri	6,022	186	3	155	83	32	17	1,102	18	1,169	19
Montana	1,005	26	3	17	66	9	34	191	19	141	14

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 total population
		Number (thousands)	Percent of total population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of dual-eligible population				
Nebraska	1,856	45	2	40	88	5	12	307	17	298	16
Nevada	2,759	49	2	25	50	25	50	413	15	392	14
New Hampshire	1,321	35	3	23	64	13	36	252	19	175	13
New Jersey	8,865	222	3	193	87	29	13	1,471	17	1,364	15
New Mexico	2,086	75	4	42	55	34	45	355	17	647	31
New York	19,570	849	4	713	84	137	16	3,305	17	5,949	30
North Carolina	9,752	341	3	259	76	83	24	1,685	17	2,001	21
North Dakota	700	16	2	13	79	3	21	118	17	86	12
Ohio	11,544	362	3	239	66	123	34	2,118	18	2,670	23
Oklahoma	3,815	124	3	101	81	24	19	671	18	1,005	26
Oregon	3,899	115	3	70	61	45	39	709	18	740	19
Pennsylvania	12,764	450	4	369	82	81	18	2,511	20	2,516	20
Rhode Island	1,050	40	4	33	83	7	17	197	19	207	20
South Carolina	4,724	161	3	137	85	25	15	882	19	1,115	24
South Dakota	833	22	3	14	62	8	38	151	18	143	17
Tennessee	6,456	284	4	155	55	129	45	1,195	19	1,531	24
Texas	26,059	711	3	409	57	302	43	3,436	13	5,179	20
Utah	2,855	37	1	32	85	6	15	323	11	378	13
Vermont	626	31	5	22	70	9	30	127	20	201	32
Virginia	8,186	196	2	129	66	67	34	1,292	16	1,146	14
Washington	6,897	186	3	133	71	53	29	1,115	16	1,386	20
West Virginia	1,855	88	5	50	58	37	42	418	23	424	23
Wisconsin	5,726	173	3	150	87	23	13	1,017	18	1,309	23
Wyoming	576	12	2	7	62	4	38	91	16	85	15

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

**Source:** Acumen LLC analysis of the Census Bureau's "Vintage 2012 State Population Datasets - Single year of age and sex population estimates: April 1, 2010 to July 1, 2012 - RESIDENT" and Medicare and Medicaid enrollment data for MedPAC and MACPAC.

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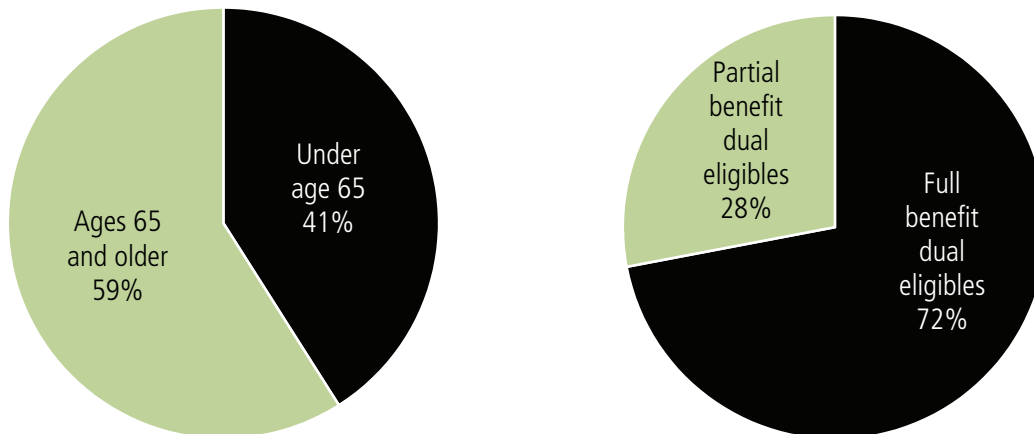






## Snapshot of dual-eligible beneficiaries by age and type of benefit, CY 2012

### 10.4 million dual-eligible beneficiaries



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

- A total of 10.4 million individuals were dually eligible for Medicare and Medicaid benefits in at least one month of CY 2012. The majority (59 percent) of dual-eligible beneficiaries were ages 65 and older.
- Most dual-eligible beneficiaries (72 percent) were eligible for full Medicaid benefits.

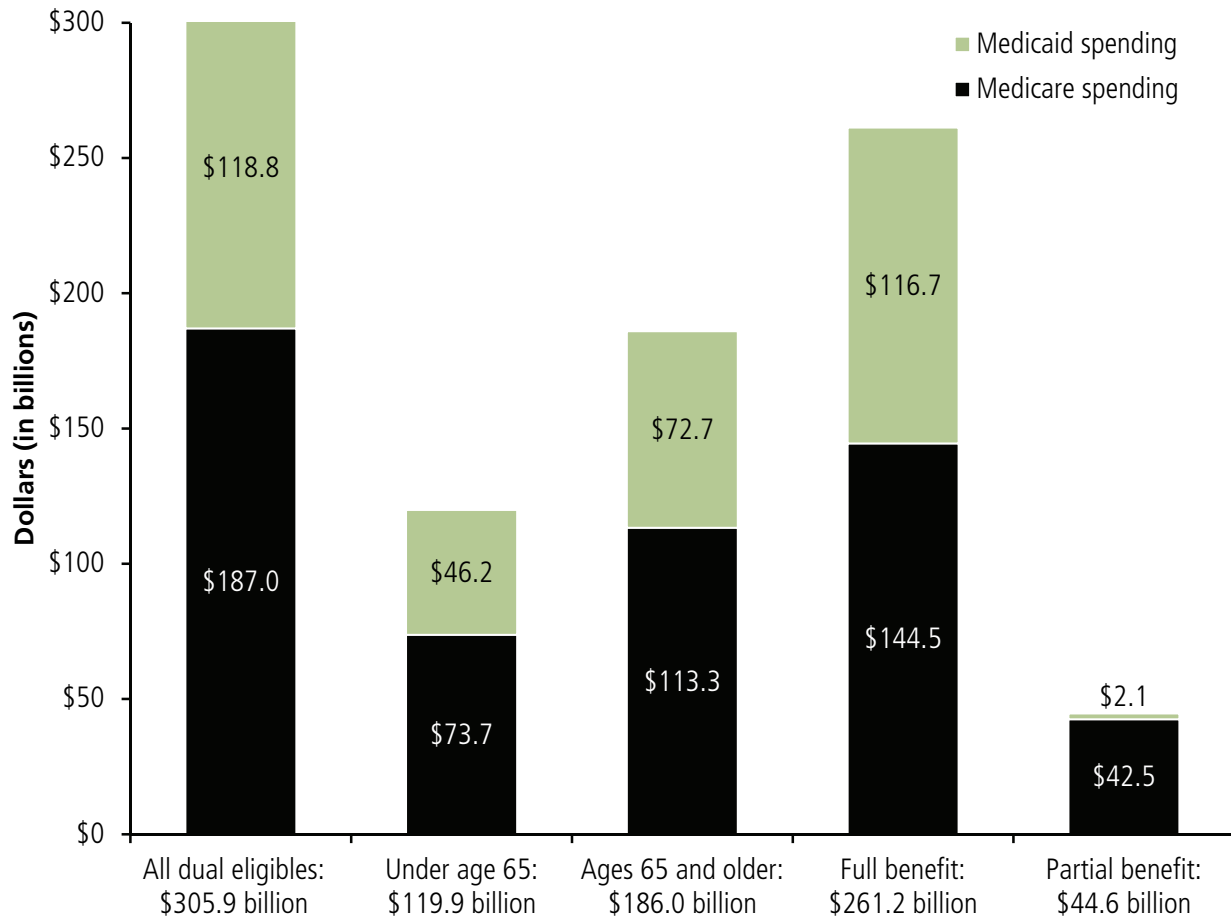
## Dual-eligible beneficiary enrollment in full- and partial-benefit categories, CY 2012

Benefit categories	Dual-eligible beneficiaries		
	All	Under age 65	Ages 65 and older
<b>Full-benefit dual-eligible beneficiaries</b>	<b>72%</b>	<b>72%</b>	<b>73%</b>
QMB plus	51	53	50
SLMB plus	3	3	3
Other full benefit	18	16	20
<b>Partial-benefit dual-eligible beneficiaries</b>	<b>28</b>	<b>28</b>	<b>27</b>
QMB only	13	14	12
SLMB only	9	10	9
QI	5	5	6
QDWI	<1	<1	<1

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

- In CY 2012, about three-quarters (72 percent) of individuals who were dually eligible for Medicare and Medicaid were eligible for full Medicaid benefits.
- Among the partial-benefit dual-eligible beneficiary categories, the greatest enrollment (13 percent) was in the QMB-only category.

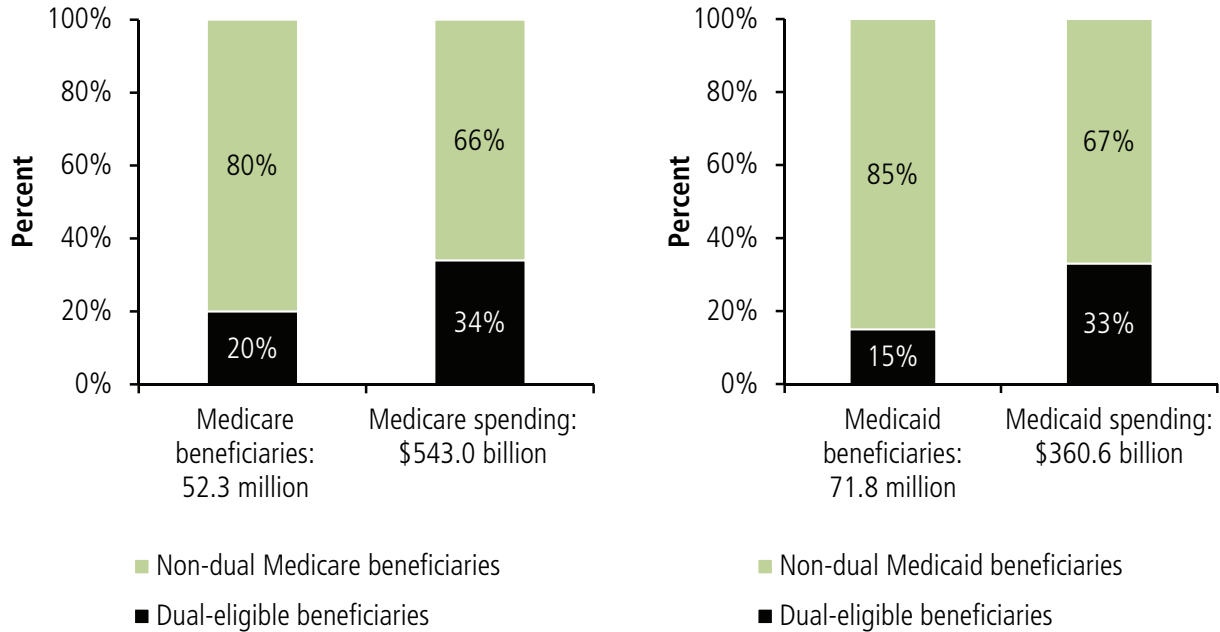
## Medicare and Medicaid spending on dual-eligible beneficiaries by age and type of benefit, CY 2012



**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 \$305.9 billion in CY 2012. Medicare accounted for about 61 percent of combined spending (\$187.0 billion).
- By age group, most Medicare and Medicaid spending on dual-eligible beneficiaries was accounted for by beneficiaries ages 65 and older (\$186.0 billion combined spending).
- Full-benefit dual-eligible beneficiaries represented a higher share of combined spending than partial-benefit dual-eligible beneficiaries (\$261.2 billion compared with \$44.6 billion, respectively).

## Dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2012



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

- Individuals dually eligible for Medicare and Medicaid benefits accounted for disproportionate shares of Medicare and Medicaid spending in CY 2012.
- Dual-eligible beneficiaries totaled 20 percent of the Medicare population in 2012 but accounted for 34 percent of Medicare spending.
- Similarly, dual-eligible beneficiaries comprised 15 percent of all Medicaid beneficiaries but accounted for 33 percent of Medicaid spending.

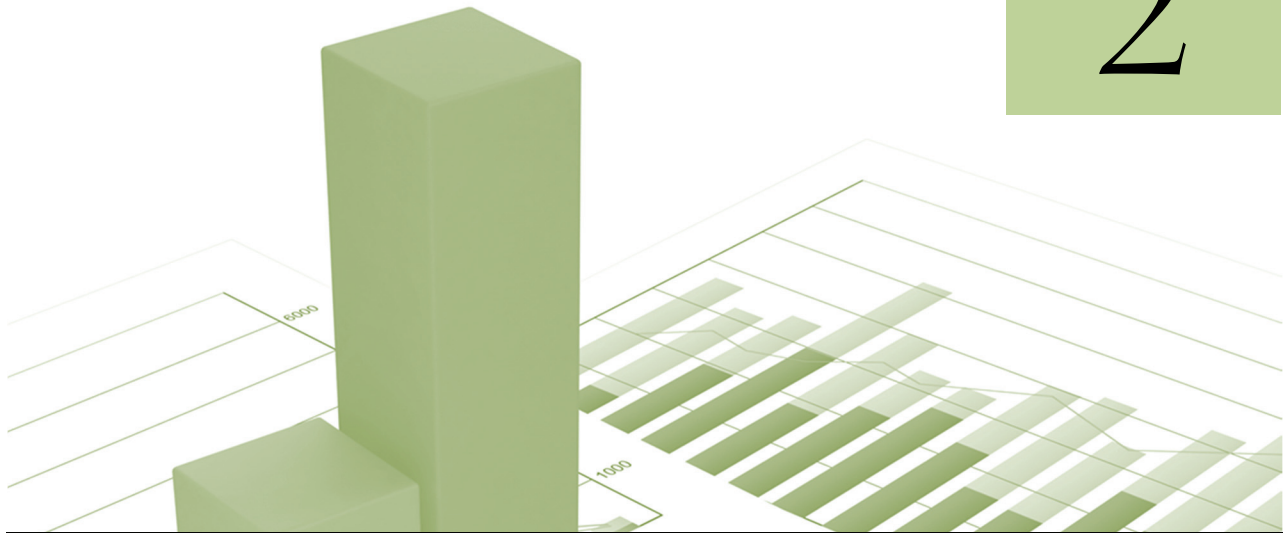
## Selected subgroups of dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2012

Dual-eligible beneficiary subgroup	Percent of all Medicare beneficiaries	Percent of all Medicare spending	Percent of all Medicaid beneficiaries	Percent of all Medicaid spending
<b>Age</b>				
Under age 65	8%	14%	6%	13%
Ages 65 and older	12	21	9	20
<b>Type of benefit</b>				
Full benefit	14%	27%	11%	32%
Partial benefit	5	8	4	1

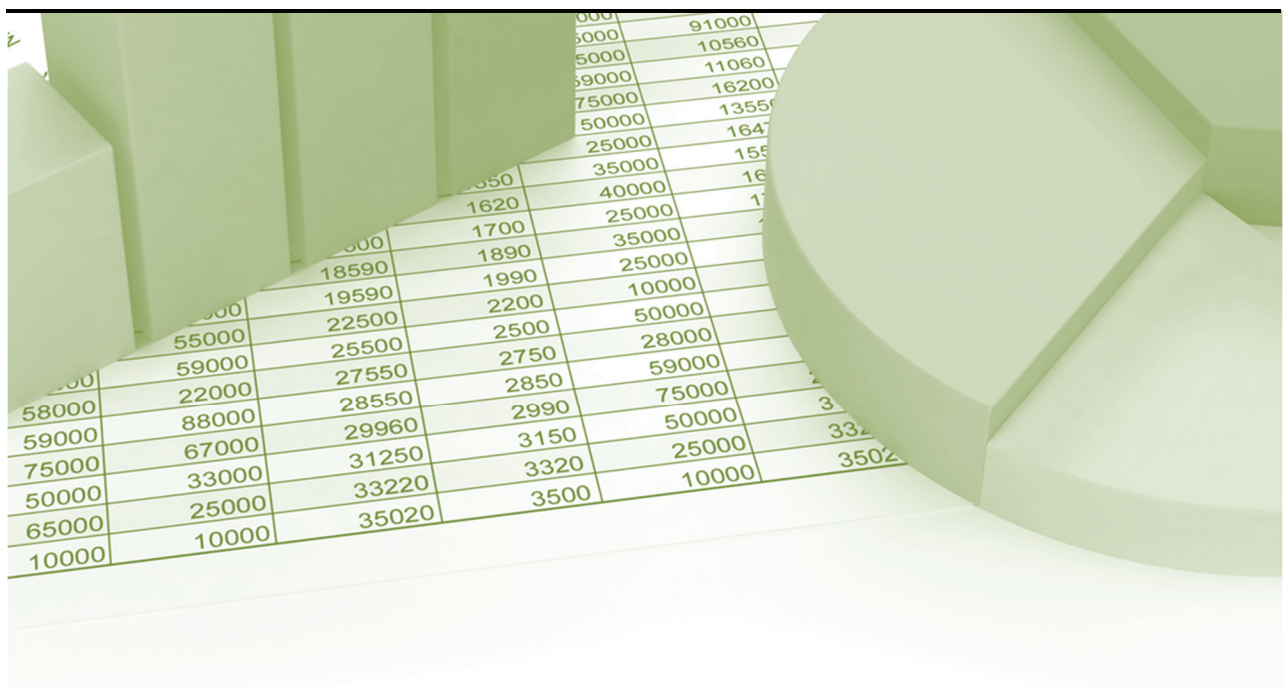
**Note:** CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). The sum of the subgroups as a percent of the total Medicare and Medicaid population or spending may not sum to the values in Exhibit 4 due to rounding. Medicaid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

- Certain subgroups of individuals dually eligible for Medicare and Medicaid benefits accounted for disproportionate shares of Medicare and Medicaid spending.
- Dual-eligible beneficiaries ages 65 and older were 12 percent of the Medicare population in CY 2012 but accounted for 21 percent of Medicare spending. These beneficiaries also accounted for 9 percent of the Medicaid population but 20 percent of Medicaid spending.
- Full-benefit dual-eligible beneficiaries also incurred disproportionate spending, particularly in Medicaid. They accounted for 14 percent of all Medicare enrollment but 27 percent of all Medicare spending and 11 percent of all Medicaid enrollment but 32 percent of all Medicaid spending.





# Characteristics of dual-eligible beneficiaries







## Demographic characteristics of dual-eligible and non-dual Medicare and Medicaid beneficiaries, CY 2012

Demographic characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries	Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit		
<b>Gender</b>							
Male	39%	48%	32%	39%	40%	47%	53%
Female	61	52	68	61	60	53	47
<b>Race/Ethnicity</b>							
White/non-Hispanic	57%	62%	54%	55%	62%	85%	52%
African American/non-Hispanic	20	24	18	20	22	8	31
Hispanic	16	11	19	17	13	5	13
Other	7	3	10	8	2	2	4
<b>Residence</b>							
Urban	76%	74%	77%	78%	70%	77%	78%
Rural	24	26	23	22	30	23	22

**Note:** CY (calendar year). Exhibit includes all dual-eligible beneficiaries and non-dual Medicare beneficiaries (fee-for-service, managed care, and end-stage renal disease) not missing demographic characteristics (the share of beneficiaries with missing information was 2 percent or less for all statistics except race/ethnicity for non-dual disabled Medicaid beneficiaries, where the share of beneficiaries with missing information was 17.5 percent). The non-dual Medicaid beneficiary category excludes nondisabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries ages 65 and older who did not have Medicare coverage. Percentages may not sum to 100 due to rounding.

- Overall, most individuals dually eligible for Medicare and Medicaid benefits in CY 2012 were female (61 percent), White (57 percent), and lived in an urban area (76 percent).
- Dual-eligible beneficiaries were proportionately more likely to be White (57 percent) than non-dual Medicaid beneficiaries who were eligible on the basis of a disability (52 percent), but less likely than non-dual Medicare beneficiaries (85 percent). There were proportionately more African American (20 percent) and Hispanic (16 percent) dual-eligible beneficiaries than African American and Hispanic non-dual Medicare beneficiaries (8 percent and 5 percent, respectively).
- By age, dual-eligible beneficiaries under age 65 were more likely than dual-eligible beneficiaries ages 65 and older to be male (48 percent vs. 32 percent), White (62 percent vs. 54 percent), or African American (24 percent vs. 18 percent). Dual-eligible beneficiaries ages 65 and older were more likely to be Hispanic than dual-eligible beneficiaries under the age of 65 (19 percent vs. 11 percent, respectively).
- Comparing full-benefit and partial-benefit dual-eligible beneficiaries, more full-benefit beneficiaries were Hispanic (17 percent vs. 13 percent) or lived in an urban area (78 percent vs. 70 percent).

## Additional characteristics of dual-eligible beneficiaries, CY 2012

Characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
<b>Limitations in ADLs</b>						
None	43%	42%	43%	37%	58%	72%
1–2 ADL limitations	26	34	22	25	28	18
3–6 ADL limitations	31	24	36	38	13	10
<b>Self-reported health status</b>						
Excellent or very good	23%	16%	26%	20%	30%	51%
Good or fair	59	59	59	61	55	43
Poor	17	24	14	18	15	6
Unknown	1	<1	1	1	1	1
<b>Living arrangement</b>						
Institution	21%	12%	26%	28%	3%	5%
Alone	30	29	30	27	39	26
Spouse	16	13	17	13	23	54
Children, nonrelatives, others	33	45	26	32	35	15
<b>Education</b>						
No high school diploma	45%	32%	52%	46%	41%	16%
High school diploma only	27	34	22	27	26	28
Some college	26	32	22	23	32	56
Other	3	2	4	4	1	1

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

**Source:** 2012 Medicare Current Beneficiary Survey.

- More than half (57 percent) of individuals dually eligible for Medicare and Medicaid benefits in CY 2012 had at least one ADL limitation. Close to half (45 percent) did not graduate from high school.
- Compared with non-dual Medicare beneficiaries, more dual-eligible beneficiaries reported being in poor health (17 percent vs. 6 percent). Dual-eligible beneficiaries were also more likely than non-dual Medicare beneficiaries to live in an institution (21 percent vs. 5 percent).
- Dual-eligible beneficiaries ages 65 and older had more ADL limitations than those under age 65 (36 percent vs. 24 percent for those with three to six ADL limitations). Dual-eligible beneficiaries ages 65 and older were also more likely than the younger dual-eligible beneficiaries to live in an institution (26 percent vs. 12 percent). More of the under-age-65 dual-eligible beneficiaries reported being in poor health (24 percent vs. 14 percent).
- Between full-benefit and partial-benefit dual-eligible beneficiaries, a greater share of the partial-benefit beneficiaries had no ADL limitations (58 percent vs. 37 percent). Over one-fourth (28 percent) of full-benefit dual-eligible beneficiaries lived in an institution, while few (3 percent) partial-benefit dual-eligible beneficiaries resided in an institution.

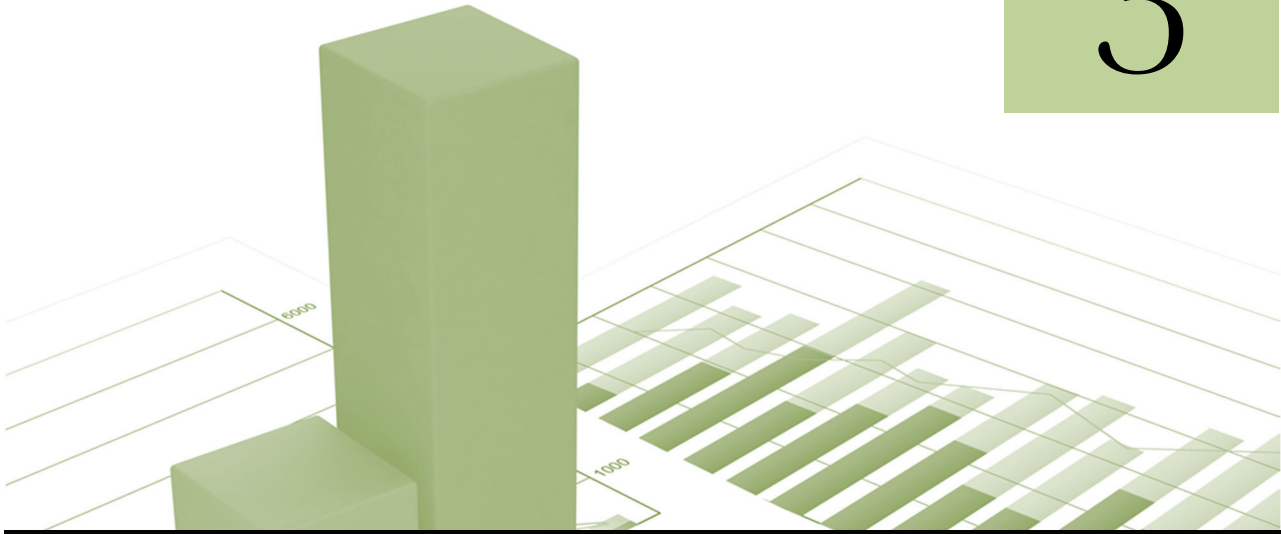
## Selected conditions for FFS dual-eligible beneficiaries by age group, CY 2012

Condition	FFS dual-eligible beneficiaries	
	Under age 65	Ages 65 and older
<b>Cognitive impairment</b>		
Alzheimer's disease or related dementia	3%	23%
Intellectual disabilities and related conditions	8	1
<b>Medical conditions</b>		
Diabetes	23%	35%
Heart failure	8	23
Hypertension	40	66
Ischemic heart disease	14	34
<b>Behavioral health conditions</b>		
Anxiety disorders	23%	14%
Bipolar disorder	15	3
Depression	32	22
Schizophrenia and other psychotic disorders	14	7

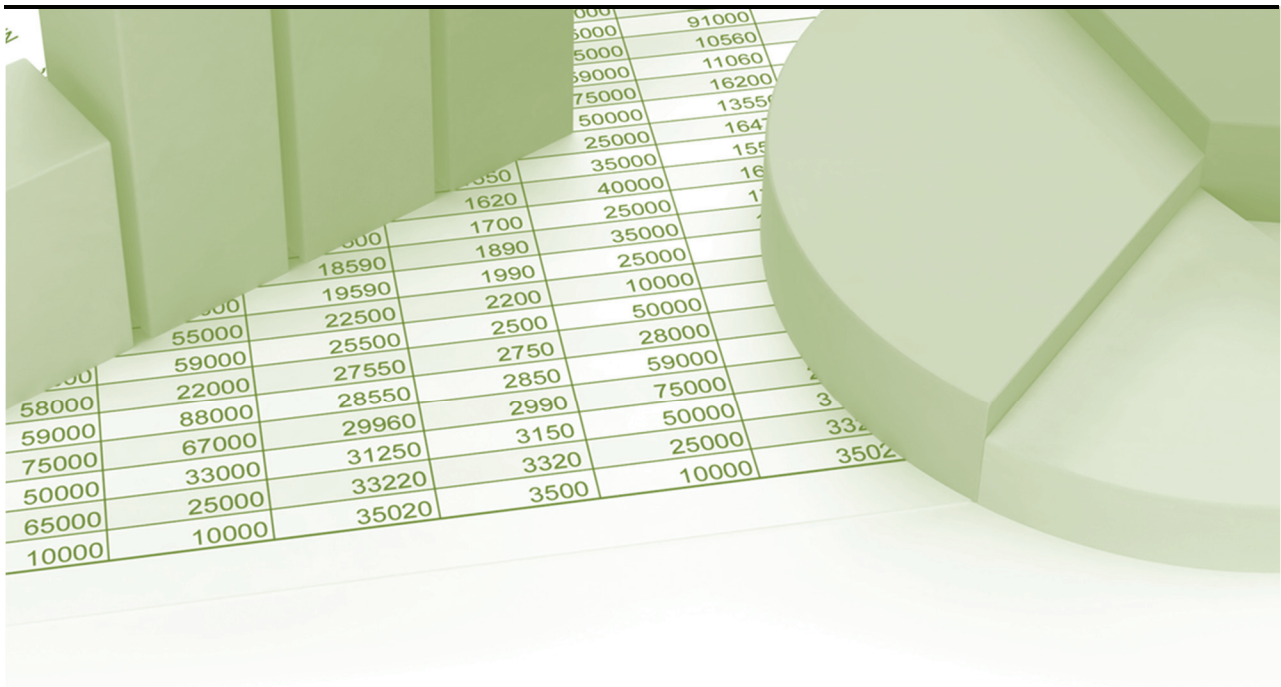
**Note:** FFS (fee-for-service), CY (calendar year). Chronic conditions are identified using Medicare FFS claims. Exhibit excludes beneficiaries enrolled in Medicare Advantage plans because Medicare FFS claims are not available for those individuals. Beneficiaries with end-stage renal disease are also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

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





Eligibility pathways, managed care enrollment, and continuity of enrollment





## Medicare eligibility pathways, CY 2012

Original reason for entitlement to Medicare	Dual-eligible beneficiaries			Non-dual Medicare beneficiaries
	All	Full benefit	Partial benefit	
Age	47%	48%	44%	83%
ESRD	1	1	1	<1
Disability	52	51	55	17
Based on own record	79	75	90	94
Based on another's record	21	25	10	6

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

- Overall, individuals dually eligible for Medicare and Medicaid benefits in CY 2012 were nearly split between those who originally qualified for Medicare benefits based on age (47 percent) and those who qualified for Medicare benefits based on disability (52 percent).
- In contrast to dual-eligible beneficiaries, most non-dual Medicare beneficiaries (83 percent) originally qualified for Medicare benefits based on their age.
- Most (75 percent) full-benefit dual-eligible beneficiaries who originally qualified for Medicare because of disability were individuals with sufficient employment history to be eligible based on their own work record. A higher portion (90 percent) of partial-benefit dual-eligible beneficiaries who originally qualified for Medicare benefits because of disability did so based on their own employment record.
- The remaining dual-eligible beneficiaries (25 percent among those with full benefits and 10 percent among those with partial benefits) who originally qualified for Medicare because of disability were eligible based on another individual's work record. These beneficiaries include, among others, adult children ages 18 and older who have been disabled since childhood.



## Medicaid eligibility pathways, CY 2012

Medicaid eligibility group	Dual-eligible beneficiaries			Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	
SSI	36%	36%	35%	79%
Poverty related	37	40	35	5
Medically needy	9	7	10	5
Section 1115 waiver	1	1	<1	2
Special income limit and other	18	16	19	9

**Note:** CY (calendar year), SSI (Supplemental Security Income). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). The non-dual Medicaid beneficiary category excludes nondisabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries ages 65 and older who did 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 2012 qualified for Medicaid benefits through the SSI program (36 percent) or through poverty-related eligibility pathways (37 percent).
- In contrast to dual-eligible beneficiaries, most non-dual Medicaid beneficiaries eligible on the basis of a disability (79 percent) qualified for Medicaid benefits through the SSI program.
- Compared with those under age 65, dual-eligible beneficiaries ages 65 and older were more likely to have been eligible for Medicaid through pathways that cover individuals who have high medical costs (“medically needy” group) or who require an institutional level of care (“special income limit and other” group).

## Medicare fee-for-service and managed care enrollment, CY 2012

Type of Medicare enrollment	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
FFS only	76%	82%	72%	80%	65%	72%
MA only	20	14	24	16	30	26
Both FFS and MA	5	4	5	4	5	1

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

- In CY 2012, most individuals dually eligible for Medicare and Medicaid services (76 percent) were enrolled only in Medicare FFS.
- Non-dual Medicare beneficiaries had higher rates of exclusive enrollment in the MA program than dual-eligible beneficiaries (26 percent vs. 20 percent).
- Dual-eligible beneficiaries ages 65 and older were more likely to be exclusively enrolled in an MA plan than those under age 65 (24 percent vs. 14 percent).
- Partial-benefit dual-eligible beneficiaries were more likely to be exclusively enrolled in an MA plan than full-benefit beneficiaries (30 percent vs. 16 percent), while full-benefit beneficiaries were more likely to be in FFS only (80 percent vs. 65 percent).

## Medicaid fee-for-service and managed care enrollment, CY 2012

Type of Medicaid enrollment	Dual-eligible beneficiaries					Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
FFS only	55%	54%	55%	41%	91%	20%
FFS and limited-benefit managed care only	30	30	30	38	7	26
At least one month of comprehensive managed care	16	16	16	21	2	54

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

- Most individuals dually eligible for Medicare and Medicaid services in CY 2012 were either enrolled only in Medicaid FFS (55 percent) or in Medicaid FFS with a limited-benefit Medicaid managed care plan (30 percent).
- Non-dual Medicaid beneficiaries eligible on the basis of a disability were more likely than dual-eligible beneficiaries to have at least one month of enrollment in a comprehensive managed care plan (54 percent vs. 16 percent) and less likely to be enrolled in Medicaid FFS only (20 percent vs. 55 percent).
- Dual-eligible beneficiaries under age 65 and ages 65 and older had similar patterns of Medicaid FFS and managed care enrollment.
- More than half of full-benefit dual-eligible beneficiaries were enrolled in some type of Medicaid managed care plan during the year.

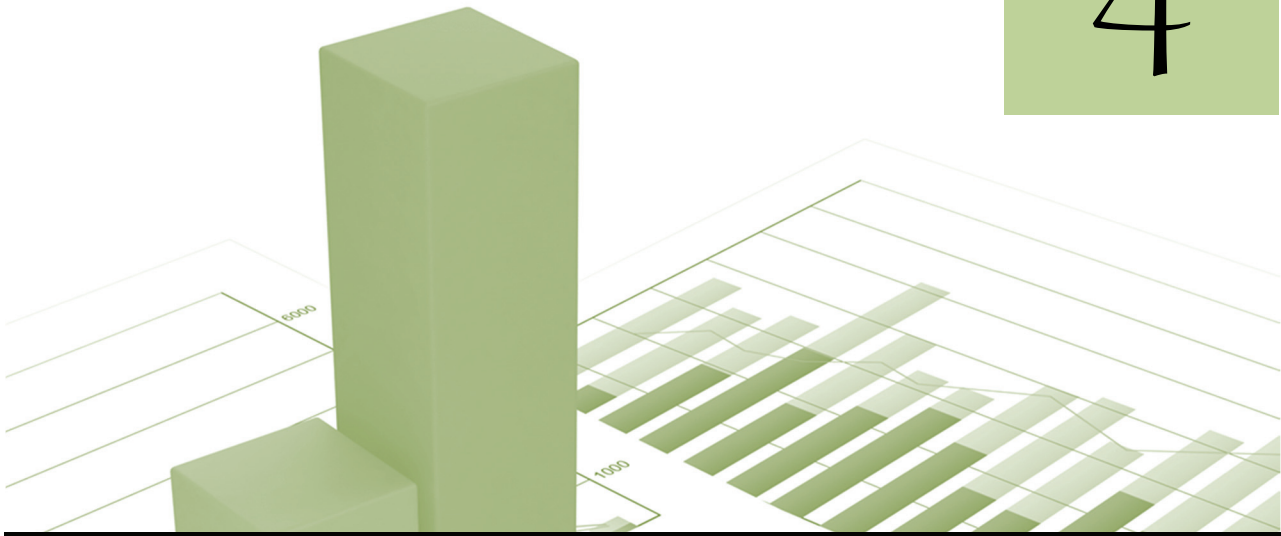
## Continuity of enrollment status for dual-eligible beneficiaries, CY 2012

Enrollment status	Dual-eligible beneficiaries				
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit
<b>Full-year enrollment status</b>					
Enrolled 12 months, all with dual-eligible status	76%	76%	75%	77%	71%
Enrolled 12 months, some with Medicare or Medicaid only	17	19	16	15	22
Enrolled less than 12 months	7	4	9	7	6
<b>Consistency of full and partial dual-eligible status during the year</b>					
Exclusively full or exclusively partial	96	94	96	97	92
Switched between full and partial	4	6	4	3	8
<b>Attainment of dual-eligible status during the year</b>					
Was previously dually eligible	89	88	89	89	87
Became dually eligible	11	12	11	11	13
<b>Of those who became dually eligible during the year, percent who were:</b>					
Medicare beneficiaries who gained Medicaid coverage	53	31	69	47	66
Medicaid beneficiaries who gained Medicare coverage	42	66	24	50	25
Individuals who gained Medicare and Medicaid coverage simultaneously	5	3	6	3	8

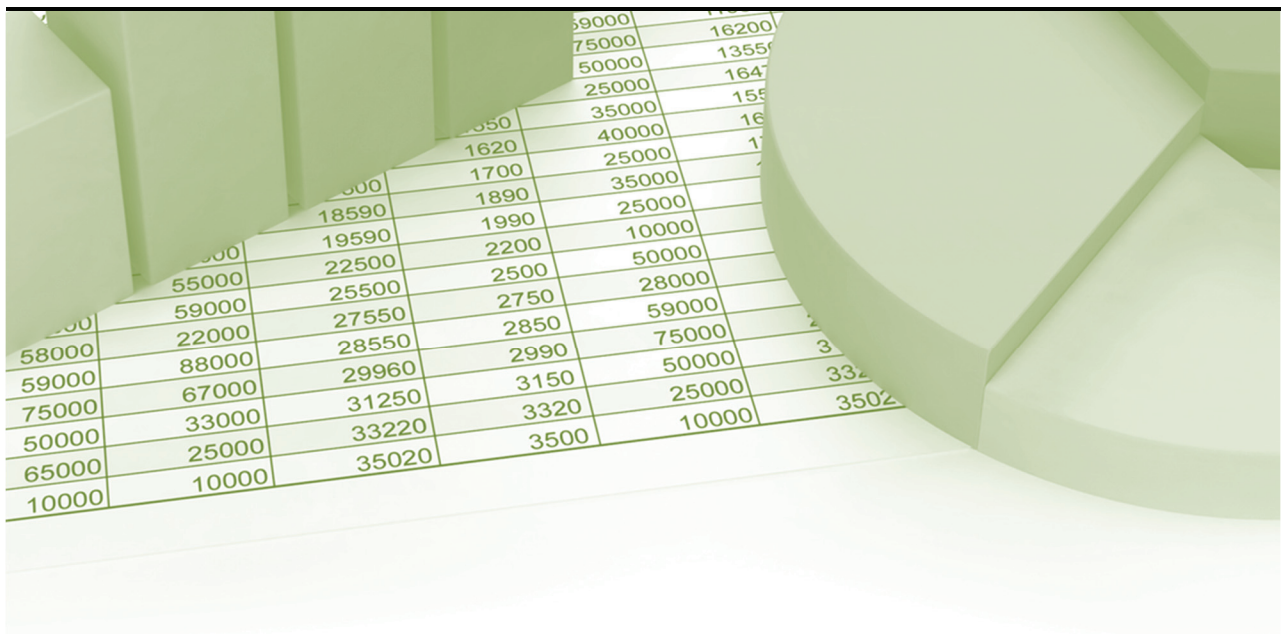
**Note:** CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Beneficiaries who became dually eligible during the year are those with no dual-eligible enrollment in the previous two years. Percentages may not sum to 100 due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

- Overall, most individuals dually eligible for Medicare and Medicaid benefits (76 percent) were dual-eligible beneficiaries during every month of CY 2012.
- Only 4 percent of all dual-eligible beneficiaries in 2012 switched between full-benefit and partial-benefit dual-eligible status.
- Eleven percent of dual-eligible beneficiaries first became dually eligible during 2012. Among those individuals, more than half (53 percent) were non-dual-eligible Medicare beneficiaries who subsequently gained Medicaid coverage.
- Among beneficiaries who became dually eligible during 2012, those under age 65 were more likely to have been non-dual Medicaid beneficiaries before they became dual-eligible beneficiaries (66 percent). Those ages 65 and older were more likely to have been non-dual Medicare beneficiaries before becoming dual-eligible beneficiaries (69 percent).
- Full-benefit beneficiaries who became dually eligible during the year were almost equally split between those who were non-dual-eligible Medicare beneficiaries first (47 percent) and those who were non-dual-eligible disabled Medicaid beneficiaries first (50 percent).





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







## Use of Medicare services and per user Medicare spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2012

Selected FFS Medicare services	Full-benefit FFS dual-eligible beneficiaries			FFS non-dual Medicare beneficiaries		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
<b>Part A and Part B services</b>						
Inpatient hospital	27%	\$19,298	37%	16%	\$16,047	33%
Skilled nursing facility	10	17,842	13	4	13,711	7
Home health	14	5,796	6	9	4,573	5
Other outpatient	95	6,102	41	92	4,484	51
<b>Part D drugs</b>	<b>93</b>	<b>4,945</b>		<b>81</b>	<b>1,661</b>	

**Note:** FFS (fee-for-service), CY (calendar year). Dual-eligible beneficiaries are limited to full-benefit dual eligibles in Medicare and Medicaid FFS. End-stage renal disease is excluded. "Inpatient hospital" includes psychiatric hospital services. "Other outpatient" includes physician services, hospice, durable medical equipment, hospital outpatient, emergency room not preceding an inpatient stay, and other outpatient facilities. The "percent of total spending" columns apply only to Part A and Part B services and do not sum to 100 because spending is shown only for selected services. The figures for Part D drugs are based only on beneficiaries who were covered by a Part D plan.

- Individuals dually eligible for Medicare and Medicaid services in CY 2012 had higher use of certain FFS Medicare services (inpatient hospital, skilled nursing facility, home health, other outpatient services, and Part D drugs) than non-dual Medicare beneficiaries.
- Per user Medicare FFS spending for these services was higher for dual-eligible beneficiaries than for non-dual Medicare beneficiaries.
- Skilled nursing facility services accounted for higher portions of Medicare FFS spending on dual-eligible beneficiaries than of Medicare FFS spending on non-dual Medicare beneficiaries (13 percent vs. 7 percent).

## Use of Medicaid services and per user Medicaid spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2012

Selected Medicaid services	Full-benefit FFS dual-eligible beneficiaries			Full-benefit FFS non-dual Medicaid beneficiaries (disabled, under age 65)		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
Inpatient hospital	13%	\$2,120	2%	17%	\$21,254	19%
Outpatient	86	2,300	11	82	5,676	25
Institutional LTSS	21	42,139	50	5	61,690	15
HCBS state plan	13	10,129	7	9	9,740	5
HCBS waiver	14	30,095	24	9	30,882	15
Drugs	48	258	1	72	3,913	15
Managed care capitation	33	2,783	5	61	1,803	6

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

- Compared with non-dual Medicaid beneficiaries eligible on the basis of a disability, individuals dually eligible for Medicare and Medicaid had higher use of FFS Medicaid-covered institutional LTSS (21 percent utilization among dual-eligible beneficiaries vs. 5 percent utilization among non-dual disabled Medicaid beneficiaries). Institutional LTSS also accounted for a higher portion of Medicaid spending on FFS dual-eligible beneficiaries than of Medicaid spending on non-dual disabled FFS Medicaid beneficiaries (50 percent vs. 15 percent).
- However, per user FFS spending on institutional LTSS was higher for non-dual disabled Medicaid beneficiaries (\$61,690) than for dual-eligible beneficiaries (\$42,139).
- Although the portion of FFS dual-eligible beneficiaries who used Medicaid HCBS services through an HCBS waiver or through a state plan was similar (14 percent vs. 13 percent), Medicaid FFS per user spending was higher for HCBS waiver services than for state plan HCBS services (\$30,095 vs. \$10,129), and HCBS waiver services accounted for a higher portion of Medicaid FFS spending on dual-eligible beneficiaries than state plan HCBS services (24 percent vs. 7 percent).

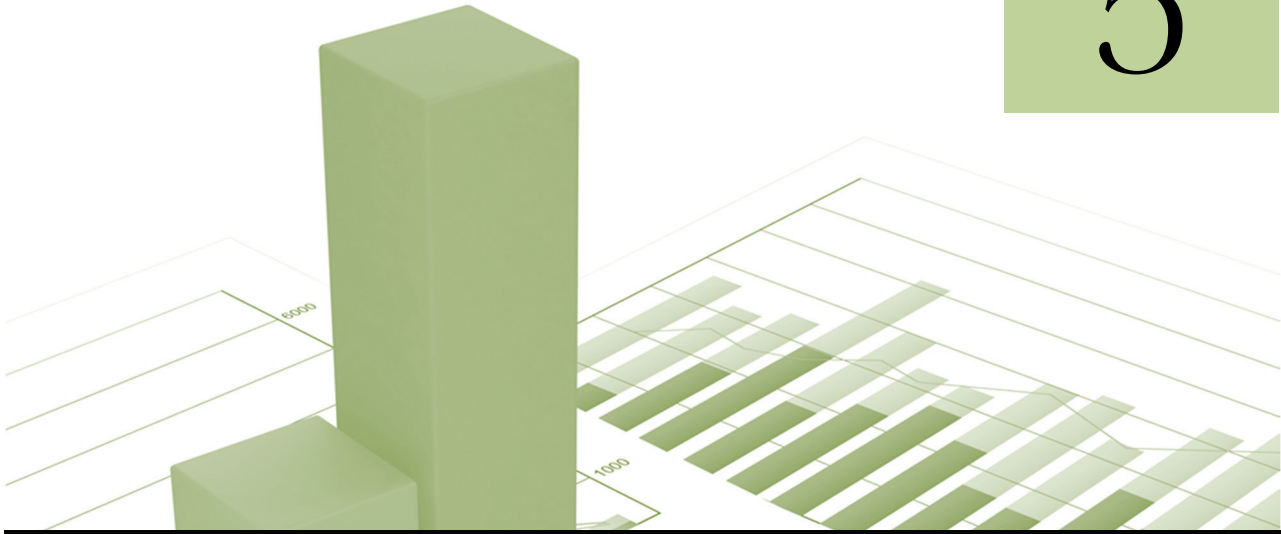
## Use of Medicare and Medicaid services and per user Medicare and Medicaid spending for FFS dual-eligible beneficiaries by age, CY 2012

Selected services	Full-benefit FFS dual-eligible beneficiaries under age 65			Full-benefit FFS dual-eligible beneficiaries ages 65 and older		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
<b>Medicare FFS services</b>						
Inpatient hospital	22%	\$20,029	27%	31%	\$18,892	28%
Skilled nursing facility	4	17,231	4	16	17,958	13
Home health	9	5,272	3	18	5,990	5
Other outpatient	93	5,249	30	96	6,756	31
Part D drugs	91	5,822	33	92	4,261	19
<b>Medicaid services</b>						
Inpatient hospital	12%	\$2,770	2%	14%	\$1,675	1%
Outpatient	89	2,721	14	84	1,946	9
Institutional LTSS	8	66,623	31	31	37,239	64
HCBS state plan	10	8,599	5	15	10,970	9
HCBS waiver	16	42,054	41	12	17,296	11
Drugs	48	363	1	48	175	<1
Managed care capitation	37	2,360	5	29	3,213	5

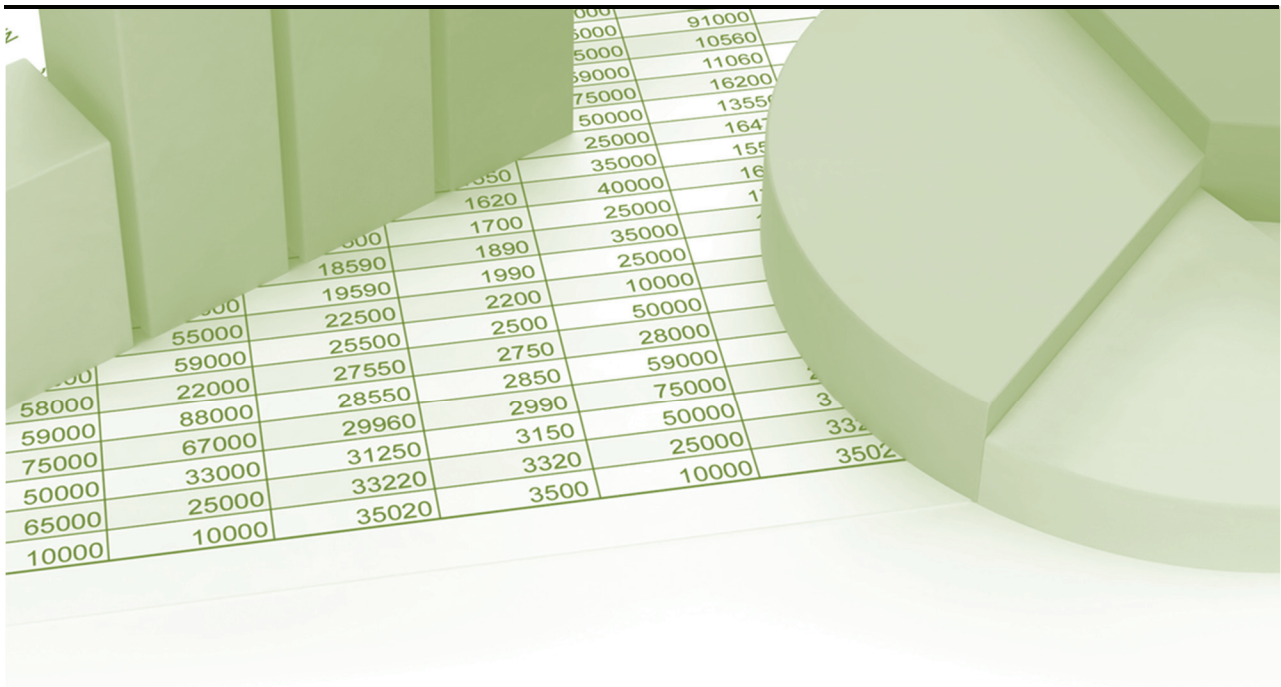
**Note:** FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicare “inpatient hospital” includes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

- Individuals dually eligible for Medicare and Medicaid services who were ages 65 and older in CY 2012 had higher use of Medicare FFS services than dual-eligible beneficiaries under age 65. Among the FFS services shown here, use of skilled nursing facilities differed the most between the two groups. Dual-eligible beneficiaries ages 65 and older used FFS skilled nursing facility services at a rate that was four times higher than those under age 65. Per user FFS Medicare spending was higher for dual-eligible beneficiaries ages 65 and older compared with those under age 65 for skilled nursing facilities, home health care, and other outpatient services.
- Compared with those ages 65 and older, FFS dual-eligible beneficiaries under age 65 had lower use of Medicaid-covered institutional LTSS (8 percent vs. 31 percent). Institutional LTSS also accounted for a higher portion of Medicaid spending on FFS dual-eligible beneficiaries 65 and older compared with those under age 65 (64 percent vs. 31 percent).





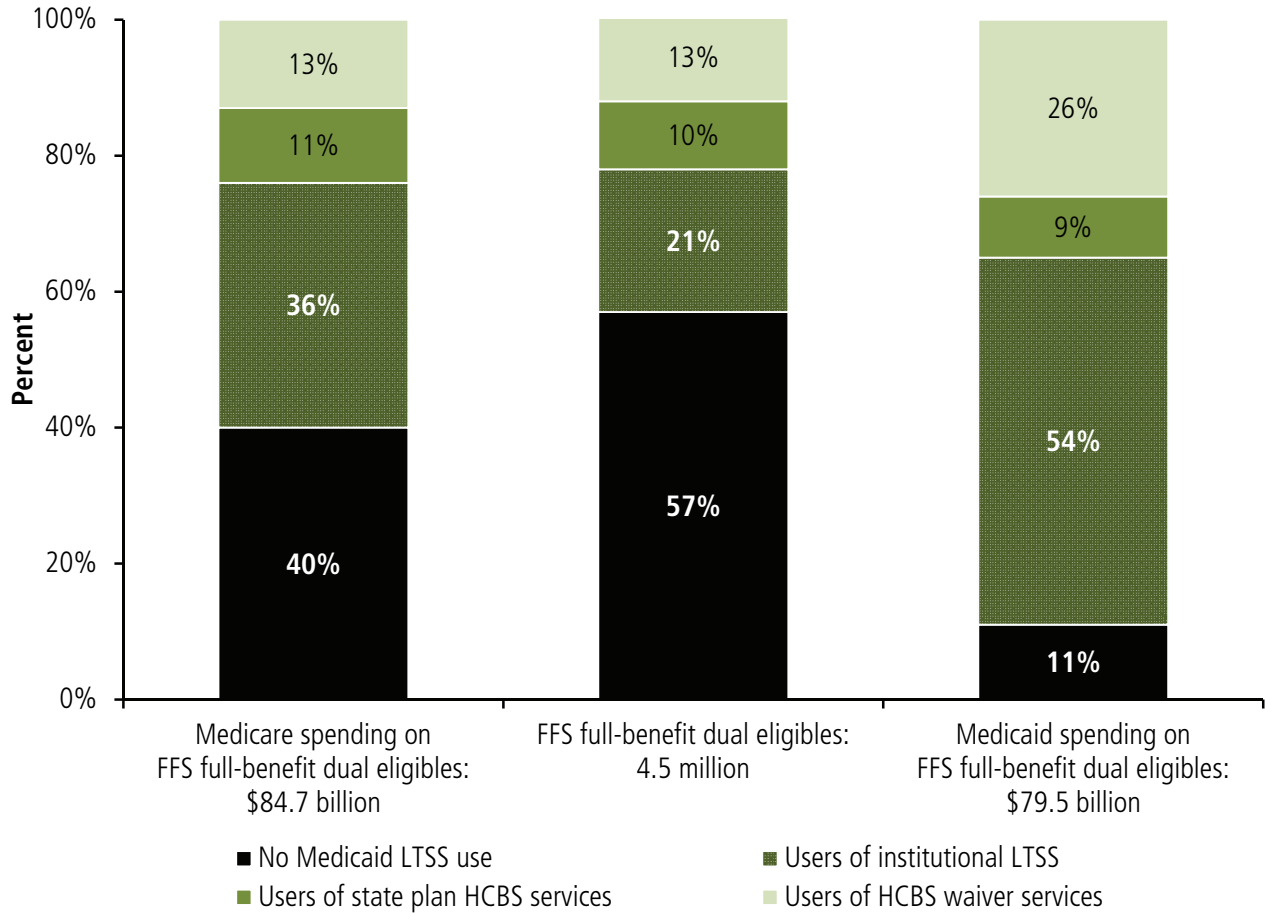
# Medicare and Medicaid spending for dual-eligible beneficiaries by LTSS use



10000	10000	35020	3500	10000	3502
65000	25000	33220	3500	10000	3502
50000	33000	31250	3150	25000	332
75000	67000	29960	2990	50000	332
59000	88000	27550	2850	75000	332
2500	22000	28550	2850	59000	332
55000	59000	27550	2750	28000	332
50000	22500	25500	2500	50000	332
18590	19590	22500	2200	10000	332
1700	1890	1990	1890	25000	332
1620	1700	1890	1890	35000	332
3500	40000	25000	25000	10000	332
25000	35000	15500	15500	10000	332
50000	25000	16400	16400	10000	332
75000	13550	13550	13550	10000	332
59000	16200	16200	16200	10000	332
50000	11060	11060	11060	10000	332
50000	10560	10560	10560	10000	332
50000	91000	91000	91000	10000	332



## Medicare and Medicaid spending on FFS full-benefit dual-eligibles by type of Medicaid LTSS, CY 2012

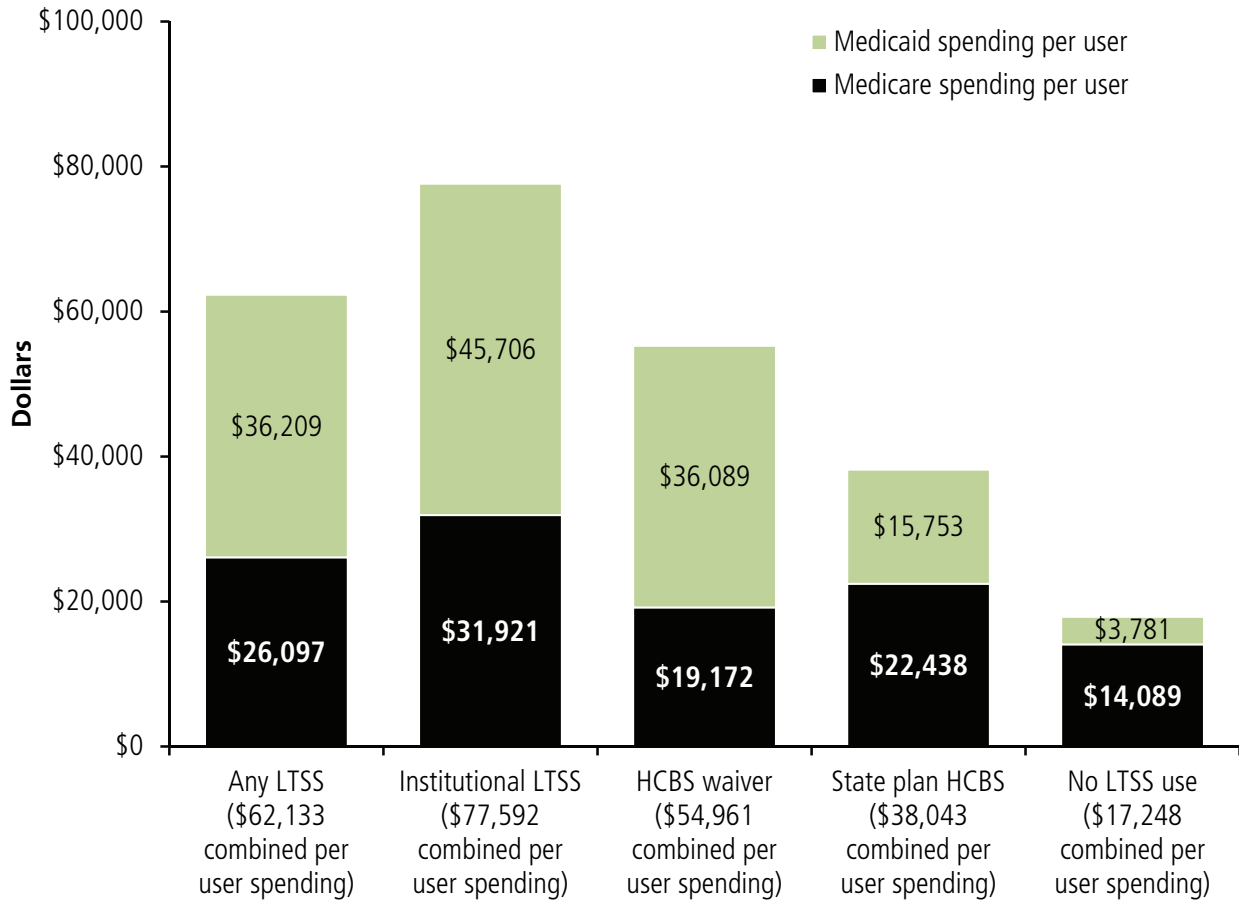


**Note:** FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible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

- In CY 2012, the majority (57 percent) of FFS full-benefit dual-eligible beneficiaries did not use Medicaid LTSS.
- Use of Medicaid-covered institutional LTSS among individuals dually eligible for Medicare and Medicaid services resulted in disproportionately high Medicare and Medicaid spending.
- The 21 percent of FFS full-benefit dual-eligible beneficiaries who used Medicaid institutional LTSS accounted for 36 percent of Medicare spending on FFS full-benefit dual-eligible beneficiaries and more than half (54 percent) of Medicaid spending on FFS full-benefit dual-eligible beneficiaries.



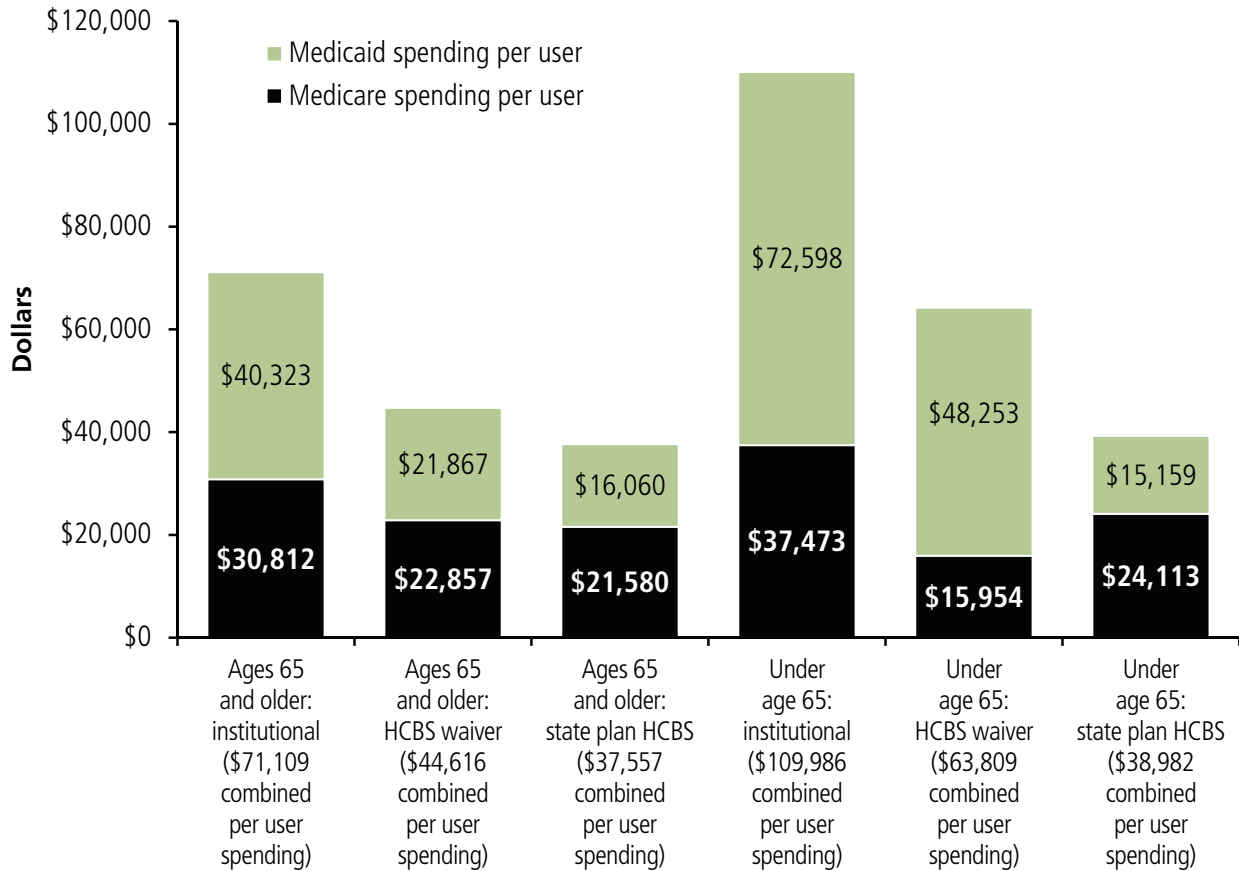
Per user Medicare and Medicaid spending on FFS full-benefit dual-eligible Medicaid LTSS users and non-users, CY 2012



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

- Users of Medicaid-covered institutional LTSS (21 percent of full-benefit dual-eligible beneficiaries, see Exhibit 17) had the highest Medicare and Medicaid per user spending in CY 2012 (\$31,921 and \$45,706, respectively) compared with users of other types of Medicaid LTSS and non-LTSS users.
- Medicare and Medicaid per user spending for any type of Medicaid LTSS user (institutional, HCBS waiver, or state plan HCBS) was higher than per user spending on non-LTSS users.
- Medicaid per user spending was generally higher than Medicare per user spending for Medicaid LTSS users, except for users of state plan HCBS. However, Medicare per user spending exceeded Medicaid per user spending for non-LTSS users.

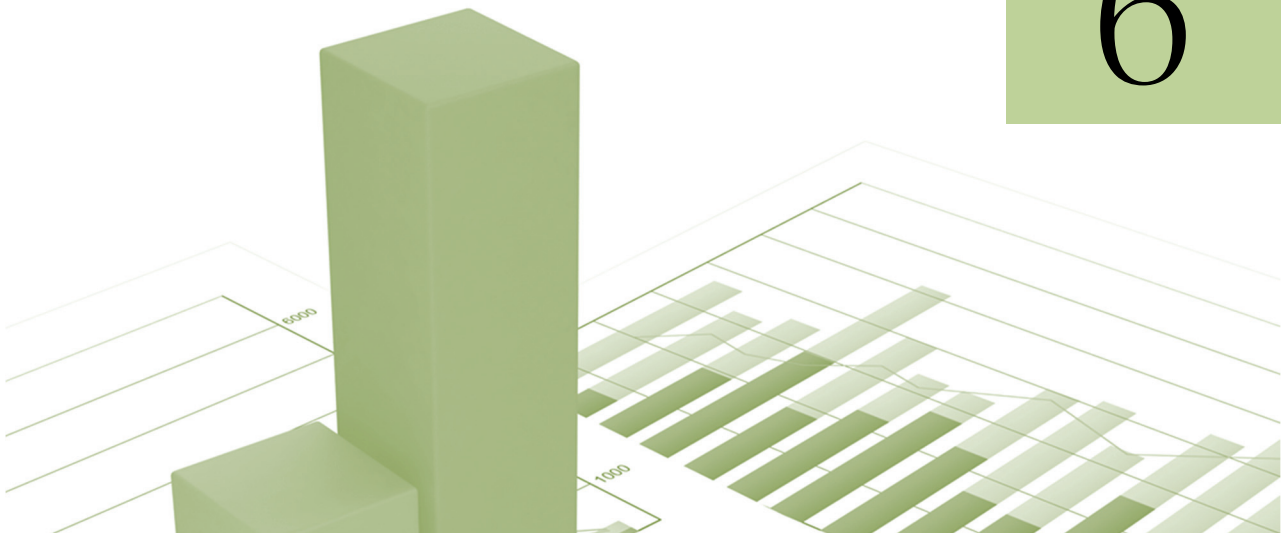
## Per user Medicare and Medicaid spending on FFS full-benefit dual-eligible Medicaid LTSS users by age, CY 2012



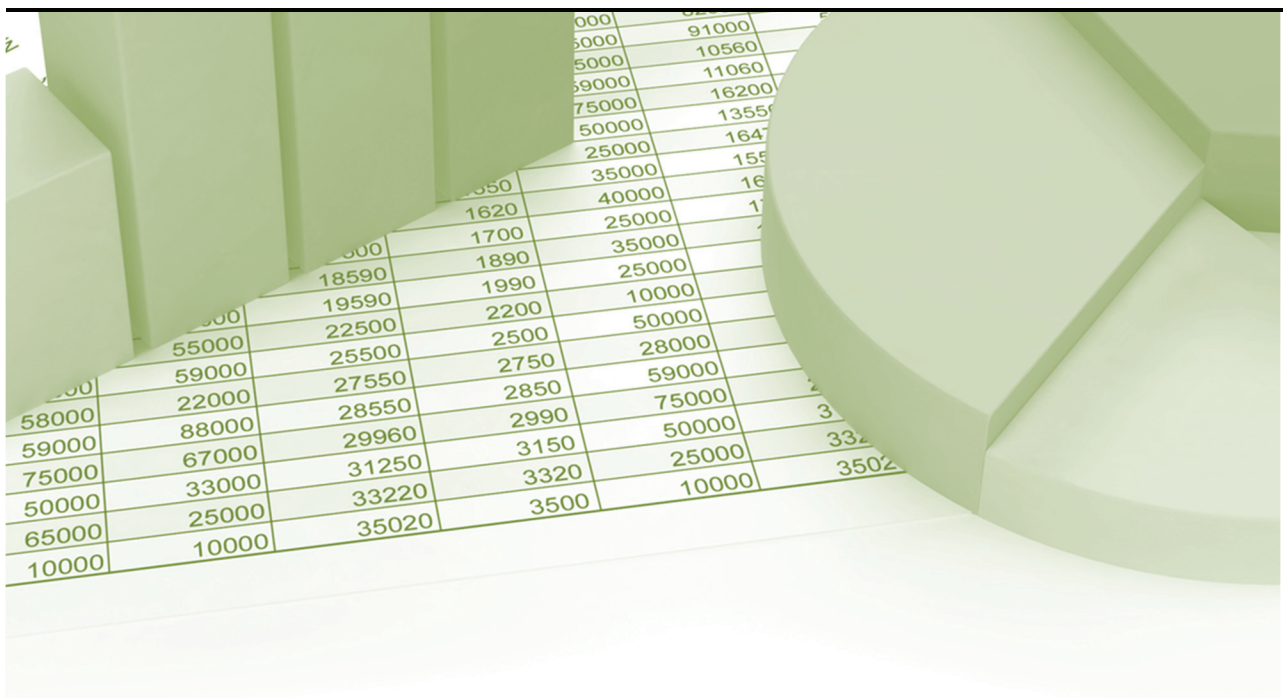
**Note:** FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible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

- Among Medicaid LTSS users who were ages 65 and older, total per user spending was higher for those who received Medicaid LTSS in an institution (\$30,812 and \$40,323) than for those who received Medicaid LTSS through HCBS waivers (\$22,857 and \$21,867) or through state plan HCBS (\$21,580 and \$16,060).
- Among Medicaid LTSS users under age 65, Medicare per user spending was higher for those who received Medicaid institutional LTSS compared with those receiving home- and community-based Medicaid LTSS.
- Medicaid per user spending on Medicaid institutional LTSS users under age 65 (\$72,598) was higher than per user spending on any other subgroup of Medicaid LTSS users. It was also almost twice as high as per user spending on Medicaid institutional LTSS users who were ages 65 and older (\$40,323).



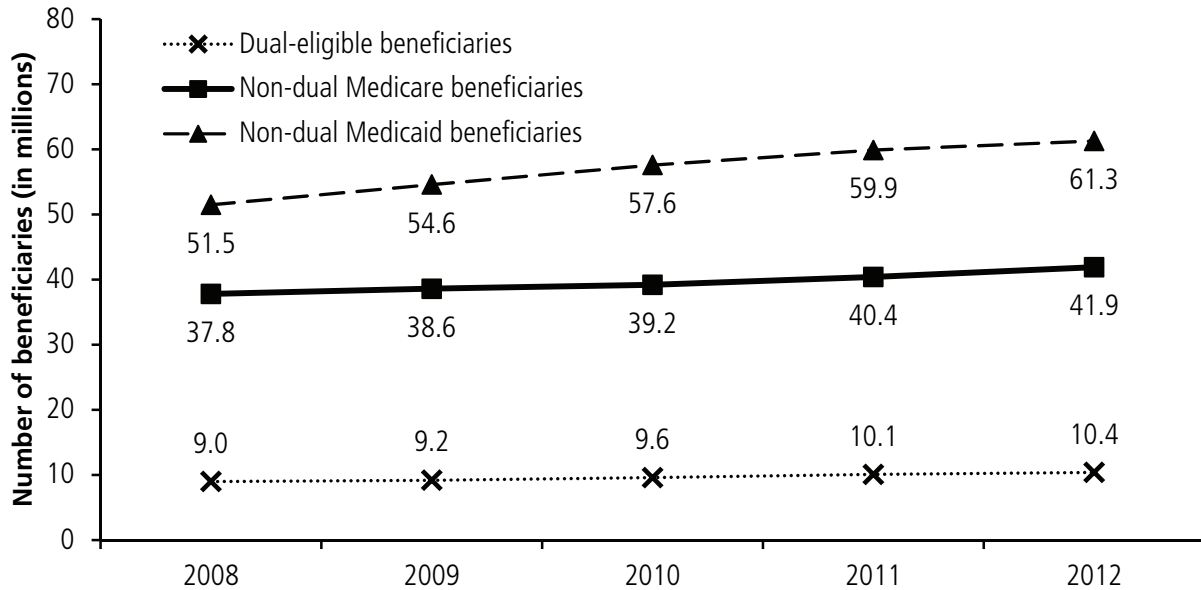


# Trends in dual-eligible population composition, spending, and service use





## Number of dual-eligible and non-dual Medicare and Medicaid beneficiaries, CY 2008–2012

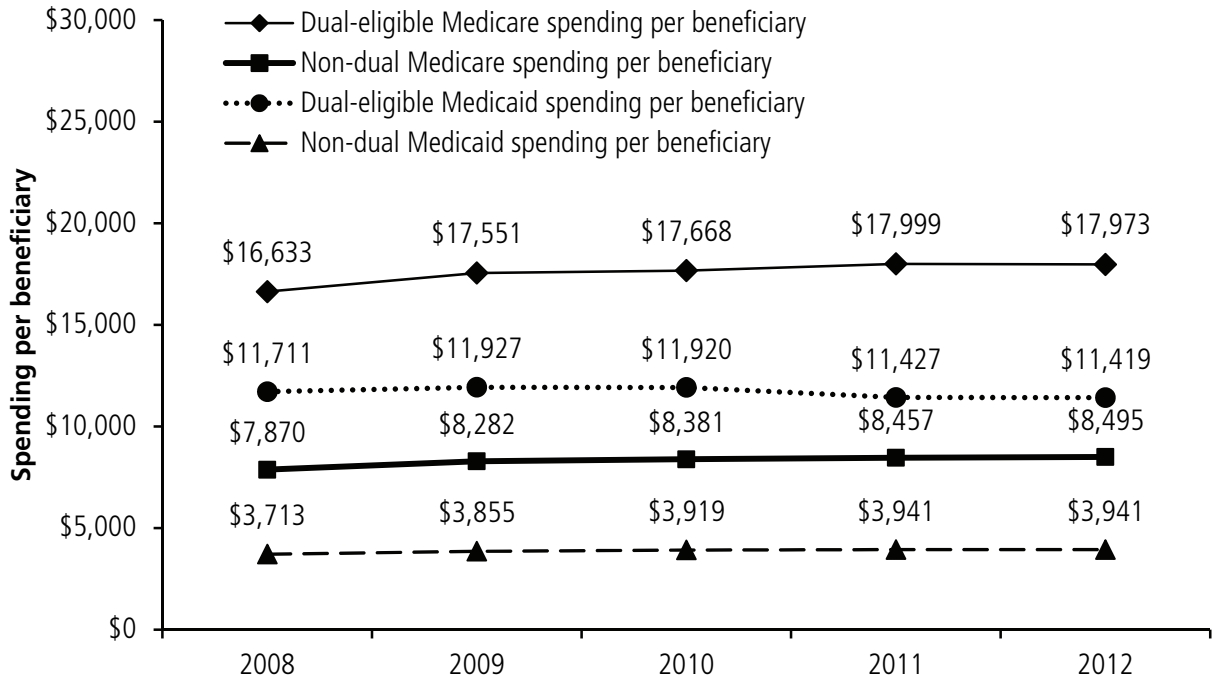


Category	Annual percentage growth in the number of beneficiaries				Cumulative growth	Average annual growth rate
	2009	2010	2011	2012		
Dual-eligible beneficiaries	2.7%	4.2%	4.5%	3.5%	15.8%	3.7%
Non-dual Medicare beneficiaries	2.0	1.8	2.9	3.7	10.8	2.6
Non-dual Medicaid beneficiaries	6.0	5.5	4.0	2.4	19.1	4.5

**Note:** CY (calendar year). Exhibit includes all dual-eligible and non-dual beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid beneficiaries include Medicaid-expansion Children’s Health Insurance Program enrollees. Individual figures shown are rounded; growth rates are computed based on unrounded numbers.

- The number of individuals dually eligible for Medicare and Medicaid grew from 9.0 million in 2008 to 10.4 million in 2012—a cumulative growth of 15.8 percent over the period and an average annual growth rate of 3.7 percent.
- The fastest growth was among non-dual-eligible Medicaid beneficiaries. Increasing from 51.5 million in 2008 to 61.3 million in 2012, the number of non-dual-eligible Medicaid beneficiaries had a cumulative growth of 19.1 percent and an average annual growth rate of 4.5 percent.
- The slowest growth was among non-dual-eligible Medicare beneficiaries. Although the number of non-dual-eligible Medicare beneficiaries increased from 37.8 million in 2008 to 41.9 million in 2012, non-dual-eligible Medicare beneficiaries had lower cumulative growth (10.8 percent) and lower average annual growth (2.6 percent) than dual-eligible beneficiaries and non-dual-eligible Medicaid beneficiaries.
- Although the number of Medicaid beneficiaries increased each year from 2008 to 2012, the rate of growth of non-dual-eligible Medicaid beneficiaries slowed in 2010, 2011, and 2012.

## Medicare and Medicaid spending per dual-eligible and non-dual beneficiary, CY 2008–2012



Category	Annual percentage growth in spending per beneficiary				Cumulative growth	Average annual growth rate
	2009	2010	2011	2012		
Dual-eligible Medicare spending per beneficiary	5.5%	0.7%	1.9%	-0.1%	8.1%	2.0%
Non-dual Medicare spending per beneficiary	5.2	1.2	0.9	0.4	7.9	1.9
Dual-eligible Medicaid spending per beneficiary	1.8	-0.1	-4.1	-0.1	-2.5	-0.6
Non-dual Medicaid spending per beneficiary	3.8	1.7	0.6	*	6.1	1.5

**Note:** CY (calendar year). Exhibit includes all dual-eligible and non-dual beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts include Medicaid-expansion Children’s Health Insurance Program amounts; amounts spent on dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Individual figures shown are rounded; growth rates are computed based on unrounded numbers.

\*Indicates a decline of less than 0.1 percent.

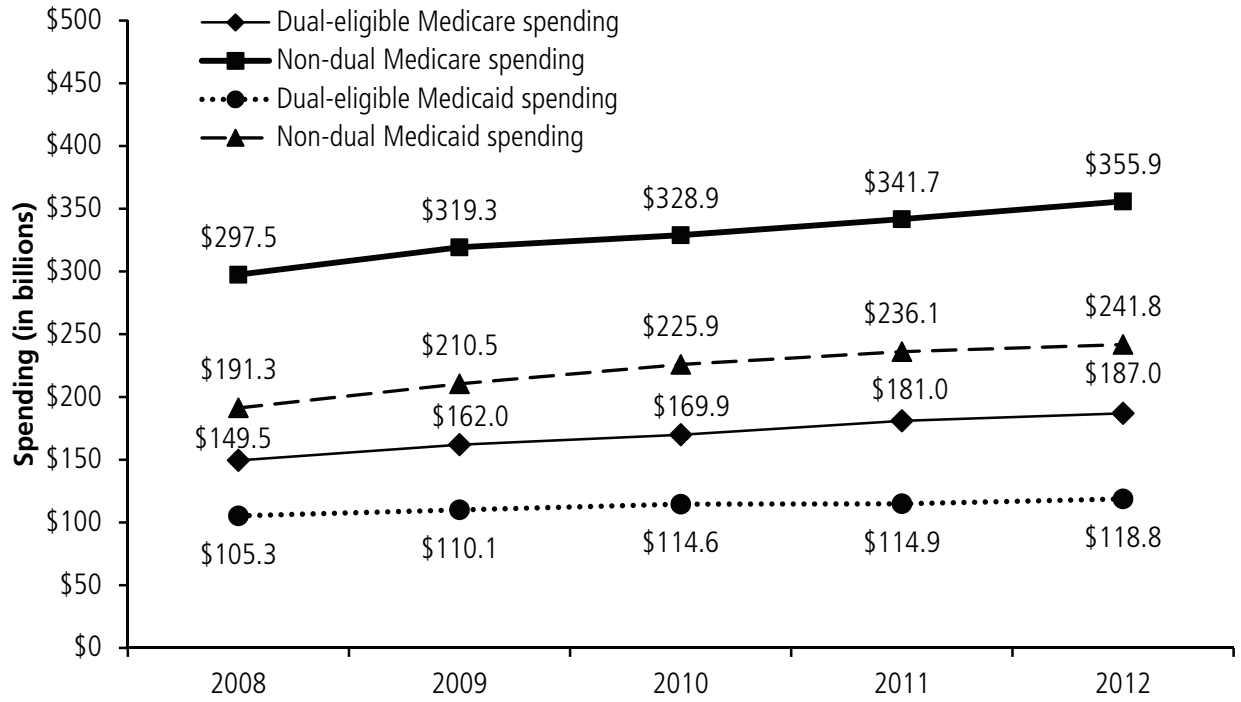
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## Medicare and Medicaid spending per dual-eligible and non-dual beneficiary, CY 2008–2012 (continued)

- Medicare per beneficiary spending grew between 2008 and 2012 for individuals dually eligible for Medicare and Medicaid (8.1 percent cumulative growth and 2.0 percent average annual growth for Medicare spending per beneficiary). However, Medicaid spending per dual-eligible beneficiary decreased between 2008 and 2012 (–2.5 percent cumulative growth and –0.6 percent average annual growth for Medicaid spending per beneficiary).
- Comparing Medicare per beneficiary spending on dual-eligible beneficiaries and non-dual beneficiaries, per beneficiary spending on dual-eligible beneficiaries increased slightly faster than per beneficiary spending on non-dual beneficiaries. Cumulative growth in Medicare per beneficiary spending between 2008 and 2012 was 8.1 percent for dual-eligible beneficiaries and 7.9 percent for non-dual beneficiaries; average annual growth was 2.0 percent for dual-eligible beneficiaries compared with 1.9 percent for non-dual beneficiaries.
- Medicaid per beneficiary spending on non-dual Medicaid beneficiaries increased, while Medicaid per beneficiary spending on dual-eligible beneficiaries decreased (6.1 percent cumulative growth and 1.5 percent average annual growth for non-dual beneficiaries compared with –2.5 percent cumulative and –0.6 percent average annual growth for dual-eligible beneficiaries).
- Medicaid spending per dual-eligible beneficiary was the only category to decline between 2008 and 2012.

## Medicare and Medicaid spending for dual-eligible and non-dual beneficiaries, CY 2008–2012



Category	Annual percentage growth in spending				Cumulative growth	Average annual growth rate
	2009	2010	2011	2012		
Dual-eligible Medicare spending	8.3%	4.9%	6.5%	3.3%	25.1%	5.8%
Non-dual Medicare spending	7.3	3.0	3.9	4.2	19.6	4.6
Dual-eligible Medicaid spending	4.6	4.1	0.2	3.4	12.9	3.1
Non-dual Medicaid spending	10.1	7.3	4.6	2.4	26.4	6.0

**Note:** CY (calendar year). Exhibit includes all dual-eligible and non-dual beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts include Medicaid-expansion Children’s Health Insurance Program amounts; amounts spent on dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Individual figures shown are rounded; growth rates are computed based on unrounded numbers.

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## Medicare and Medicaid spending for dual-eligible and non-dual beneficiaries, CY 2008–2012 (continued)

- Although Medicare and Medicaid spending on individuals dually eligible for Medicare and Medicaid and non-dual beneficiaries grew between 2008 and 2012, 2009 had the highest rate of growth for Medicare and Medicaid spending on dual-eligible beneficiaries and non-dual beneficiaries.
- Medicare spending on dual-eligible beneficiaries increased from \$149.5 billion in 2008 to \$187.0 billion in 2012—a cumulative growth of 25.1 percent and an average annual growth of 5.8 percent.
- Medicaid spent less than Medicare on dual-eligible beneficiaries between 2008 and 2012—Medicaid spending on dual-eligible beneficiaries was \$105.3 billion in 2008 and \$118.8 billion in 2012. Compared with the growth in Medicare spending on dual-eligible beneficiaries, both the cumulative growth of Medicaid spending on this population and the average annual growth rate were lower (12.9 percent and 3.1 percent, respectively).
- Non-dual Medicaid spending grew faster than Medicare and Medicaid spending on dual-eligible beneficiaries and faster than Medicare spending on non-dual beneficiaries. Increasing from \$191.3 billion in 2008 to \$241.8 billion in 2012, Medicaid spending on non-dual beneficiaries had a cumulative growth of 26.4 percent and an average annual growth rate of 6.0 percent.
- Although total Medicare spending was higher for non-dual beneficiaries than for dual-eligible beneficiaries between 2008 and 2012, Medicare spending on dual-eligible beneficiaries grew faster over this period compared with Medicare spending on non-dual beneficiaries. Cumulative growth in Medicare spending on dual-eligible beneficiaries was 25.1 percent compared with 19.6 percent for non-dual beneficiaries; average annual growth was 5.8 percent for dual-eligible beneficiaries compared with 4.6 percent for non-dual beneficiaries.

## Share of dual-eligible beneficiaries by selected beneficiary characteristics, CY 2008 and CY 2012

Beneficiary characteristic	2008	2012	2008–2012 percentage point change
<b>Age</b>			
65 and older	60.6%	58.6%	–2.0%
Under 65	39.4	41.4	2.0
<b>Benefit level</b>			
Full benefit	77.4%	72.5%	–4.9%
Partial benefit	22.6	27.5	4.9
<b>Original reason for entitlement to Medicare</b>			
Age	49.5%	47.0%	–2.5%
ESRD	1.0	0.8	–0.2
Disability	49.5	51.9	2.5
<b>Medicaid eligibility pathway</b>			
SSI	40.0%	35.5%	–4.5%
Poverty related	32.2	37.4	5.2
Medically needy	8.5	8.7	0.2
Section 1115 waiver	0.6	0.5	–0.1
Special income limit and other	18.7	17.8	–0.9
<b>Medicare FFS and managed care</b>			
FFS only	80.1%	75.7%	–4.3%
MA only	14.7	19.7	5.0
Both FFS and MA	5.2	4.5	–0.7
<b>Medicaid FFS and managed care</b>			
FFS only	58.8%	54.6%	–4.2%
FFS and limited-benefit managed care only	29.3	29.6	0.3
At least one month of comprehensive managed care	11.9	15.8	3.9

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

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## Share of dual-eligible beneficiaries by selected beneficiary characteristics, CY 2008 and CY 2012 (continued)

- Between CY 2008 and CY 2012, there was an increase in the share of dual-eligible beneficiaries who were under age 65 (2.0 percentage point increase) and in the share who received partial benefits (4.9 percentage point increase). The share of dual-eligible beneficiaries who were enrolled in FFS Medicare and the share who were enrolled in FFS Medicaid declined (4.3 and 4.2 percentage point decrease, respectively).
- The share of dual-eligible beneficiaries who qualified for Medicaid through poverty-related pathways, which often provide partial benefits, increased by 5.2 percentage points, from 32.2 percent of the dual-eligible population in 2008 to 37.4 percent of the population in 2012.
- There was a slight shift in dual-eligible beneficiaries' Medicare eligibility pathways between 2008 and 2012. In 2008, almost half (49.5 percent) of all dual-eligible beneficiaries originally qualified for Medicare on the basis of age. However, by 2012, slightly over half (51.9 percent) of dual-eligible beneficiaries originally qualified for Medicare on the basis of disability.
- The share whose only Medicare enrollment was in Medicare Advantage increased by 5.0 percentage points over this period. However, the share with enrollment in both Medicare FFS and Medicare Advantage decreased by 0.7 percentage points.
- The share of dual-eligible beneficiaries whose only Medicaid enrollment was in Medicaid FFS and a limited-benefit Medicaid managed care plan increased by 0.3 percentage points. The share with at least one month of comprehensive Medicaid managed care enrollment increased by 3.9 percentage points.

## Use of Medicare services and per user spending for FFS beneficiaries, CY 2008 and CY 2012

Select Medicare services	Full-benefit FFS dual-eligible beneficiaries			FFS non-dual Medicare beneficiaries		
	2008	2012	2008–2012	2008	2012	2008–2012
<b>Share using service in each year and percentage point change during period</b>						
Inpatient hospital	28.9%	26.8%	–2.0	18.3%	16.3%	–2.0
Skilled nursing facility	11.1	10.4	–0.8	4.3	4.2	–0.1
Home health	12.6	14.0	1.4	8.7	9.1	0.4
Other outpatient	94.1	94.7	0.7	91.4	91.8	0.4
Part D drugs	N/A	93.1	N/A	N/A	80.9	N/A
<b>Per user FFS spending in each year and average annual growth during period</b>						
Inpatient hospital	\$16,966	\$19,298	3.3%	\$14,215	\$16,047	3.1%
Skilled nursing facility	15,418	17,842	3.7	12,055	13,711	3.3
Home health	6,185	5,796	–1.6	4,534	4,573	0.2
Other outpatient	5,198	6,102	4.1	3,821	4,484	4.1
Part D drugs	4,469	4,945	2.6	1,436	1,661	3.7

**Note:** FFS (fee-for-service), CY (calendar year), N/A (not available). Dual-eligible beneficiaries are limited to full-benefit dual eligibles in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicare “inpatient hospital” includes psychiatric hospital services. Medicare “other outpatient” includes physician services, hospice, durable medical equipment, hospital outpatient, emergency room not preceding an inpatient stay, and other outpatient facilities. The figures for “Part D drugs” are based only on beneficiaries who were covered by a Part D plan; we do not have figures for the share of beneficiaries who filled Part D prescriptions in 2008. Percentage point change is calculated using unrounded numbers.

- Medicare per user FFS spending on full-benefit dual-eligible individuals increased between 2008 and 2012 for inpatient hospital services (3.3 percent average annual growth), skilled nursing facility services (3.7 percent average annual growth), other outpatient services (4.1 percent average annual growth) and Part D prescription fills (2.6 percent average annual growth). Medicare per user FFS spending on full-benefit dual-eligible beneficiaries decreased between 2008 and 2012 for home health services (–1.6 percent average annual growth).
- During this period, the share of full-benefit dual-eligible beneficiaries using home health services and other outpatient services increased (by 1.4 and 0.7 percentage points, respectively). The share of full-benefit dual-eligible beneficiaries using inpatient hospital services decreased by 2.0 percentage points and the share using skilled nursing facility services decreased by 0.8 percentage points.
- Comparing full-benefit dual-eligible beneficiaries with non-dual Medicare beneficiaries, per user FFS spending in 2008 and 2012 was higher for dual-eligible beneficiaries for each type of service. Growth in per user spending was faster for dual-eligible beneficiaries compared with non-dual Medicare beneficiaries for inpatient hospital services and skilled nursing facility services; it was similar or slower for home health services, other outpatient services, and Part D drugs.
- Between 2008 and 2012, a greater share of full-benefit dual-eligible beneficiaries were users of the select Medicare services shown in this exhibit than were non-dual Medicare beneficiaries.

## Use of Medicaid services and per user spending for FFS beneficiaries, CY 2008 and CY 2012

Select Medicaid services	Full-benefit FFS dual-eligible beneficiaries			Full-benefit FFS non-dual Medicaid beneficiaries (disabled, under age 65)		
	2008	2012	2008–2012	2008	2012	2008–2012
<b>Share using service in each year and percentage point change during period</b>						
Inpatient hospital	14.5%	13.1%	–1.3	17.4%	16.6%	–0.9
Outpatient	86.7	86.4	–0.3	86.9	82.4	–4.5
Institutional LTSS	22.5	20.8	–1.7	4.8	4.6	–0.1
HCBS state plan	14.8	13.0	–1.8	11.9	8.7	–3.2
HCBS waiver	13.3	13.8	0.5	8.4	9.3	1.0
Drugs	51.4	47.8	–3.6	77.3	72.1	–5.2
Managed care capitation	36.4	32.8	–3.6	63.3	61.4	–2.0
<b>Per user spending in each year and average annual growth during period</b>						
Inpatient hospital	\$2,023	\$2,120	1.2%	\$20,138	\$21,254	1.4%
Outpatient	2,255	2,300	0.5	5,079	5,676	2.8
Institutional LTSS	38,862	42,139	2.0	54,348	61,690	3.2
HCBS state plan	9,853	10,129	0.7	8,465	9,740	3.6
HCBS waiver	26,575	30,095	3.2	28,819	30,882	1.7
Drugs	320	258	–5.2	4,083	3,913	–1.1
Managed care capitation	1,167	2,783	24.3	1,032	1,803	15.0

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

- Medicaid per user FFS spending on full-benefit individuals dually eligible for Medicare and Medicaid increased between 2008 and 2012 for inpatient hospital services, outpatient services, institutional LTSS, HCBS state plan services, HCBS waiver services, and Medicaid managed care capitation payments.
- The share of full-benefit dual-eligible beneficiaries using institutional LTSS declined between 2008 and 2012 by 1.7 percentage points but remained above 20 percent in each year. The share of dual-eligible beneficiaries using HCBS waiver services increased over this period but remained below 15 percent.
- Medicaid per user spending on managed care had the largest percentage increase between 2008 and 2012 for both dual-eligible beneficiaries and non-dual disabled Medicaid beneficiaries (24.3 percent and 15.0 percent average annual growth, respectively). However, the share of beneficiaries in these groups with managed care capitation payments decreased between 2008 and 2012 by 3.6 percentage points for dual-eligible beneficiaries and 2.0 percentage points for non-dual disabled beneficiaries.

## Number of and spending for FFS full-benefit dual-eligible beneficiaries by Medicaid LTSS use, CY 2008 and CY 2012

Type of LTSS user	Full-benefit FFS dual-eligible beneficiaries (in millions)			Medicare spending (in billions)			Medicaid spending (in billions)		
	2008	2012	2008–2012 average annual growth	2008	2012	2008–2012 average annual growth	2008	2012	2008–2012 average annual growth
Users of institutional LTSS	1.0	0.9	–2.3%	\$29.4	\$30.1	0.5%	\$43.9	\$43.1	–0.5%
Users of HCBS waiver services	0.5	0.6	1.5	9.4	10.8	3.6	18.1	20.7	3.5
Users of HCBS state plan services	0.5	0.4	–3.2	9.9	9.7	–0.6	7.5	6.8	–2.1
No Medicaid LTSS use	2.5	2.6	0.4	29.0	34.1	4.2	6.9	8.9	6.6

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

- Among the categories of LTSS users, Medicaid and Medicare spending on individuals dually eligible for Medicare and Medicaid was highest in both 2008 and 2012 for dual-eligible beneficiaries who used institutional LTSS services compared with dual-eligible beneficiaries who used HCBS waiver or state plan services.
- In 2008 and 2012, Medicare spending was higher than Medicaid spending for users of HCBS state plan services and for dual-eligible beneficiaries who did not use LTSS services, while Medicaid spending was higher for users of institutional LTSS and users of HCBS waiver services. Medicare spending generally grew faster than Medicaid spending between 2008 and 2012 for all LTSS users.
- Medicare spending on institutional LTSS users grew each year by an average of 0.5 percent, while Medicaid spending on institutional LTSS users declined by 0.5 percent each year on average.



## Average annual growth in dual-eligible enrollment by state, CY 2008–2012

State	Average annual growth in number of dual-eligible beneficiaries			Number of dual-eligible beneficiaries (in thousands)					
	CY 2008–2012			CY 2008			CY 2012		
	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit
National	3.7%	2.0%	9.0%	8,989	6,957	2,031	10,406	7,542	2,864
Alabama	1.4	-0.4	3.0	203	96	107	215	95	120
Alaska	4.9	4.6	16.9	14	13	0	17	16	1
Arizona	4.3	3.7	6.3	155	120	34	183	139	44
Arkansas	2.6	0.2	6.0	121	74	48	134	74	60
California	2.7	2.6	9.6	1,196	1,167	29	1,333	1,291	42
Colorado	4.8	3.6	8.2	82	62	20	99	72	27
Connecticut	12.3	0.9	35.4	104	79	25	165	82	83
Delaware	4.5	3.2	5.6	24	11	12	28	13	15
District of Columbia	7.1	2.8	24.4	22	18	3	29	20	8
Florida	6.9	3.1	11.4	589	338	251	768	382	386
Georgia	3.5	0.3	7.3	259	145	114	297	146	151
Hawaii	3.8	2.8	12.2	32	29	3	38	33	5
Idaho	5.1	2.5	10.8	32	23	9	39	25	14
Illinois	4.1	4.3	3.3	319	277	41	375	328	47
Indiana	4.4	4.3	4.7	157	103	54	186	121	65
Iowa	2.8	1.4	9.5	80	67	13	89	71	19
Kansas	3.6	0.1	12.0	63	46	16	72	47	26
Kentucky	2.3	-0.4	6.2	173	106	67	190	105	86
Louisiana	4.3	1.5	8.3	177	108	69	209	115	95
Maine	2.8	1.9	3.9	93	53	39	103	57	46
Maryland	5.2	3.5	8.6	109	74	35	134	85	49
Massachusetts	2.8	1.9	15.1	252	239	14	282	258	24
Michigan	4.3	2.9	13.3	265	234	31	313	263	50
Minnesota	3.1	2.6	6.4	130	115	14	146	128	18
Mississippi	2.0	0.2	4.0	153	84	69	165	84	81
Missouri	1.9	0.2	12.9	173	154	19	186	155	32
Montana	8.8	2.3	31.4	18	15	3	26	17	9
Nebraska	2.0	1.3	7.7	42	38	4	45	40	5
Nevada	5.7	3.2	8.5	40	22	18	49	25	25
New Hampshire	5.3	2.2	12.3	29	21	8	35	23	13
New Jersey	2.2	2.2	2.4	203	177	26	222	193	29
New Mexico	7.7	1.4	19.3	56	39	17	75	42	34
New York	3.6	2.4	11.3	737	648	89	849	713	137
North Carolina	2.4	0.9	8.1	310	250	60	341	259	83
North Dakota	1.3	3.1	-4.4	15	11	4	16	13	3
Ohio	4.2	3.1	6.7	307	212	95	362	239	123
Oklahoma	2.6	1.8	6.5	112	94	18	124	101	24
Oregon	6.3	3.4	11.9	90	62	29	115	70	45

State	Average annual growth in number of dual-eligible beneficiaries			Number of dual-eligible beneficiaries (in thousands)					
	CY 2008–2012			CY 2008			CY 2012		
	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit
Pennsylvania	4.1	3.1	9.0	384	326	58	450	369	81
Rhode Island	0.4	-0.2	4.1	39	33	6	40	33	7
South Carolina	2.2	1.3	7.7	148	130	18	161	137	25
South Dakota	1.9	*	5.6	20	14	7	22	14	8
Tennessee	0.2	-7.8	17.6	282	214	68	284	155	129
Texas	3.8	1.4	7.8	611	387	224	711	409	302
Utah	5.3	3.6	17.7	30	27	3	37	32	6
Vermont	2.6	2.1	3.8	28	20	8	31	22	9
Virginia	3.5	1.9	6.8	171	119	52	196	129	67
Washington	5.7	4.1	10.4	149	113	36	186	133	53
West Virginia	2.8	1.1	5.3	78	48	30	88	50	37
Wisconsin	4.0	3.7	6.6	148	130	18	173	150	23
Wyoming	4.1	1.7	8.9	10	7	3	12	7	4

**Note:** Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Beneficiaries are attributed to a state based on their most recent month of enrollment. The sum of the state counts exceeds the unduplicated national count because a small number (less than 1 percent) of beneficiaries were reported in more than one state for their most recent month of enrollment in the Medicaid program. Average annual growth rates are calculated using unrounded numbers.

\* Indicates a decline of less than 0.1 percent.

**Source:** Acumen LLC analysis of Medicare and Medicaid enrollment data for MedPAC and MACPAC.

- Between CY 2008 and 2012, national average annual growth in total dual-eligible enrollment was 3.7 percent, 2.0 percent for the full-benefit population, and 9.0 percent for the partial-benefit population.
- Average annual growth in total dual-eligible enrollment varied substantially by state. One state had a growth rate in excess of 10 percent (Connecticut).
- No state had average annual growth in full-benefit dual-eligible enrollment of more than 5 percent. The number of full-benefit dual eligibles declined in five states (Alabama, Kentucky, Rhode Island, South Dakota and Tennessee).
- In contrast, partial-benefit enrollment growth rates exceeded 5 percent in all but nine states, and exceeded 15 percent in eight states. Partial-benefit enrollment growth rates decreased in North Dakota.





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