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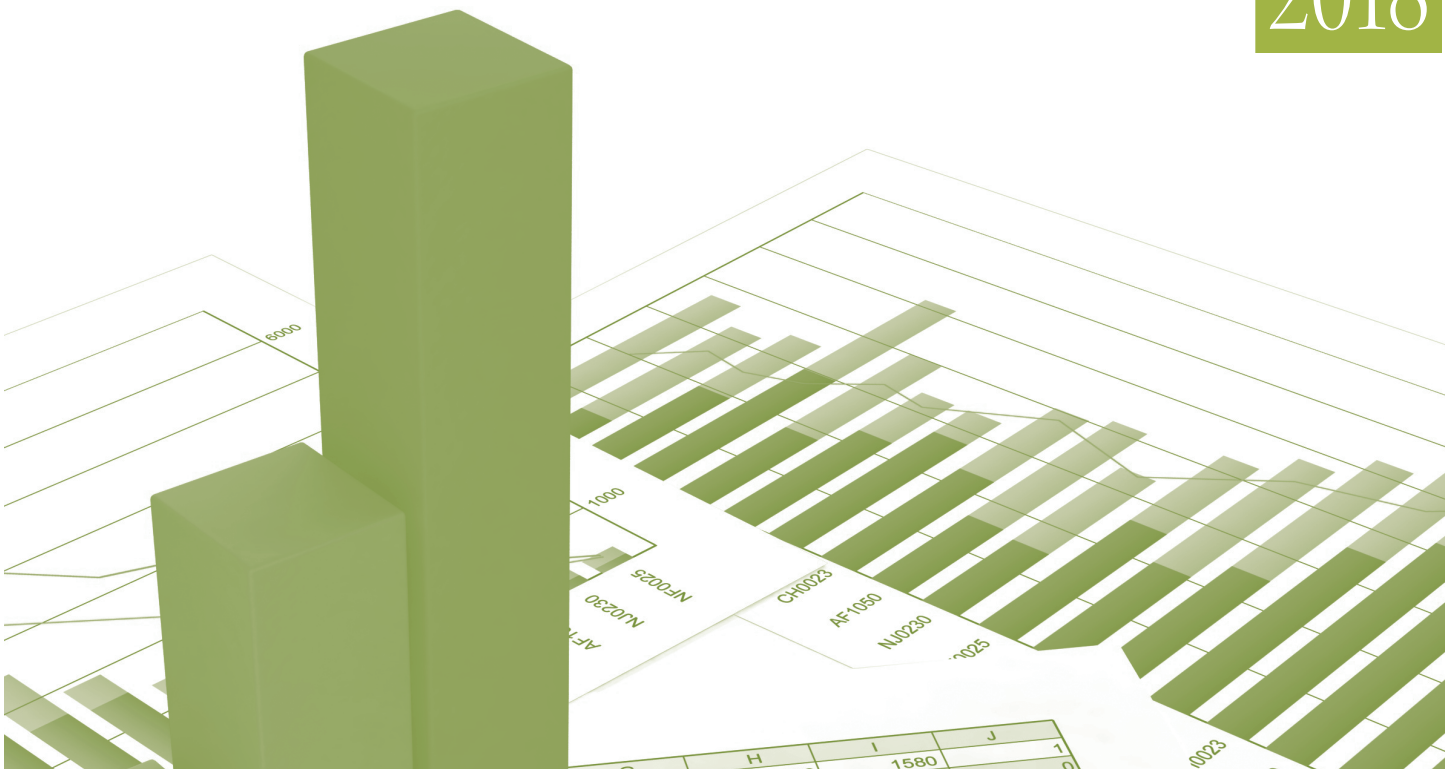

DATA BOOK

BENEFICIARIES DUALLY ELIGIBLE FOR MEDICARE AND MEDICAID

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

MEDPAC Medicare Payment Advisory Commission

MACPAC Medicaid and CHIP Payment and Access Commission

Acknowledgments

We would like to thank Natalia Panikashvili and the team from Acumen LLC for their insights and assistance while we produced this data book.

About MedPAC

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

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

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

About MACPAC

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

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

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

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

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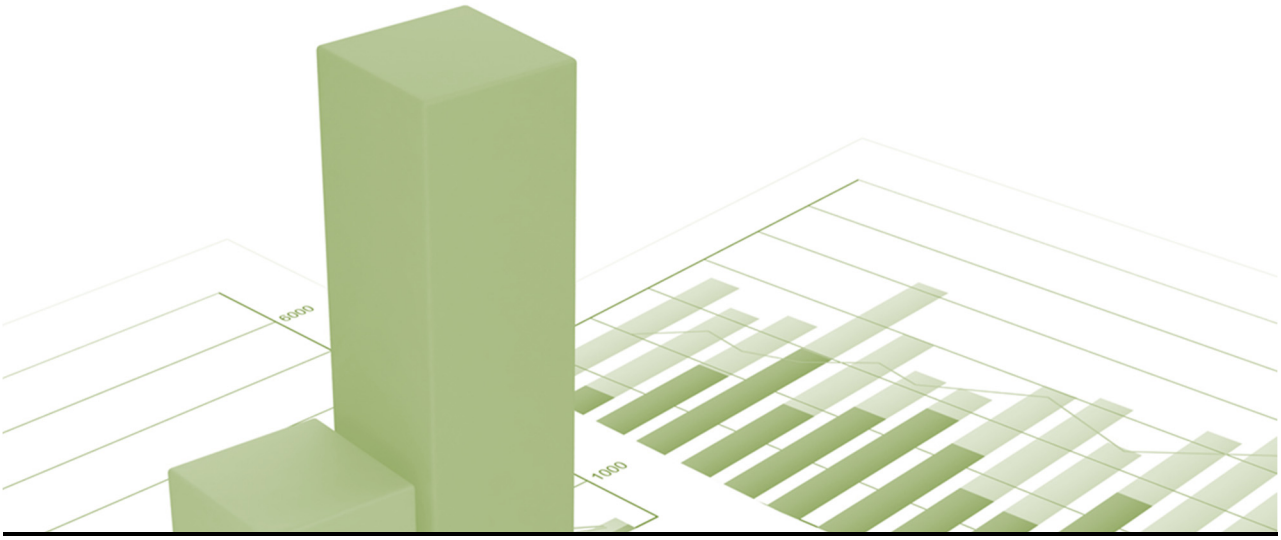
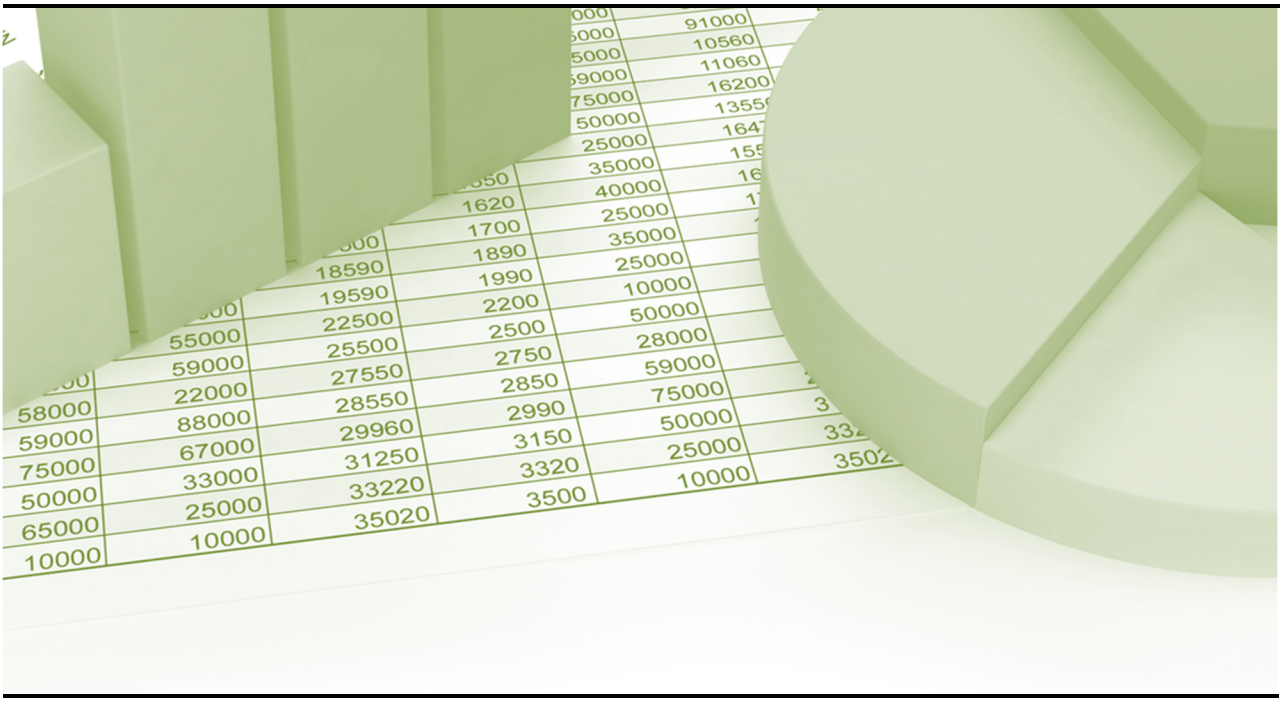


Introduction



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

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

Policymakers have expressed particular interest in dual-eligible beneficiaries because of the relatively large expenditures by both Medicare and Medicaid for this relatively small group of individuals. Concerns have also been raised as to how the existence of separate funding streams creates barriers to coordination of care and the extent to which lack of coordination increases costs and leads to poor health outcomes. Because these issues are of concern to both commissions, we thought it prudent to combine resources and conduct a joint analysis of federal Medicare and Medicaid data. This data book, the fifth we have jointly produced, 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) 2013, 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 2009 and CY 2013.

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 2018, the FMAP ranges from 50 percent to about 76 percent (Office of the Secretary, Department of Health and Human Services 2016).

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 2017	Benefits
Medicare Savings Program (MSP) beneficiaries			
Qualified Medicare beneficiary (QMB)	Partial: QMB only	▪ At or below 100% FPL ▪ $7,390 / $11,090	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: ▪ Medicare Part A premiums (if needed) ▪ Medicare Part B premiums ▪ At state option, certain premiums charged by Medicare Advantage plans ▪ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program)

	Full: QMB plus	▪ At or below 100% FPL ▪ $2,000 / $3,000	Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of: ▪ Medicare Part A premiums (if needed) ▪ Medicare Part B premiums ▪ At state option, certain premiums charged by Medicare Advantage plans ▪ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D) ▪ All Medicaid-covered services
Specified low-income Medicare beneficiary (SLMB)	Partial: SLMB only	▪ 101%–120% FPL ▪ $7,390 / $11,090	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: ▪ Medicare Part B premiums
	Full: SLMB plus	▪ 101%–120% FPL ▪ $2,000 / $3,000	Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of: ▪ Medicare Part B premiums ▪ At state option, certain premiums charged by Medicare Advantage plans ▪ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid ▪ All Medicaid-covered services
Qualifying individual (QI)	Partial	▪ 121%–135% FPL ▪ $7,390 / $11,090	Entitled to Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: ▪ Medicare Part B premiums
Qualified disabled and working individuals (QDWI)	Partial	▪ At or below 200% FPL ▪ $4,000 / $6,000	Lost Medicare Part A benefits because of their return to work but eligible to purchase Medicare Part A, only eligible for Medicaid under MSP, and qualify for Medicaid payment of: ▪ Medicare Part A premiums
Non-MSP beneficiaries			
Other full-benefit dual-eligible beneficiaries	Full	▪ Income limit varies, but generally at or below 300% of the federal Supplemental Security Income benefit rate (about 225% FPL for an individual) ▪ $2,000 / $3,000	Eligible under a mandatory or optional Medicaid pathway, not eligible for MSP, and qualify for Medicaid payment of: ▪ At state option, certain premiums charged by Medicare Advantage plans ▪ Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid ▪ All Medicaid-covered services

Note: *FPL (federal poverty level), MSP (Medicare Savings Program), QI (qualifying individual), QMB (qualified Medicare beneficiary), QDWI (qualified disabled and working individuals), SLMB (specified low-income Medicare beneficiary). Medicaid benefits for dual-eligible beneficiaries are jointly financed by states and the federal government. 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. Some 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 2011, 2013a, and 2013b; Medicaid and CHIP Payment and Access Commission 2015; Office of Inspector General, Department of Health and Human Services 2012; Social Security Act; Social Security Administration 2017.*

In addition, states have the authority to expand eligibility for MSP benefits by using less restrictive methodologies for counting income and assets. As of November 2017, the following states and the District of Columbia have expanded eligibility (Table 2).

Table 2. States with expanded Medicare Savings Program (MSP) income and asset levels, as of November 2017

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
Federal standard	**100%**	**$7,390**	**$11,090**	**120%**	**$7,390**	**$11,090**	**135%**	**$7,390**	**$11,090**
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[1]	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[2]	300	No limit	No limit	N/A	N/A	N/A	N/A	N/A	N/A
Indiana	150	$7,390	$11,090	170	$7,390	$11,090	185	$7,390	$11,090
Maine[3]	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[4]	100	$7,390	$11,090	135	$7,390	$11,090	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.*

[1]In Connecticut, QMB, SLMB, and QI income levels are calculations and are rounded.

[2]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.

[3]Liquid assets refers to cash or other resources that can be converted into cash on demand.

[4]Maryland does not have a QI program because it has expanded eligibility for the SLMB program to 135 percent of FPL. The state also allows beneficiaries to exclude some assets as part of a burial allowance.

Source: *Alabama Medicaid Agency 2017; Arizona Health Care Cost Containment System 2017; Baltimore County Government 2017; Baltimore County SHIP 2017; Centers for Medicare & Medicaid Services 2017a; Connecticut Department of Social Services 2017; Delaware Health and Social Services 2017; District of Columbia Department of Health Care Finance 2017; District of Columbia Department of Health Care Finance 2013; Indiana Family and Social Services Administration 2017; Maine Department of Health and Human Services 2017; Minnesota Department of Human Services 2017; Mississippi Division of Medicaid 2016; New York State Department of Health 2017; Oregon Department of Human Services 2017; 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 2017c.*

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 (QIs) 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 (Medicaid and CHIP Payment and Access Commission 2015). 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, 2017 and 2013

Part A	
Premium	Premium-free for insured individuals and their dependents and survivors; for uninsured individuals "buying in," $413 per month in 2017 or $227 for individuals with at least 30 quarters of coverage ($441 and $243, respectively, in 2013), plus the Part B premium (Part A cannot be purchased by itself)
Hospital stays	$1,316 deductible in 2017 for days 1–60 of each benefit period ($1,184 in 2013)
	$329 per day in 2017 for days 61–90 of each benefit period (1/4 of hospital deductible each year) ($296 in 2013)
	$658 per "lifetime reserve day" in 2017 (1/2 of hospital deductible each year) after day 90 of each benefit period (up to 60 days over lifetime) ($592 in 2013)
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
	$164.50 per day in 2017 (1/8 of hospital deductible each year) for days 21–100 of each benefit period ($148 in 2013)
	All costs for each day after day 100 of each benefit period
Hospice care	$0 for hospice visits; up to a $5 copay for outpatient prescription drugs
	5% of the Medicare-approved amount for inpatient respite care
Blood	All costs for the first three pints (unless donated to replace what is used)
Part B	
Premium	$134.00 per month (the standard premium) in 2017 ($104.90 in 2013), except for beneficiaries who pay the previous year's premium of $109.00 since the hold-harmless provision kept their premium from increasing because of the level of the cost-of-living adjustment in Social Security benefits in 2017; Part B premiums have been higher for higher income individuals since 2007
Deductible	The first $183 of Part B–covered services or items in 2017 ($147 in 2013)
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 2017 (21.9% in 2013); 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 2017 (35% in 2013)
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)
Part D, standard benefit	
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 2017 is $35.63 ($31.17 in 2013); higher premiums for higher income individuals as of 2011; dual-eligible beneficiaries have access to at least one plan in which the premium is fully subsidized; other low-income individuals can have partial subsidization of their premiums.
Deductible	$400 in 2017 ($325 in 2013); not applied to dual-eligible beneficiaries; dual-eligible beneficiaries pay only nominal copayments
Initial coverage limit	$3,700 in 2017 ($2,970 in 2013); dual-eligible beneficiaries pay only nominal copayments
Out-of-pocket threshold (catastrophic cap)	$4,950 in 2017 ($4,750 in 2013); 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 2017, from $1.20 for generic or preferred multisource drugs up to $8.25 for other drugs, depending on the person's subsidy category (a range of $1.15 to $6.60 in 2013).
Rules for Medicare Advantage plans	
Part A and Part B premiums and cost sharing	Plans can vary the services for which cost sharing is charged and the level of cost sharing, but for certain services, the cost sharing cannot exceed Medicare levels or other limits as specified in Medicare rules. In addition, the overall cost sharing in the plan for Part A and Part B services may not exceed, on average, the actuarial value of the cost sharing of traditional FFS Medicare. In lieu of cost sharing at the point of service, plans may obtain cost-sharing revenue through a monthly premium that all enrollees would pay. MA plans are prohibited from billing QMBs and full-benefit dual-eligible beneficiaries for Medicare cost sharing if the state has financial responsibility for the cost sharing, but the plan can require beneficiaries to pay cost sharing at levels permitted under the Medicaid program of a given state. The MA plan or its providers can bill the state for any cost sharing that is payable by the state.

Note: *FFS (fee-for-service), MA (Medicare Advantage), QMB (qualified Medicare beneficiary). A benefit period in Part A begins the day a beneficiary is admitted to a hospital or skilled nursing facility and ends when the beneficiary has not received hospital or skilled nursing care for 60 days in a row. If the beneficiary is admitted to the hospital after one benefit period has ended, a new benefit period begins, and the beneficiary must again pay the inpatient hospital deductible. There is no limit to the number of benefit periods. Part A cost sharing increases over time by the same percentage update applied to payments to inpatient hospitals and is adjusted to reflect real change in case mix.*
Source: *Medicare Payment Advisory Commission 2013 and Centers for Medicare & Medicaid Services 2012a, 2012b, 2012c, 2014, 2016a, 2016b, 2016c.*

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 is also an entitlement for individuals meeting criteria for eligibility pathways 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 some 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 2009 through 2013. When the analytic work for this data book began, CY 2013 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 now uses 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 2013 identified through analyses completed for this data book (4.1 million). More recent state-reported figures show that there were about 1 million Medicaid managed care LTSS users in 2015 (Centers for Medicare & Medicaid Services 2017b).

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 about 50 percent of Medicaid FFS spending on inpatient and outpatient hospital services (Medicaid and CHIP Payment and Access Commission 2016). The MSIS data also exclude Medicaid payments for Medicare premiums—$13.8 billion in 2013, of which $8.1 billion was the federal share and $5.6 billion was the state share (Medicaid and CHIP Payment and Access Commission 2017)—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 Policy Research 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.

  At the time we conducted the analyses for this data book, three states—Alaska, Kansas, and Rhode Island—had not submitted complete MSIS data for 2013. We have used the 2012 data for these states (for both Medicare and Medicaid) instead of the incomplete 2013 data. These states collectively account for about 1 percent of all dual-eligible beneficiaries, and using their 2012 data has little effect on the national figures presented here.

- *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 2013

Type of cost sharing	Full-benefit dual-eligible beneficiaries			Limited-benefit dual-eligible beneficiaries		Non-dual Medicare beneficiaries
	QMB plus	SLMB plus	Other full benefit	QMB only	SLMB only, QI, and QDWI	
Part A total	**$2.8**	**$0.3**	**$1.7**	**$0.4**	**$0.4**	**$9.5**
Hospital deductible	1.3	0.1	0.5	0.3	0.3	6.0
Hospital-day copayments	0.3	<0.1	0.2	<0.1	<0.1	0.5
SNF-day copayments	1.1	0.2	1.0	0.1	0.1	3.0
Part B total	**6.1**	**0.4**	**2.2**	**1.3**	**1.2**	**30.8**
Deductible	0.5	<0.1	0.2	0.1	0.1	3.6
Coinsurance	5.6	0.4	2.0	1.2	1.0	27.2
Part A and Part B total	**8.9**	**0.7**	**3.9**	**1.7**	**1.6**	**40.3**

Note: *QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual), QDWI (qualified disabled and working individuals), 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 96 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 2013

	Number of beneficiaries (millions)		Average monthly as a percent of ever enrolled
	Ever enrolled	Average monthly	
Dual-eligible beneficiaries	**10.7**	**9.5**	**89%**
Under age 65	4.4	4.0	90
Ages 65 and older	6.2	5.5	89
Medicare beneficiaries with no dual-eligible enrollment	**43.3**	**41.7**	**96**
Under age 65	4.5	4.4	99
Ages 65 and older	38.8	37.3	96
Medicaid beneficiaries with no dual-eligible enrollment	**62.9**	**51.9**	**83**
Nondisabled under age 65	55.9	45.4	81
Disabled under age 65	6.3	5.8	92
Ages 65 and older	0.7	0.6	92
All Medicare beneficiaries	**53.9**	**51.2**	**95**
All Medicaid beneficiaries	**73.6**	**61.4**	**83**

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 2013 (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. We also did not include managed care enrollees in our figures for utilization due to concerns about the completeness of the encounter data submitted by both MA and Medicaid managed care plans. 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 2013 (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 vs. 2 percent). This difference reflects the ability of dual-eligible beneficiaries to enroll in or disenroll from MA on a month-by-month basis (whereas non-dual Medicare beneficiaries generally can only make changes during a limited open enrollment period each year). Dual-eligible beneficiaries were less likely to have been in comprehensive Medicaid managed care plans than non-dual disabled Medicaid beneficiaries under age 65 (17 percent vs. 57 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, they are disproportionately represented in the FFS population because they are the only class of Medicare beneficiaries specifically prohibited from enrolling in MA plans (except in certain circumstances; this prohibition will be lifted in 2021). 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 2013

	All beneficiaries	Non-ESRD	ESRD	ESRD as percent of total
Population				
All Medicare beneficiaries (in millions)	53.9	53.3	0.6	1.1%
Dual-eligible beneficiaries (in millions)	10.7	10.4	0.3	2.4
Dual-eligible beneficiaries as percent of category	20%	20%	42%	
Medicare expenditures				
Total spending (in billions)	$565.2	$527.4	$37.8	6.7
Per person per year	10,478	9,889	61,996	
Spending on dual-eligible beneficiaries (in billions)	193.5	173.5	20.1	10.4
Per person per year	18,112	16,636	77,785	
Spending on non-dual beneficiaries (in billions)	371.7	353.9	17.8	4.8
Per person per year	8,593	8,249	50,428	
Medicaid expenditures				
Spending on dual-eligible beneficiaries (in billions)	$118.9	$115.1	$3.8	3.2
Per person per year	11,126	11,040	14,612	

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 2013, annual per capita Medicare spending for dual-eligible ESRD beneficiaries was $77,785; per capita Medicaid spending for the same population was $14,612. With the ESRD population included, annual per capita Medicare spending for dual-eligible beneficiaries averaged $18,112 in 2013; excluding ESRD beneficiaries, per capita Medicare spending on dual-eligible beneficiaries averaged $16,636 for the year. In

comparison, Medicaid per capita spending on dual-eligible beneficiaries including the ESRD population was $11,126; excluding these individuals, the amount was $11,040.

Table 8. Dual-eligible, Medicare, and Medicaid beneficiaries as a percent of population by state, CY 2013 (continued next page)

State	Total population (thousands)	Dual-eligible beneficiaries						All Medicare beneficiaries		All Medicaid beneficiaries	
		All		Full		Partial					
		Number (thousands)	Percent of total population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of total population	Number (thousands)	Percent of total population
National	316,129	10,684	3%	7,672	72%	3,013	28%	53,939	17%	73,559	23%
Alabama	4,834	219	5	94	43	125	57	970	20	1,204	25
Alaska	735	17	2	16	96	1	4	77	11	150	20
Arizona	6,627	189	3	144	76	46	24	1,099	17	1,624	25
Arkansas	2,959	136	5	74	54	63	46	601	20	773	26
California	38,333	1,364	4	1,324	97	41	3	5,624	15	13,078	34
Colorado	5,268	106	2	76	72	30	28	760	14	920	17
Connecticut	3,596	173	5	82	48	90	52	640	18	855	24
Delaware	926	29	3	13	45	16	55	176	19	252	27
District of Columbia	646	33	5	23	72	9	28	91	14	251	39
Florida	19,553	794	4	381	48	413	52	3,925	20	4,236	22
Georgia	9,992	322	3	154	48	167	52	1,490	15	1,977	20
Hawaii	1,404	39	3	34	88	5	12	241	17	333	24
Idaho	1,612	42	3	26	62	16	38	274	17	296	18
Illinois	12,882	379	3	330	87	49	13	2,085	16	3,086	24
Indiana	6,571	190	3	125	66	65	34	1,155	18	1,283	20
Iowa	3,090	91	3	72	79	19	21	578	19	635	21
Kansas	2,894	72	3	47	64	26	36	480	17	422	15
Kentucky	4,395	191	4	104	54	87	46	868	20	959	22
Louisiana	4,625	214	5	115	54	99	46	795	17	1,396	30
Maine	1,328	101	8	57	56	45	44	305	23	365	27
Maryland	5,929	139	2	87	63	52	37	926	16	1,257	21
Massachusetts	6,693	301	4	275	91	26	9	1,222	18	1,597	24
Michigan	9,896	319	3	271	85	48	15	1,900	19	2,253	23
Minnesota	5,420	149	3	130	87	19	13	909	17	1,143	21
Mississippi	2,991	169	6	86	51	83	49	566	19	782	26
Missouri	6,044	183	3	152	83	31	17	1,129	19	1,149	19
Montana	1,015	27	3	17	64	10	36	198	20	151	15

State	Total population (thousands)	Dual-eligible beneficiaries						All Medicare beneficiaries		All Medicaid beneficiaries	
		All		Full		Partial					
		Number (thousands)	Percent of total population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of total population	Number (thousands)	Percent of total population
Nebraska	1,869	45	2	40	89	5	11	314	17	295	16
Nevada	2,790	51	2	26	50	26	50	434	16	397	14
New Hampshire	1,323	36	3	23	64	13	36	261	20	177	13
New Jersey	8,899	224	3	197	88	28	12	1,504	17	1,447	16
New Mexico	2,085	78	4	44	56	34	44	367	18	671	32
New York	19,651	888	5	717	81	170	19	3,384	17	6,148	31
North Carolina	9,848	346	4	264	76	82	24	1,746	18	2,016	20
North Dakota	723	16	2	13	79	3	21	120	17	84	12
Ohio	11,571	370	3	241	65	129	35	2,171	19	2,748	24
Oklahoma	3,851	125	3	101	81	24	19	686	18	1,018	26
Oregon	3,930	120	3	72	60	48	40	737	19	735	19
Pennsylvania	12,774	461	4	377	82	84	18	2,567	20	2,536	20
Rhode Island	1,052	40	4	33	83	7	17	197	19	207	20
South Carolina	4,775	164	3	137	84	26	16	916	19	1,167	24
South Dakota	845	22	3	14	62	9	38	155	18	143	17
Tennessee	6,496	288	4	153	53	135	47	1,233	19	1,537	24
Texas	26,448	725	3	412	57	313	43	3,569	13	5,175	20
Utah	2,901	38	1	32	84	6	16	337	12	378	13
Vermont	627	31	5	22	70	9	30	131	21	201	32
Virginia	8,260	200	2	131	66	68	34	1,336	16	1,187	14
Washington	6,971	193	3	135	70	58	30	1,160	17	1,404	20
West Virginia	1,854	88	5	50	58	37	42	425	23	433	23
Wisconsin	5,743	177	3	153	86	24	14	1,047	18	1,301	23
Wyoming	583	12	2	7	61	5	39	94	16	84	14

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

Source: *Acumen LLC analysis of the Census Bureau's "Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2013" and Medicare and Medicaid enrollment data for MedPAC and MACPAC.*

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Section

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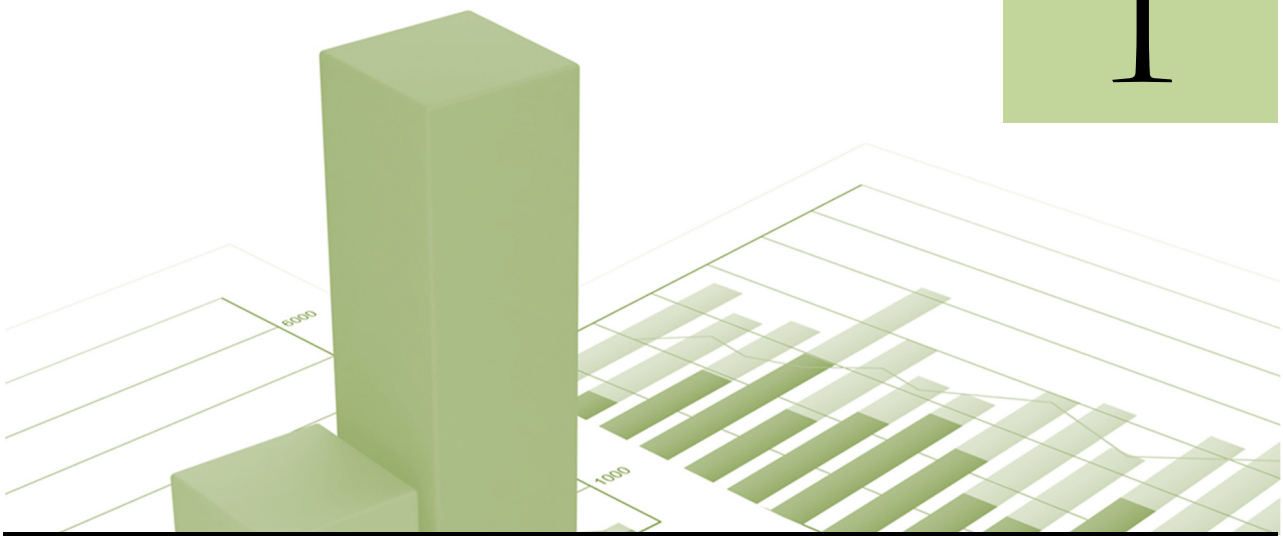


Overview of dual-eligible beneficiaries

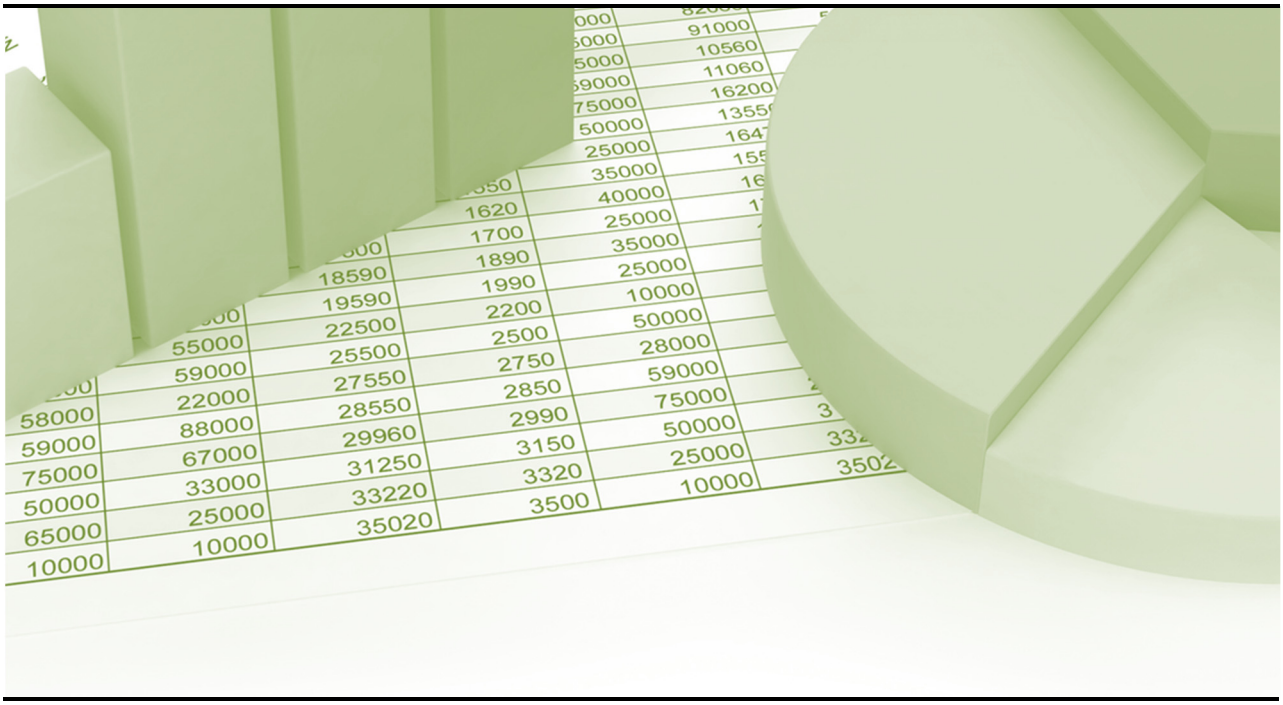
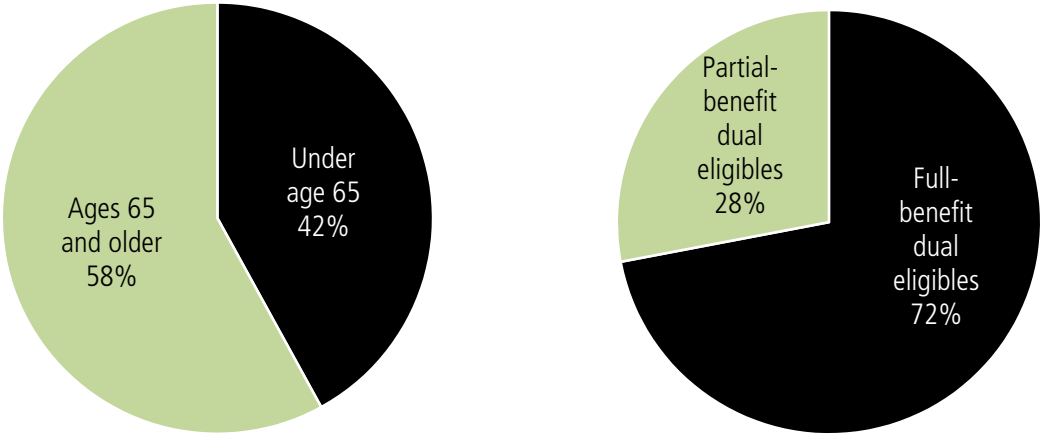


Exhibit 1

Snapshot of dual-eligible beneficiaries by age and type of benefit, CY 2013

10.7 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 10.7 million individuals were dually eligible for Medicare and Medicaid benefits in at least one month of CY 2013. The majority (58 percent) of dual-eligible beneficiaries were ages 65 and older.
- Most dual-eligible beneficiaries (72 percent) were eligible for full Medicaid benefits.

Exhibit 2

Dual-eligible beneficiary enrollment in full- and partial-benefit categories, CY 2013

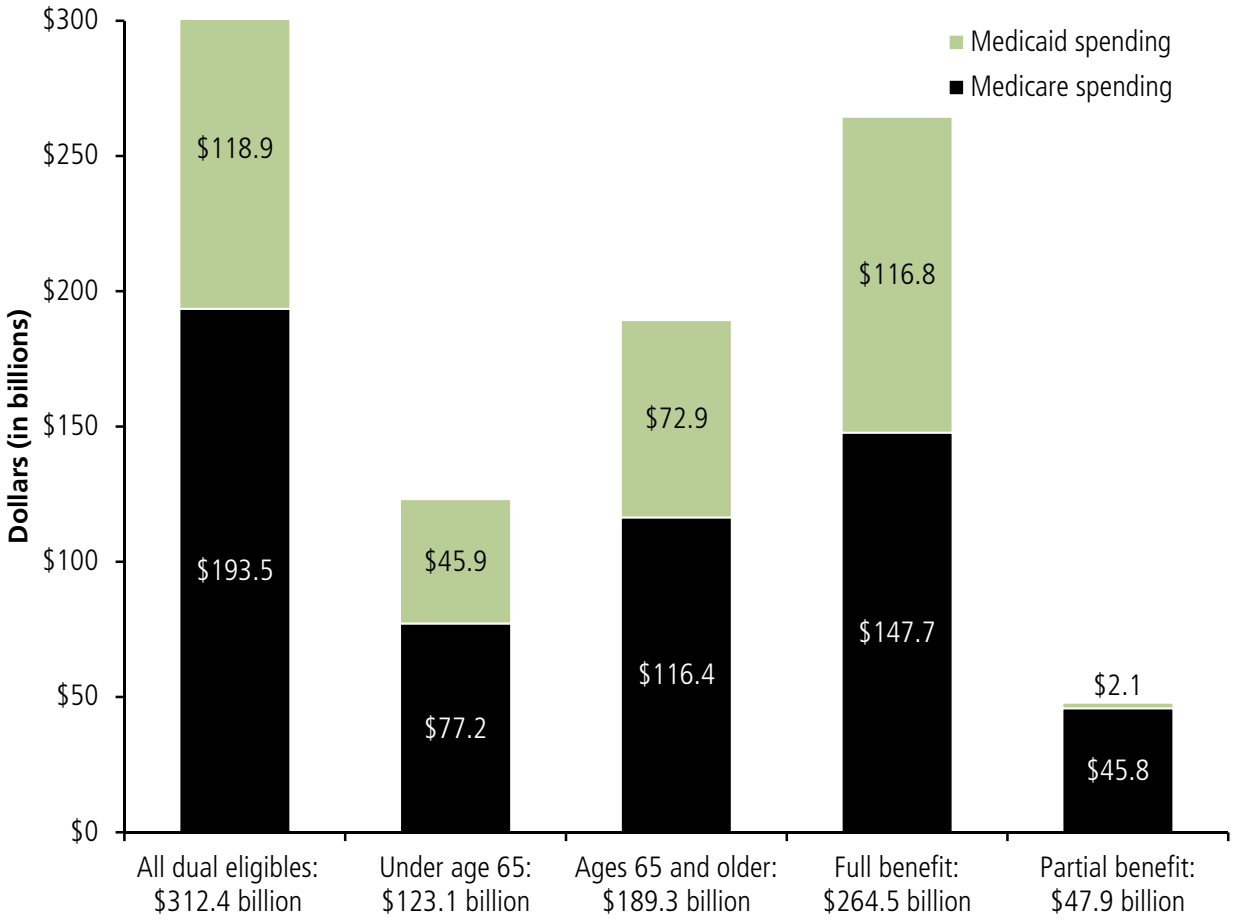
Benefit categories	Dual-eligible beneficiaries		
	All	Under age 65	Ages 65 and older
Full-benefit dual-eligible beneficiaries	**72%**	**71%**	**72%**
QMB plus	51	53	50
SLMB plus	3	3	3
Other full benefit	18	16	19
Partial-benefit dual-eligible beneficiaries	**28**	**29**	**28**
QMB only	13	14	12
SLMB only	9	10	9
QI	6	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 individuals). 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 2013, 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.

Exhibit 3

Medicare and Medicaid spending on dual-eligible beneficiaries by age and type of benefit, CY 2013

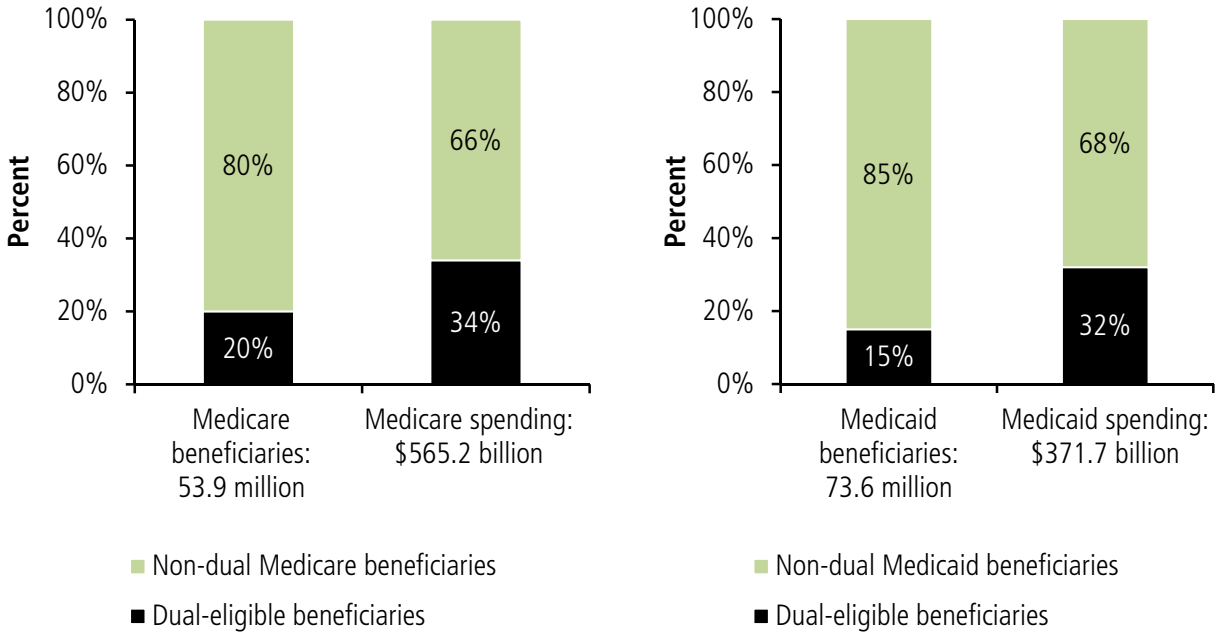


Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Totals may not sum due to rounding. Exhibit excludes administrative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

- Combined Medicare and Medicaid spending on individuals who were dually eligible for both Medicare and Medicaid was $312.4 billion in CY 2013. Medicare accounted for about 62 percent of combined spending ($193.5 billion).
- By age group, most Medicare and Medicaid spending on dual-eligible beneficiaries was accounted for by beneficiaries ages 65 and older ($189.3 billion in combined spending).
- Full-benefit dual-eligible beneficiaries represented a higher share of combined spending than partial-benefit dual-eligible beneficiaries ($264.5 billion compared with $47.9 billion, respectively).

Exhibit 4

Dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2013



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 2013.
- Dual-eligible beneficiaries totaled 20 percent of the Medicare population in 2013 but accounted for 34 percent of Medicare spending.
- Similarly, dual-eligible beneficiaries comprised 15 percent of all Medicaid beneficiaries but accounted for 32 percent of Medicaid spending.

Exhibit 5

Selected subgroups of dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2013

Dual-eligible beneficiary subgroup	Percent of all Medicare beneficiaries	Percent of all Medicare spending	Percent of all Medicaid beneficiaries	Percent of all Medicaid spending
Age				
Under age 65	8%	14%	6%	12%
Ages 65 and older	12	21	8	20
Type of benefit				
Full benefit	14%	26%	10%	31%
Partial benefit	6	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 2013 but accounted for 21 percent of Medicare spending. These beneficiaries also accounted for 8 percent of the Medicaid population but 20 percent of Medicaid spending.
- Full-benefit dual-eligible beneficiaries also incurred disproportionate spending, particularly in Medicaid. They accounted for 14 percent of all Medicare enrollment but 26 percent of all Medicare spending and 10 percent of all Medicaid enrollment but 31 percent of all Medicaid spending.

Section

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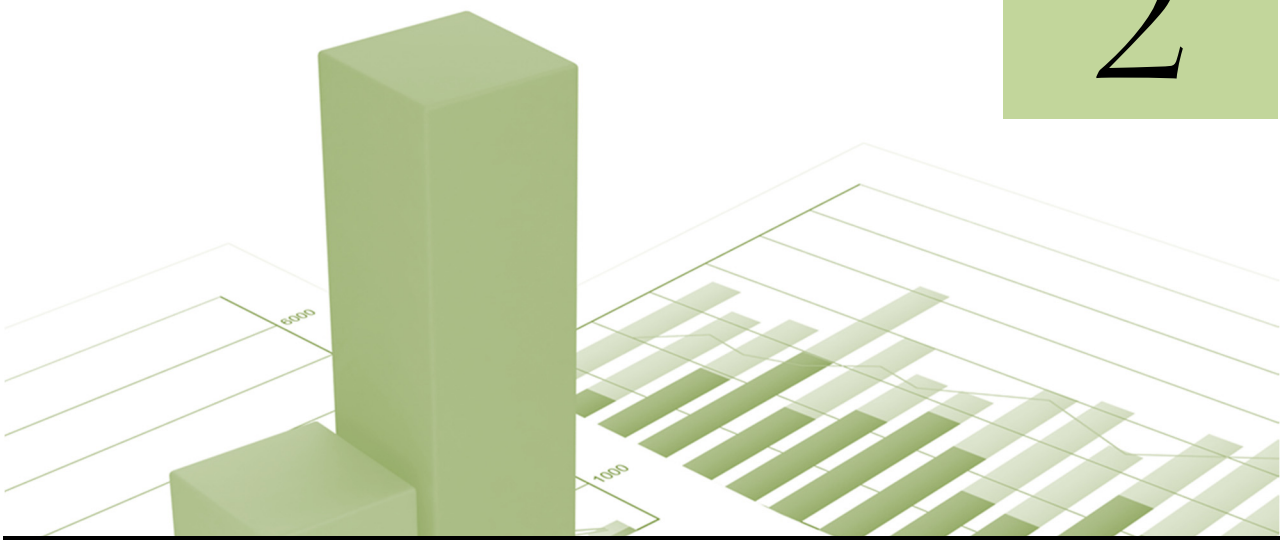

Characteristics of dual-eligible beneficiaries

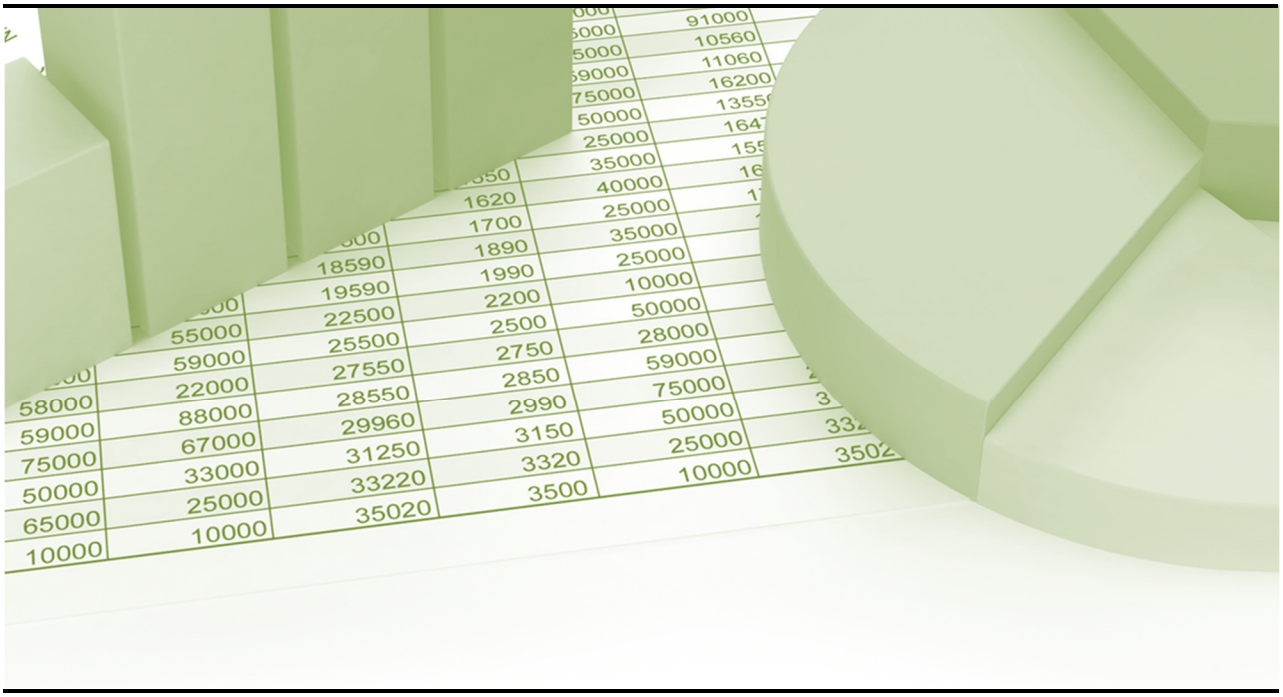

Exhibit 6

Demographic characteristics of dual-eligible and non-dual Medicare and Medicaid beneficiaries, CY 2013

Demographic characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries	Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit		
Gender							
Male	39%	48%	33%	39%	40%	47%	53%
Female	61	52	67	61	60	53	47
Race/Ethnicity							
White/non-Hispanic	57%	61%	53%	54%	62%	84%	52%
African American/non-Hispanic	21	25	18	20	23	8	31
Hispanic	16	11	19	17	13	5	13
Other	7	3	10	8	2	3	4
Residence							
Urban	76%	74%	78%	78%	70%	77%	79%
Rural	24	26	22	22	30	23	21

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 2.1 percent or less for all statistics except race/ethnicity for non-dual disabled Medicaid beneficiaries, where the share of beneficiaries with missing information was 18.4 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 2013 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 (84 percent). There were proportionately more African American (21 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. 33 percent), White (61 percent vs. 53 percent), or African American (25 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).

Exhibit 7

Additional characteristics of dual-eligible beneficiaries, CY 2013

Characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
Limitations in ADLs						
None	44%	45%	44%	38%	62%	74%
1–2 ADL limitations	26	33	21	24	29	17
3–6 ADL limitations	30	22	36	38	9	9
Self-reported health status						
Excellent or very good	22%	17%	26%	20%	29%	51%
Good or fair	59	60	58	59	58	43
Poor	18	22	15	20	13	6
Unknown	1	1	1	1	1	<1
Living arrangement						
Institution	21%	11%	27%	27%	4%	5%
Alone	28	27	28	25	35	24
Spouse	15	14	16	13	22	55
Children, nonrelatives, others	36	48	29	36	39	16
Education						
No high school diploma	43%	30%	51%	45%	39%	15%
High school diploma only	28	35	24	28	29	28
Some college	25	33	20	23	31	57
Other	4	2	5	5	<1	1

Note: *CY (calendar year), ADL (activity of daily living). Exhibit includes all dual-eligible and non-dual Medicare 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: *2013 Medicare Current Beneficiary Survey.*

- More than half (56 percent) of individuals dually eligible for Medicare and Medicaid benefits in CY 2013 had at least one ADL limitation. A plurality (43 percent) did not graduate from high school.
- Compared with non-dual Medicare beneficiaries, more dual-eligible beneficiaries reported being in poor health (18 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. 22 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 (27 percent vs. 11 percent). More of the dual-eligible beneficiaries under age 65 reported being in poor health (22 percent vs. 15 percent).
- Between full-benefit and partial-benefit dual-eligible beneficiaries, a greater share of the partial-benefit beneficiaries had no ADL limitations (62 percent vs. 38 percent). Over one-fourth (27 percent) of full-benefit dual-eligible beneficiaries lived in an institution, while few (4 percent) partial-benefit dual-eligible beneficiaries resided in an institution.

Exhibit 8

Selected conditions for FFS dual-eligible beneficiaries by age group, CY 2013

Condition	FFS dual-eligible beneficiaries	
	Under age 65	Ages 65 and older
Cognitive impairment		
Alzheimer's disease or related dementia	4%	23%
Intellectual disabilities and related conditions	8	1
Medical conditions		
Diabetes	23%	35%
Heart failure	8	22
Hypertension	39	65
Ischemic heart disease	14	33
Behavioral health conditions		
Anxiety disorders	24%	15%
Bipolar disorder	15	3
Depression	33	22
Schizophrenia and other psychotic disorders	13	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. 4 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.

Section

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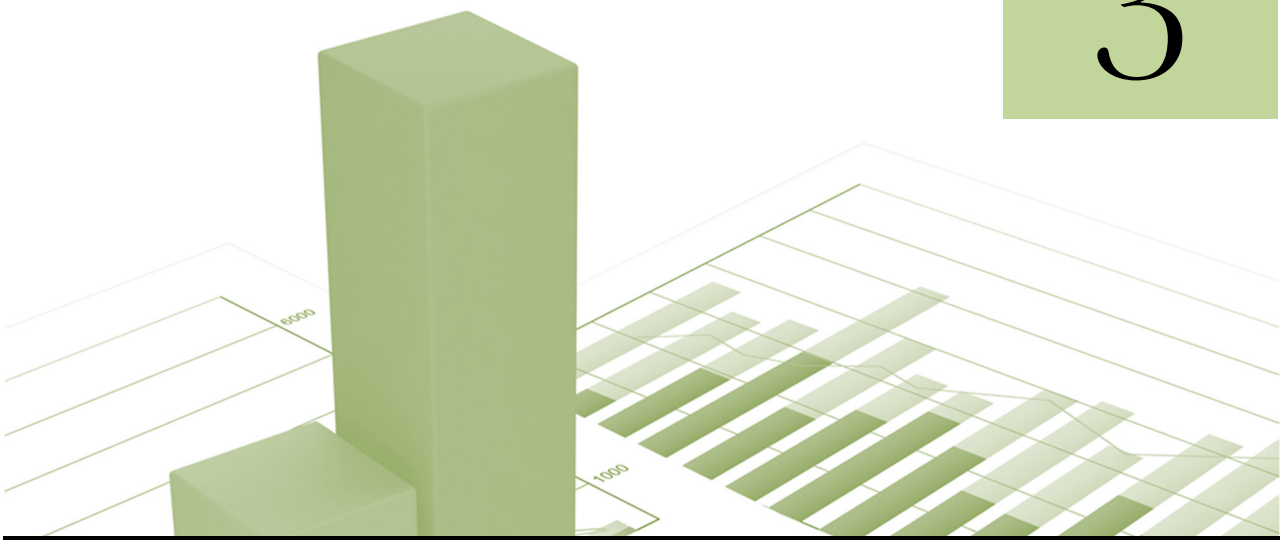

Eligibility pathways, managed care enrollment, and continuity of enrollment

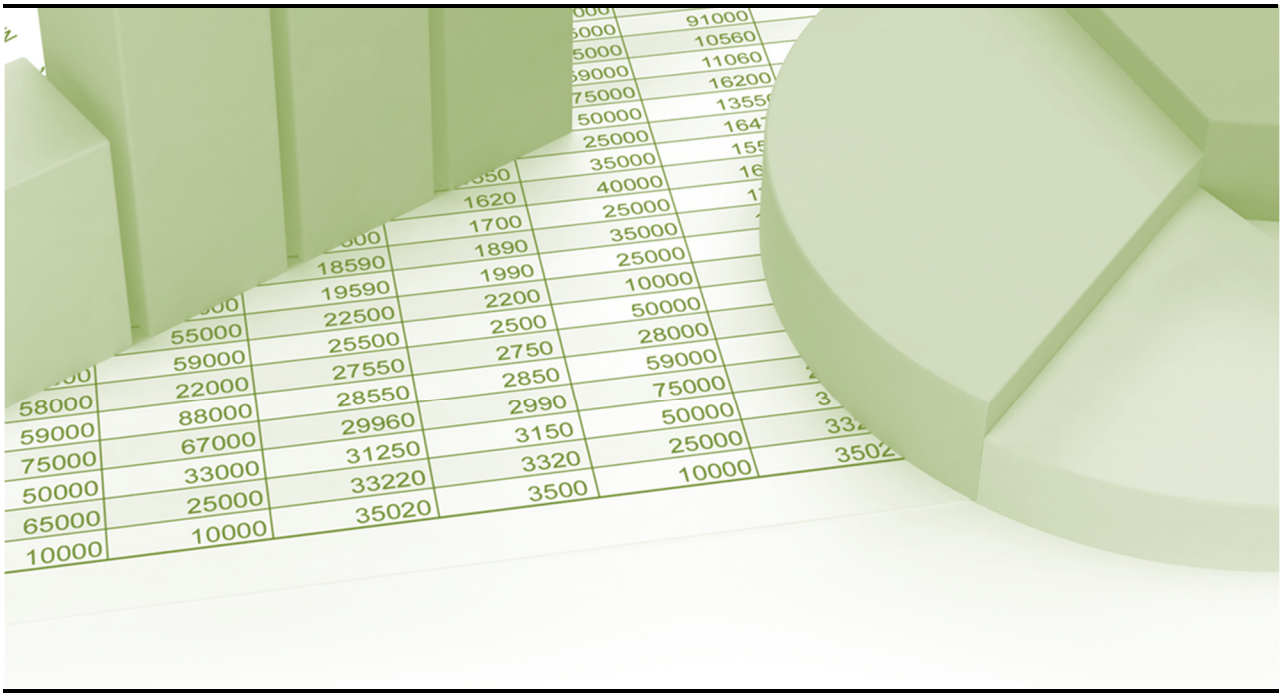

Exhibit 9

Medicare eligibility pathways, CY 2013

Original reason for entitlement to Medicare	Dual-eligible beneficiaries			Non-dual Medicare beneficiaries
	All	Full benefit	Partial benefit	
Age	46%	47%	44%	83%
ESRD	1	1	1	<1
Disability	52	51	55	17
Based on own record	80	75	91	95
Based on another's record	20	25	9	5

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 2013 were nearly split between those who originally qualified for Medicare benefits based on age (46 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 (91 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 9 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.

Exhibit 10

Medicaid eligibility pathways, CY 2013

Medicaid eligibility group	Dual-eligible beneficiaries			Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	
SSI	35%	36%	34%	80%
Poverty related	38	41	36	6
Medically needy	9	6	10	5
Section 1115 waiver	1	1	<1	1
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 2013 qualified for Medicaid benefits through the SSI program (35 percent) or through poverty-related eligibility pathways (38 percent).
- In contrast to dual-eligible beneficiaries, most non-dual Medicaid beneficiaries eligible on the basis of a disability (80 percent) qualified for Medicaid benefits through the SSI program.
- Compared with those under age 65, dual-eligible beneficiaries ages 65 and older were more likely to have been eligible for Medicaid through pathways that cover individuals who have high medical costs ("medically needy" group) or who require an institutional level of care ("special income limit and other" group).

Exhibit 11

Medicare fee-for-service and managed care enrollment, CY 2013

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	73%	79%	69%	77%	62%	71%
MA only	22	16	26	18	32	27
Both FFS and MA	5	5	5	5	5	2

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 2013, most individuals dually eligible for Medicare and Medicaid services (73 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 (27 percent vs. 22 percent).
- Dual-eligible beneficiaries ages 65 and older were more likely to be exclusively enrolled in an MA plan than those under age 65 (26 percent vs. 16 percent).
- Partial-benefit dual-eligible beneficiaries were more likely to be exclusively enrolled in an MA plan than full-benefit beneficiaries (32 percent vs. 18 percent), while full-benefit beneficiaries were more likely to be in FFS only (77 percent vs. 62 percent).

Exhibit 12

Medicaid fee-for-service and managed care enrollment, CY 2013

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	52%	53%	52%	37%	91%	17%
FFS and limited-benefit managed care only	31	30	31	40	7	25
At least one month of comprehensive managed care	17	17	17	23	2	57

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 2013 were either enrolled only in Medicaid FFS (52 percent) or in Medicaid FFS with a limited-benefit Medicaid managed care plan (31 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 (57 percent vs. 17 percent) and less likely to be enrolled in Medicaid FFS only (17 percent vs. 52 percent).
- Dual-eligible beneficiaries under age 65 and ages 65 and older had similar patterns of Medicaid FFS and managed care enrollment.
- Nearly two-thirds (63 percent) of full-benefit dual-eligible beneficiaries were enrolled in some type of Medicaid managed care plan during the year.

Exhibit 13

Continuity of enrollment status for dual-eligible beneficiaries, CY 2013

Enrollment status	Dual-eligible beneficiaries				
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit
Full-year enrollment status					
Enrolled 12 months, all with dual-eligible status	77%	78%	77%	79%	73%
Enrolled 12 months, some with Medicare or Medicaid only	16	18	14	14	21
Enrolled less than 12 months	7	4	9	7	6
Consistency of full and partial dual-eligible status during the year					
Exclusively full or exclusively partial	95	94	96	97	92
Switched between full and partial	5	6	4	3	8
Attainment of dual-eligible status during the year					
Was previously dually eligible	89	89	89	90	88
Became dually eligible	11	11	11	10	12
Of those who became dually eligible during the year, percent who were:					
Medicare beneficiaries who gained Medicaid coverage	53	31	69	47	66
Medicaid beneficiaries who gained Medicare coverage	42	66	25	50	26
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 (77 percent) were dual-eligible beneficiaries during every month of CY 2013.
- Only 5 percent of all dual-eligible beneficiaries in 2013 switched between full-benefit and partial-benefit dual-eligible status.
- Eleven percent of dual-eligible beneficiaries first became dually eligible during 2013. 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 2013, 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).

Section

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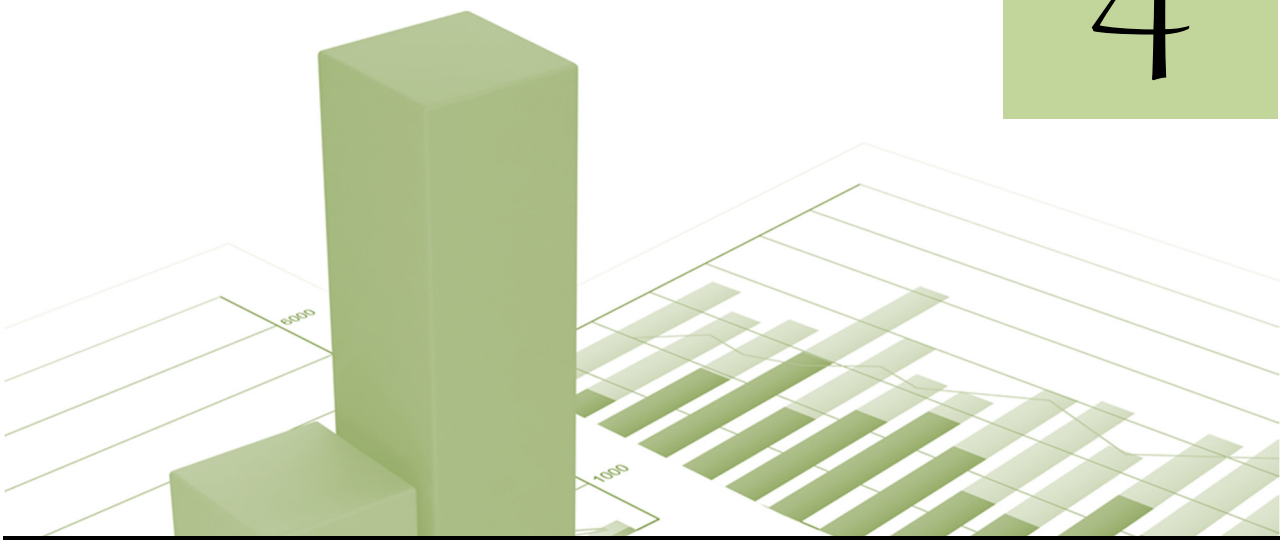


Dual-eligible beneficiaries' utilization of and spending on Medicare and Medicaid services

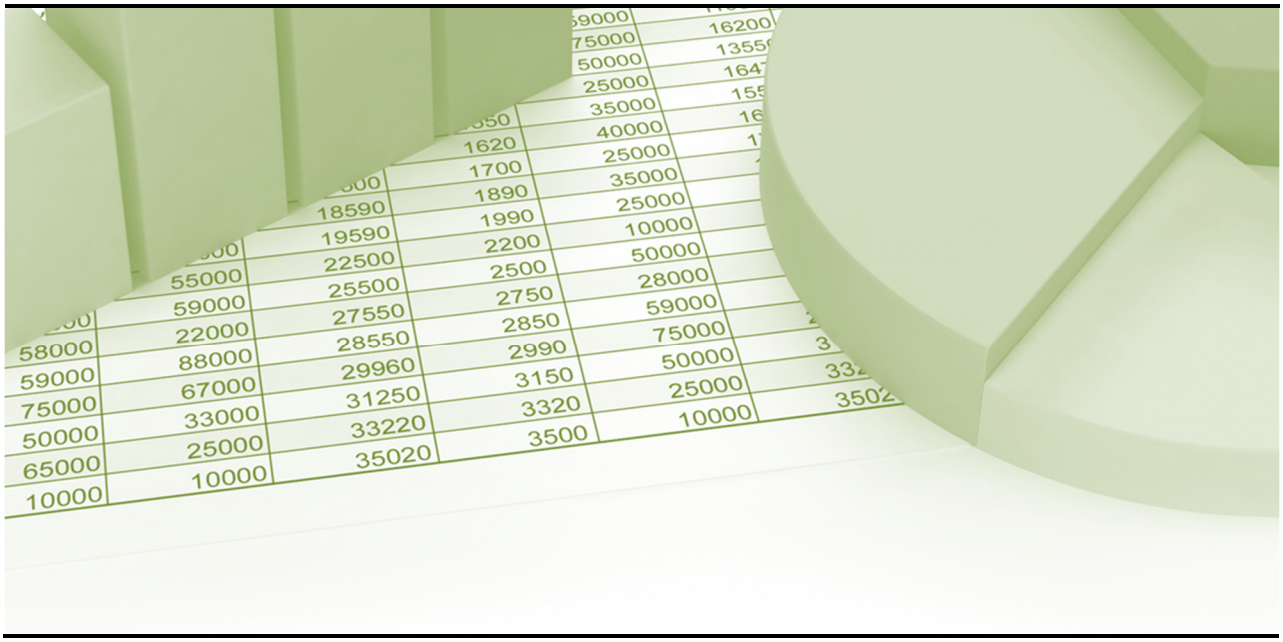


Exhibit 14

Use of Medicare services and per user Medicare spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2013

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
Part A and Part B services						
Inpatient hospital	26%	$19,580	37%	16%	$16,362	32%
Skilled nursing facility	10	18,141	13	4	13,992	7
Home health	14	5,655	6	9	4,531	5
Other outpatient	95	5,962	41	92	4,486	52
Part D drugs	**93**	**5,120**		**77**	**1,834**	

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 2013 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).

Exhibit 15

Use of Medicaid services and per user Medicaid spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2013

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%	$2,033	1%	16%	$21,428	18%
Outpatient	86	2,325	12	81	5,875	25
Institutional LTSS	20	41,903	49	5	60,147	14
HCBS state plan	12	8,662	6	9	10,116	5
HCBS waiver	14	29,144	24	9	30,403	15
Drugs	35	272	1	71	3,907	15
Managed care capitation	35	3,781	8	64	2,481	8

Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Dual-eligible beneficiaries are limited to full-benefit dual eligibles in Medicare and Medicaid FFS. End-stage renal disease is excluded. "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 (20 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 (49 percent vs. 14 percent).
- However, per user FFS spending on institutional LTSS was higher for non-dual disabled Medicaid beneficiaries ($60,147) than for dual-eligible beneficiaries ($41,903).
- 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. 12 percent), Medicaid FFS per user spending was higher for HCBS waiver services than for state plan HCBS services ($29,144 vs. $8,662), 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. 6 percent).

Exhibit 16

Use of Medicare and Medicaid services and per user Medicare and Medicaid spending for FFS dual-eligible beneficiaries by age, CY 2013

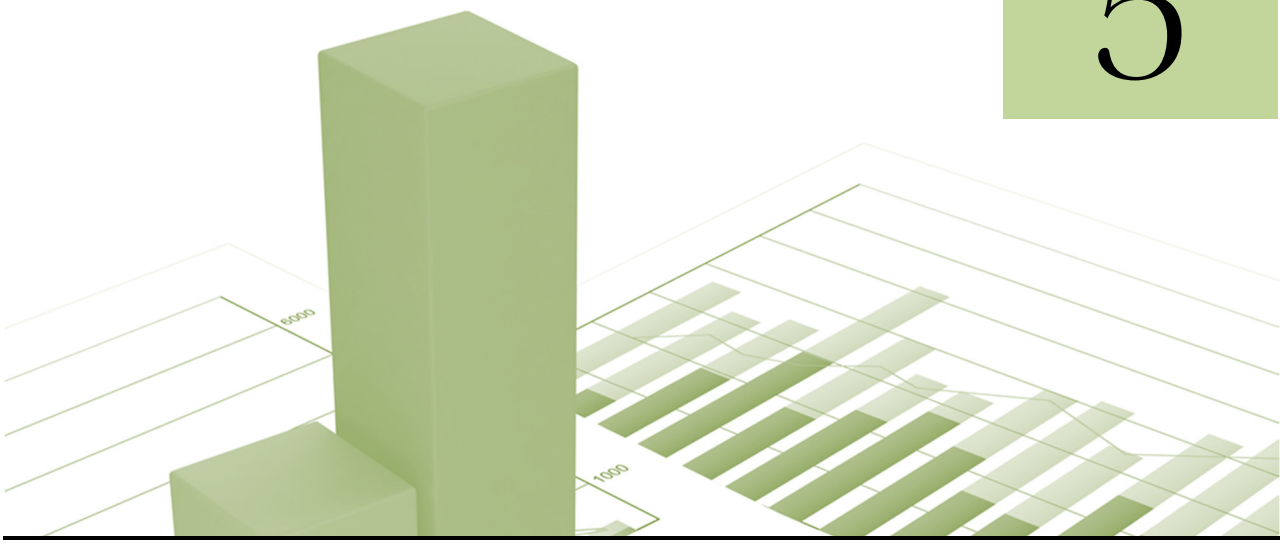
Selected services	Full-benefit FFS dual-eligible beneficiaries under age 65			Full-benefit FFS dual-eligible beneficiaries ages 65 and older		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
Medicare FFS services						
Inpatient hospital	21%	$20,418	27%	30%	$19,102	28%
Skilled nursing facility	4	17,556	4	15	18,258	14
Home health	9	5,221	3	18	5,823	5
Other outpatient	93	5,229	30	96	6,538	31
Part D drugs	91	6,054	34	93	4,377	20
Medicaid services						
Inpatient hospital	12%	$2,587	2%	14%	$1,649	1%
Outpatient	89	2,768	15	84	1,946	9
Institutional LTSS	8	63,273	29	30	37,555	63
HCBS state plan	10	8,575	5	14	8,712	7
HCBS waiver	16	41,201	41	13	16,595	12
Drugs	33	398	1	37	181	<1
Managed care capitation	38	3,049	7	33	4,478	8

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 2013 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 about 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. 30 percent). Institutional LTSS also accounted for a higher portion of Medicaid spending on FFS dual-eligible beneficiaries 65 and older compared with those under age 65 (63 percent vs. 29 percent).

Section

5



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

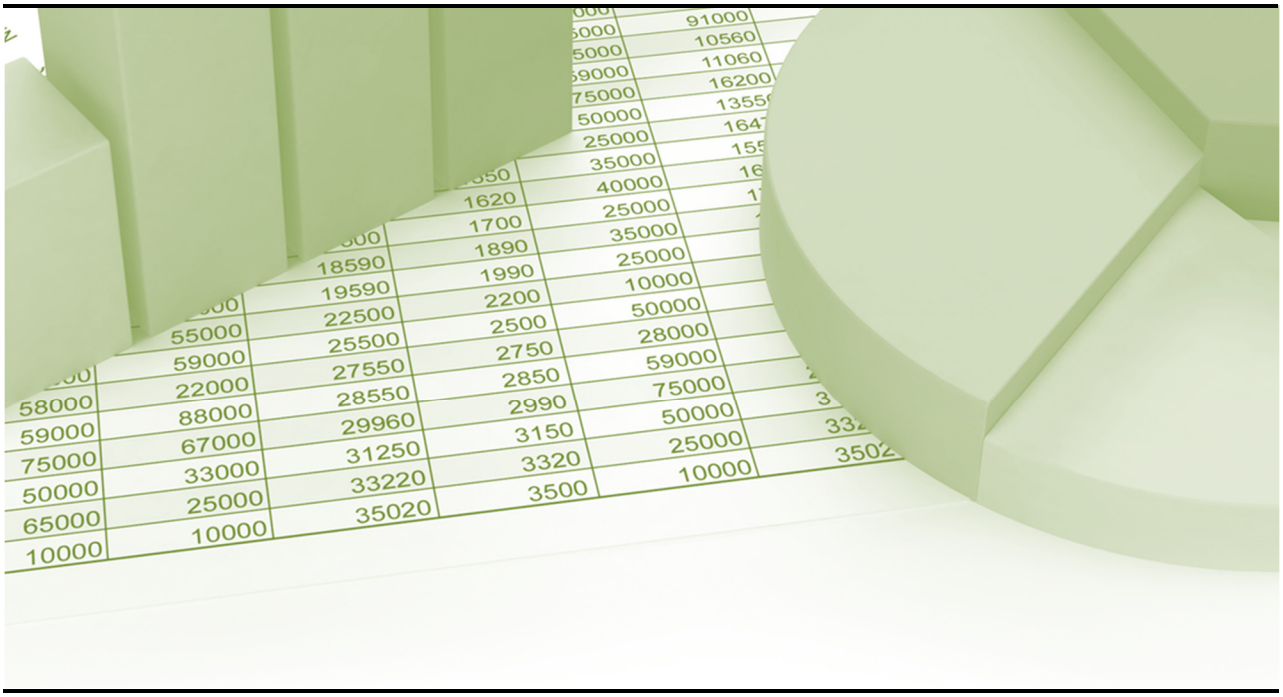
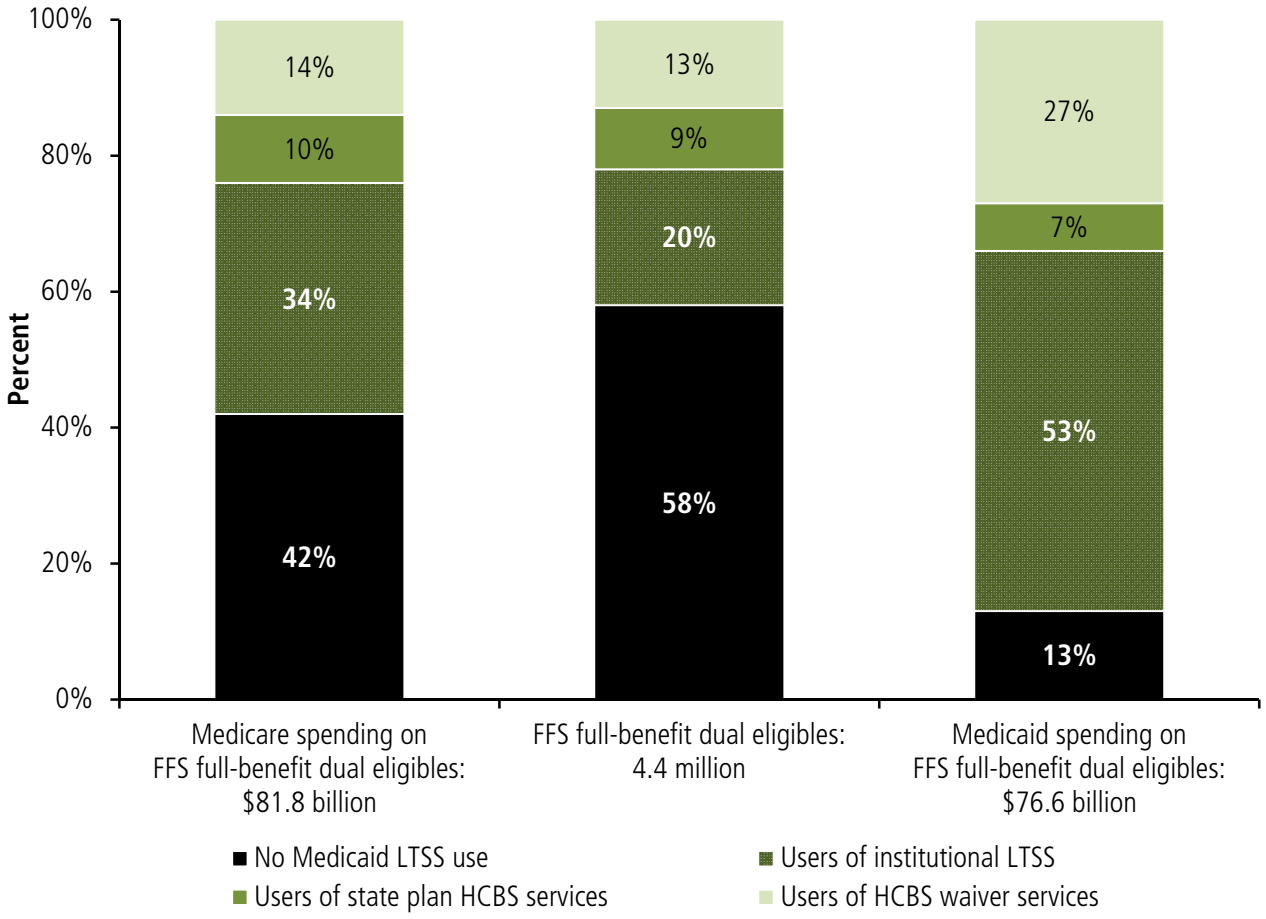


Exhibit 17

Medicare and Medicaid spending on FFS full-benefit dual-eligibles by type of Medicaid LTSS, CY 2013

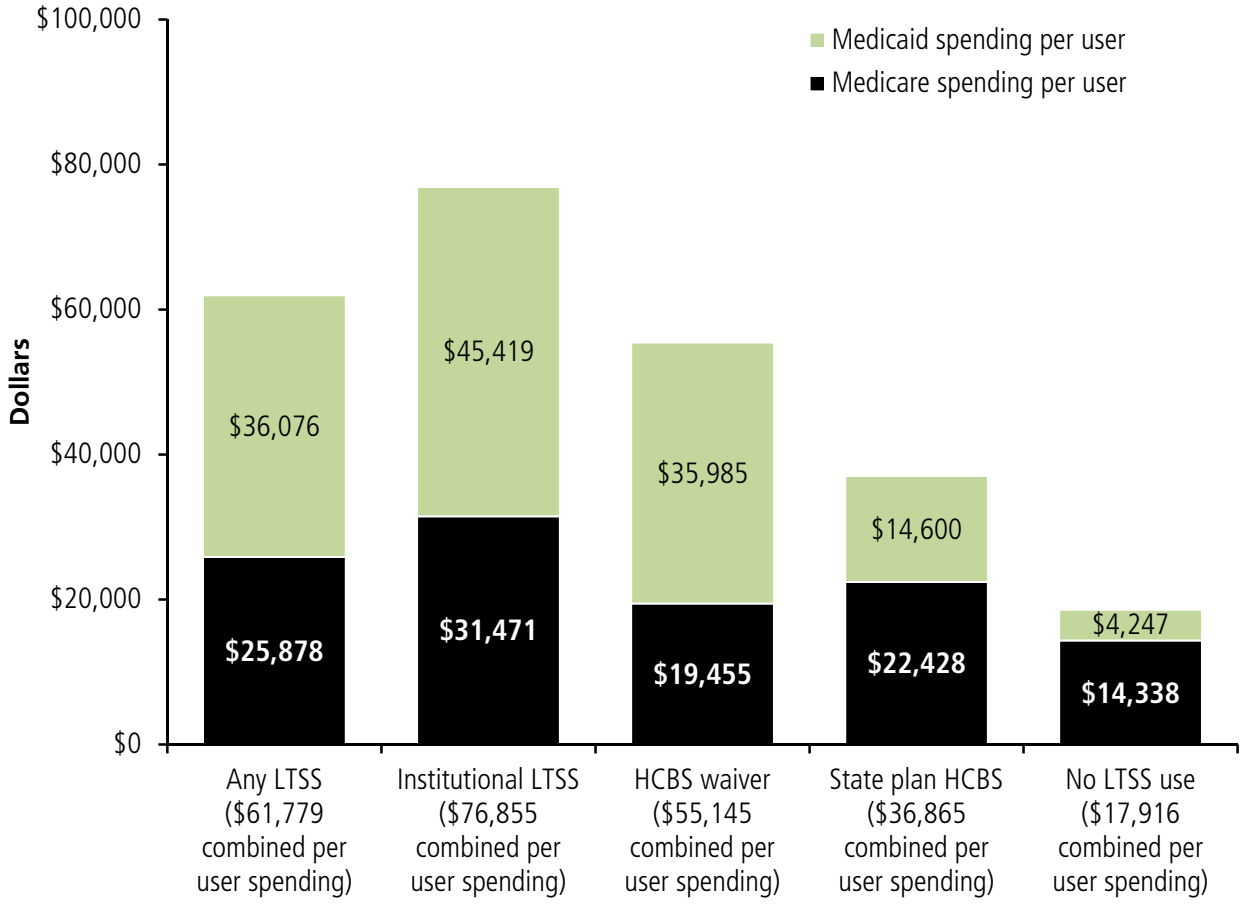


Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible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

- In CY 2013, the majority (58 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 20 percent of FFS full-benefit dual-eligible beneficiaries who used Medicaid institutional LTSS accounted for 34 percent of Medicare spending on FFS full-benefit dual-eligible beneficiaries and more than half (53 percent) of Medicaid spending on FFS full-benefit dual-eligible beneficiaries.

Exhibit 18

Per user Medicare and Medicaid spending on FFS full-benefit dual-eligible Medicaid LTSS users and non-users, CY 2013

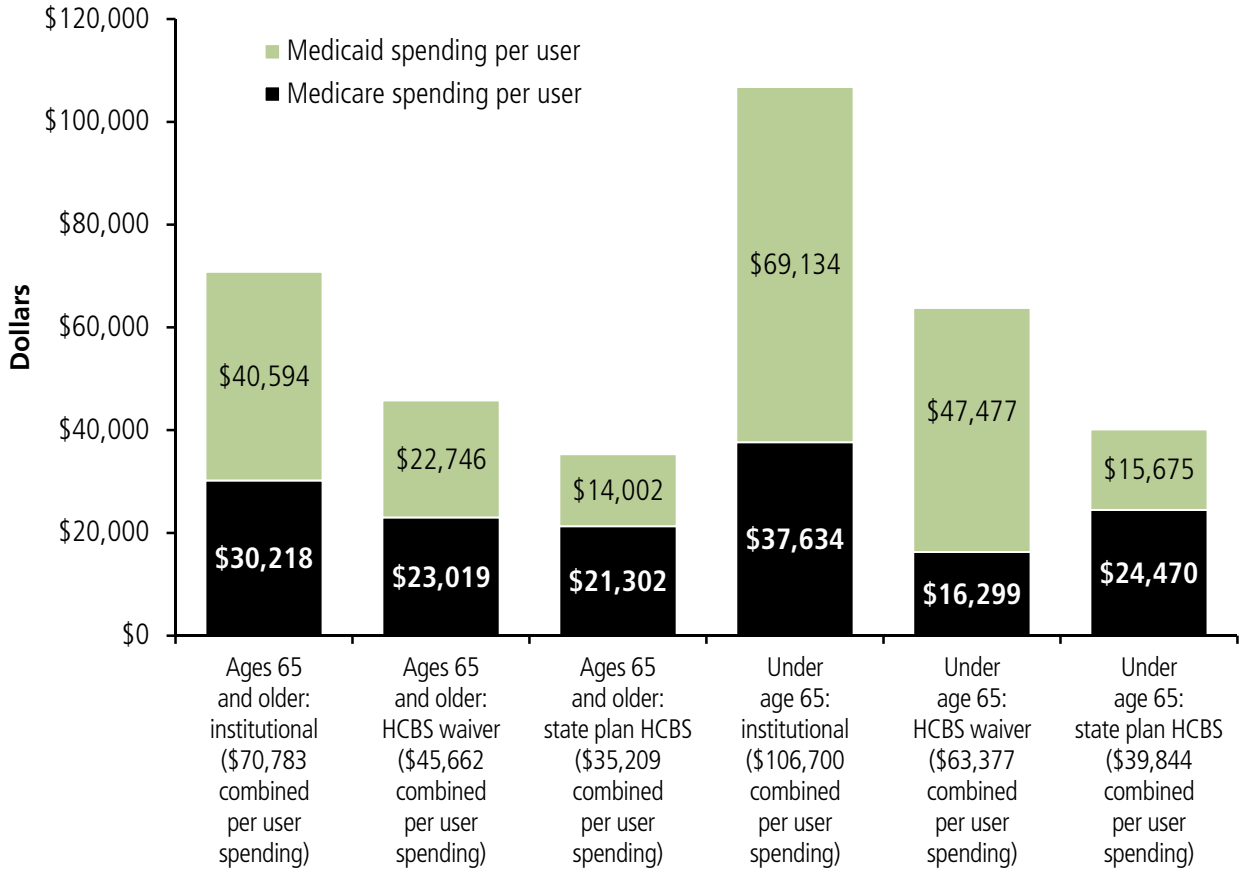


Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible 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 (20 percent of full-benefit dual-eligible beneficiaries; see Exhibit 17) had the highest Medicare and Medicaid per user spending in CY 2013 ($31,471 and $45,419, 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.

Exhibit 19

Per user Medicare and Medicaid spending on FFS full-benefit dual-eligible Medicaid LTSS users by age, CY 2013

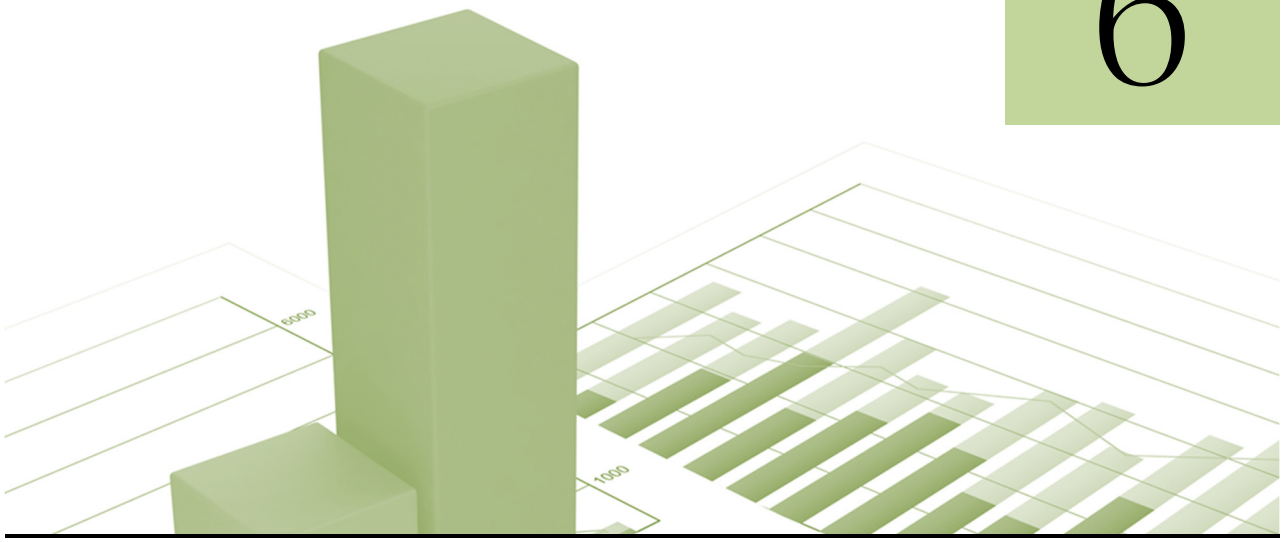


Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible 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 ($30,218 and $40,594) than for those who received Medicaid LTSS through HCBS waivers ($23,019 and $22,746) or through state plan HCBS ($21,302 and $14,002).
- Among Medicaid LTSS users under age 65, Medicare per user spending was higher for those who received Medicaid institutional LTSS compared with Medicare per user spending for those receiving home- and community-based Medicaid LTSS.
- Medicaid per user spending on Medicaid institutional LTSS users under age 65 ($69,134) was higher than per user spending on any other subgroup of Medicaid LTSS users. It was also substantially higher than per user spending on Medicaid institutional LTSS users who were ages 65 and older ($40,594).

Section

6



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

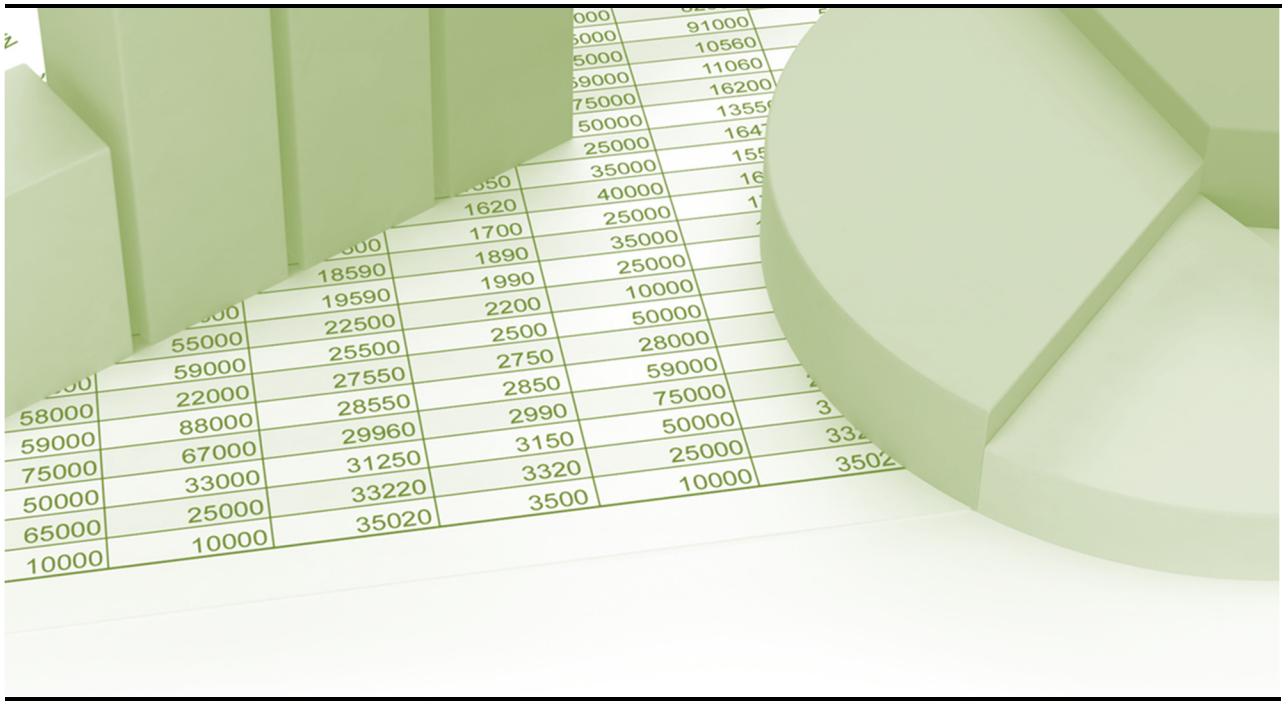
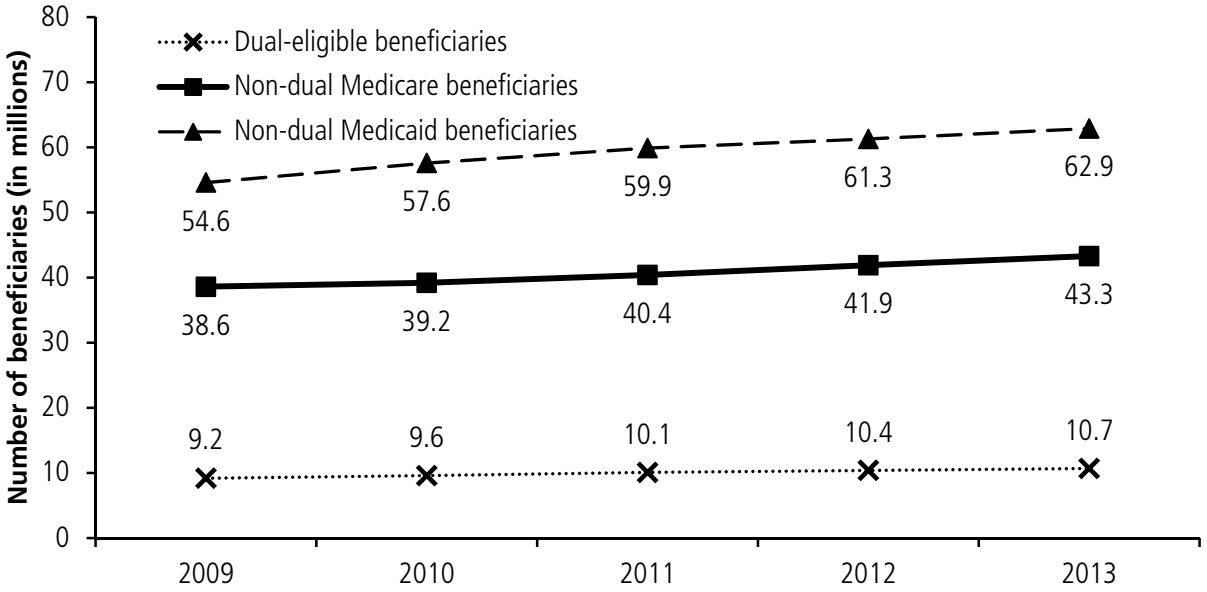


Exhibit 20

Number of dual-eligible and non-dual Medicare and Medicaid beneficiaries, CY 2009–2013



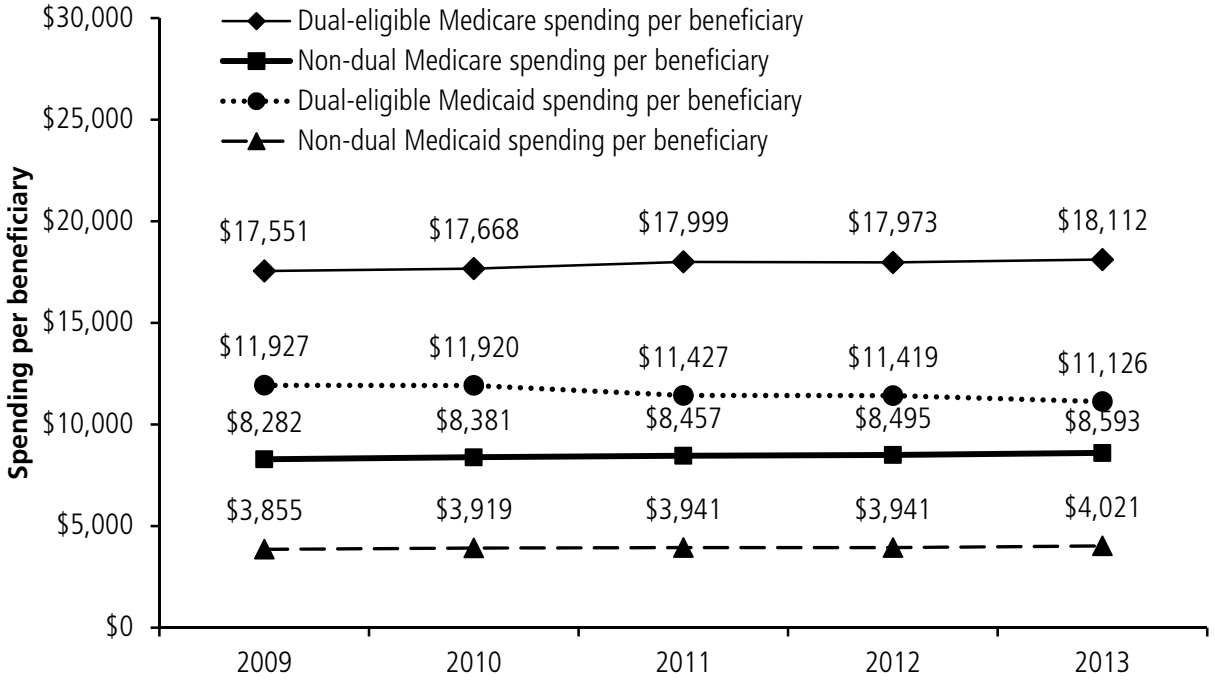
Category	Annual percentage growth in the number of beneficiaries				Cumulative growth	Average annual growth rate
	2010	2011	2012	2013		
Dual-eligible beneficiaries	4.2%	4.5%	3.5%	2.7%	15.8%	3.7%
Non-dual Medicare beneficiaries	1.8	2.9	3.7	3.2	12.2	2.9
Non-dual Medicaid beneficiaries	5.5	4.0	2.4	2.5	15.1	3.6

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 9.2 million in 2009 to 10.7 million in 2013—a cumulative growth of 15.8 percent over the period and an average annual growth rate of 3.7 percent.
- The number of non-dual-eligible Medicaid beneficiaries grew at a similar rate, increasing from 54.6 million in 2009 to 62.9 million in 2013, for a cumulative growth of 15.1 percent and an average annual growth rate of 3.6 percent.
- The slowest growth was among non-dual-eligible Medicare beneficiaries. Although the number of non-dual-eligible Medicare beneficiaries increased from 38.6 million in 2009 to 43.3 million in 2013, non-dual-eligible Medicare beneficiaries had lower cumulative growth (12.2 percent) and lower average annual growth (2.9 percent) than the other two groups of beneficiaries.

Exhibit 21

Medicare and Medicaid spending per dual-eligible and non-dual beneficiary, CY 2009–2013



Category	Annual percentage growth in spending per beneficiary				Cumulative growth	Average annual growth rate
	2010	2011	2012	2013		
Dual-eligible Medicare spending per beneficiary	0.7%	1.9%	–0.1%	0.8%	3.2%	0.8%
Non-dual Medicare spending per beneficiary	1.2	0.9	0.4	1.1	3.7	0.9
Dual-eligible Medicaid spending per beneficiary	–0.1	–4.1	–0.1	–2.6	–6.7	–1.7
Non-dual Medicaid spending per beneficiary	1.7	0.6	*	2.0	4.3	1.1

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.*

(Continued next page)

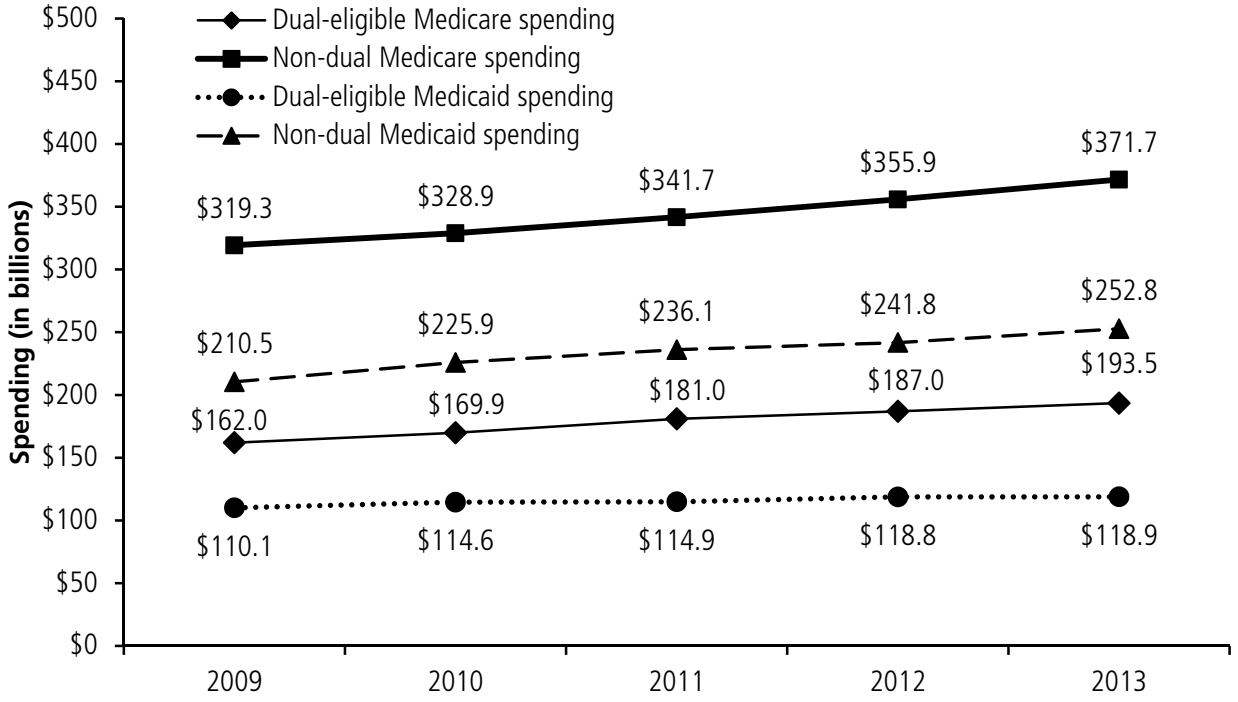
Exhibit 21

Medicare and Medicaid spending per dual-eligible and non-dual beneficiary, CY 2009–2013 (continued)

- Medicare per beneficiary spending grew between 2009 and 2013 for individuals dually eligible for Medicare and Medicaid (3.2 percent cumulative growth and 0.8 percent average annual growth for Medicare spending per beneficiary).
- In contrast, Medicaid per beneficiary spending on dual-eligible beneficiaries decreased between 2009 and 2013 (–6.7 percent cumulative growth and –1.7 percent average annual growth for Medicaid spending per beneficiary). This decline is largely due to different growth rates in the number of dual-eligible beneficiaries that were entitled to partial Medicaid benefits versus full Medicaid benefits. Between 2009 and 2013, the number of dual-eligible beneficiaries receiving partial Medicaid benefits grew more rapidly than the number receiving full Medicaid benefits, with cumulative growth of 36.7 percent and 9.2 percent, respectively (figures not shown in the exhibit). Average Medicaid spending on dual-eligible beneficiaries who receive partial benefits is much lower than spending on those who receive full Medicaid benefits, and the faster growth for the partial-benefit segment had the effect of lowering the overall average for the entire dual-eligible population.
- Comparing Medicare per beneficiary spending on dual-eligible beneficiaries and non-dual beneficiaries, per beneficiary spending on dual-eligible beneficiaries increased at a slightly slower rate than per beneficiary spending on non-dual beneficiaries. Cumulative growth in Medicare per beneficiary spending between 2009 and 2013 was 3.2 percent for dual-eligible beneficiaries and 3.7 percent for non-dual beneficiaries; average annual growth was 0.8 percent for dual-eligible beneficiaries compared with 0.9 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 (4.3 percent cumulative growth and 1.1 percent average annual growth for non-dual beneficiaries compared with –6.7 percent cumulative and –1.7 percent average annual growth for dual-eligible beneficiaries).

Exhibit 22

Medicare and Medicaid spending for dual-eligible and non-dual beneficiaries, CY 2009–2013



Category	Annual percentage growth in spending				Cumulative growth	Average annual growth rate
	2010	2011	2012	2013		
Dual-eligible Medicare spending	4.9%	6.5%	3.3%	3.5%	19.5%	4.5%
Non-dual Medicare spending	3.0	3.9	4.2	4.4	16.4	3.9
Dual-eligible Medicaid spending	4.1	0.2	3.4	*	8.0	1.9
Non-dual Medicaid spending	7.3	4.6	2.4	4.6	20.1	4.7

Note: *CY (calendar year). Exhibit includes all dual-eligible and non-dual beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid 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 an increase of less than 0.1 percent.*

(Continued next page)

Exhibit 22

Medicare and Medicaid spending for dual-eligible and non-dual beneficiaries, CY 2009–2013 (continued)

- Medicare spending on dual-eligible beneficiaries increased from $162.0 billion in 2009 to $193.5 billion in 2013—a cumulative growth of 19.5 percent and an average annual growth of 4.5 percent.
- Medicaid spent less than Medicare on dual-eligible beneficiaries between 2009 and 2013—Medicaid spending on dual-eligible beneficiaries was $110.1 billion in 2009 and $118.9 billion in 2013. 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 (8.0 percent and 1.9 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 $210.5 billion in 2009 to $252.8 billion in 2013, Medicaid spending on non-dual beneficiaries had a cumulative growth of 20.1 percent and an average annual growth rate of 4.7 percent.
- Although total Medicare spending was higher for non-dual beneficiaries than for dual-eligible beneficiaries between 2009 and 2013, 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 19.5 percent compared with 16.4 percent for non-dual beneficiaries; average annual growth was 4.5 percent for dual-eligible beneficiaries compared with 3.9 percent for non-dual beneficiaries.

Exhibit 23

Share of dual-eligible beneficiaries by selected beneficiary characteristics, CY 2009 and CY 2013

Beneficiary characteristic	2009	2013	2009–2013 percentage point change
Age			
65 and older	59.9%	58.5%	–1.5%
Under 65	40.1	41.5	1.5
Benefit level			
Full benefit	76.1%	71.8%	–4.3%
Partial benefit	23.9	28.2	4.3
Original reason for entitlement to Medicare			
Age	48.9%	46.4%	–2.6%
ESRD	0.9	1.3	0.4
Disability	50.2	52.4	2.2
Medicaid eligibility pathway			
SSI	38.6%	34.9%	–3.6%
Poverty related	33.3	38.2	4.8
Medically needy	8.4	8.7	0.3
Section 1115 waiver	0.5	0.5	*
Special income limit and other	19.2	17.7	–1.5
Medicare FFS and managed care			
FFS only	79.3%	73.1%	–6.2%
MA only	16.4	21.8	5.4
Both FFS and MA	4.3	5.1	0.8
Medicaid FFS and managed care			
FFS only	57.9%	52.4%	–5.6%
FFS and limited-benefit managed care only	30.3	30.7	0.4
At least one month of comprehensive managed care	11.8	16.9	5.2

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.*

**Indicates a decline of less than 0.1 percent.*

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Exhibit 23

Share of dual-eligible beneficiaries by selected beneficiary characteristics, CY 2009 and CY 2013 (continued)

- Between CY 2009 and CY 2013, there was an increase in the share of dual-eligible beneficiaries who were under age 65 (1.5 percentage point increase) and in the share who received partial benefits (4.3 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 (6.2 and 5.6 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 4.8 percentage points, from 33.3 percent of the dual-eligible population in 2009 to 38.2 percent of the population in 2013.
- There was a slight shift in dual-eligible beneficiaries' Medicare eligibility pathways between 2009 and 2013, with the share who originally qualified for Medicare on the basis of disability increasing by 2.2 percentage points, from 50.2 percent in 2009 to 52.4 percent in 2013.
- The share whose only Medicare enrollment was in Medicare Advantage increased by 5.4 percentage points over this period, while the share with enrollment in both Medicare FFS and Medicare Advantage increased by 0.8 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 0.4 percentage points. The share with at least one month of comprehensive Medicaid managed care enrollment increased by 5.2 percentage points.

Exhibit 24

Use of Medicare services and per user spending for FFS beneficiaries, CY 2009 and CY 2013

Select Medicare services	Full-benefit FFS dual-eligible beneficiaries			FFS non-dual Medicare beneficiaries		
	2009	2013	2009–2013	2009	2013	2009–2013
Share using service in each year and percentage point change during period						
Inpatient hospital	28.4%	26.1%	–2.3	17.9%	15.8%	–2.0
Skilled nursing facility	10.8	10.1	–0.7	4.3	4.2	–0.1
Home health	13.5	13.8	0.3	9.1	9.1	*
Other outpatient	94.4	94.7	0.3	91.7	91.8	0.1
Part D drugs	N/A	93.0	N/A	N/A	77.0	N/A
Per user FFS spending in each year and average annual growth during period						
Inpatient hospital	$18,133	$19,580	1.9%	$15,049	$16,362	2.1%
Skilled nursing facility	16,597	18,141	2.2	12,899	13,992	2.1
Home health	6,631	5,655	–3.9	4,883	4,531	–1.9
Other outpatient	5,587	5,962	1.6	4,048	4,486	2.6
Part D drugs	4,601	5,120	2.7	1,497	1,834	5.2

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 2009. Percentage point change is calculated using unrounded numbers.*

**Indicates an increase of less than 0.1 percent*

- Medicare per user FFS spending on full-benefit dual-eligible individuals increased between 2009 and 2013 for inpatient hospital services (1.9 percent average annual growth), skilled nursing facility services (2.2 percent average annual growth), other outpatient services (1.6 percent average annual growth) and prescription drugs under Medicare Part D (2.7 percent average annual growth). Medicare per user FFS spending on full-benefit dual-eligible beneficiaries decreased between 2009 and 2013 for home health services (–3.9 percent average annual growth).
- During this period, the share of full-benefit dual-eligible beneficiaries using home health services and other outpatient services increased (each by 0.3 percentage points). The share of full-benefit dual-eligible beneficiaries using inpatient hospital services decreased by 2.3 percentage points, and the share using skilled nursing facility services decreased by 0.7 percentage points.
- Comparing full-benefit dual-eligible beneficiaries with non-dual Medicare beneficiaries, per user FFS spending in 2009 and 2013 was higher for dual-eligible beneficiaries for each type of service. Growth in per user spending was similar for dual-eligible beneficiaries compared with non-dual Medicare beneficiaries for inpatient hospital services and skilled nursing facility services; it was slower for home health services, other outpatient services, and Part D drugs.
- In 2009 and 2013, a greater share of full-benefit dual-eligible beneficiaries were users of the select Medicare services shown in this exhibit than were non-dual Medicare beneficiaries.

Exhibit 25

Use of Medicaid services and per user spending for FFS beneficiaries, CY 2009 and CY 2013

Select Medicaid services	Full-benefit FFS dual-eligible beneficiaries			Full-benefit FFS non-dual Medicaid beneficiaries (disabled, under age 65)		
	2009	2013	2009–2013	2009	2013	2009–2013
Share using service in each year and percentage point change during period						
Inpatient hospital	13.8%	12.7%	–1.1	17.6%	15.6%	–2.0
Outpatient	87.2	86.4	–0.8	87.1	81.3	–5.8
Institutional LTSS	21.5	20.3	–1.2	4.6	4.5	–0.1
HCBS state plan	14.9	12.4	–2.4	11.5	8.7	–2.8
HCBS waiver	13.2	14.3	1.1	8.5	9.4	0.9
Drugs	51.7	35.2	–16.5	77.3	70.6	–6.7
Managed care capitation	43.0	35.2	–7.8	64.8	63.8	–1.0
Per user spending in each year and average annual growth during period						
Inpatient hospital	$2,114	$2,033	–1.0%	$20,571	$21,428	1.0%
Outpatient	2,417	2,325	–1.0	5,364	5,875	2.3
Institutional LTSS	40,588	41,903	0.8	55,490	60,147	2.0
HCBS state plan	10,083	8,662	–3.7	9,298	10,116	2.1
HCBS waiver	28,629	29,144	0.4	29,844	30,403	0.5
Drugs	299	272	–2.3	3,943	3,907	–0.2
Managed care capitation	1,310	3,781	30.4	1,128	2,481	21.8

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

- Medicaid per user FFS spending on full-benefit individuals dually eligible for Medicare and Medicaid increased between 2009 and 2013 for institutional LTSS, HCBS waiver services, and Medicaid managed care capitation payments.
- The share of full-benefit dual-eligible beneficiaries using institutional LTSS declined between 2009 and 2013 by 1.2 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 2009 and 2013 for both dual-eligible beneficiaries and non-dual disabled Medicaid beneficiaries (30.4 percent and 21.8 percent average annual growth, respectively). However, the share of beneficiaries in these groups with managed care capitation payments decreased between 2009 and 2013 by 7.8 percentage points for dual-eligible beneficiaries and 1.0 percentage points for non-dual disabled beneficiaries.

Exhibit 26

Number of and spending for FFS full-benefit dual-eligible beneficiaries by Medicaid LTSS use, CY 2009 and CY 2013

Type of LTSS user	Full-benefit FFS dual-eligible beneficiaries (in millions)			Medicare spending (in billions)			Medicaid spending (in billions)		
	2009	2013	2009–2013 average annual growth	2009	2013	2009–2013 average annual growth	2009	2013	2009–2013 average annual growth
Users of institutional LTSS	1.0	0.9	–2.9%	$30.6	$28.0	–2.2%	$44.3	$40.4	–2.3%
Users of HCBS waiver services	0.6	0.6	0.9	10.2	11.1	2.2	19.5	20.8	1.6
Users of HCBS state plan services	0.5	0.4	–6.9	10.8	8.6	–5.6	8.1	5.6	–8.7
No Medicaid LTSS use	2.6	2.5	–0.5	31.7	34.2	1.9	7.9	9.8	5.5

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. 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 2009 and 2013 for dual-eligible beneficiaries who used institutional LTSS services compared with dual-eligible beneficiaries who used HCBS waiver or state plan services.
- In 2009 and 2013, 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 and Medicaid spending on institutional LTSS users declined by an annual average of 2.2 percent and 2.3 percent, respectively.

Exhibit

27 Average annual growth in dual-eligible enrollment by state, CY 2009–2013

State	Average annual growth in number of dual-eligible beneficiaries			Number of dual-eligible beneficiaries (in thousands)					
	CY 2009–2013			CY 2009			CY 2013		
	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit
National	3.7%	2.2%	8.1%	9,229	7,026	2,203	10,684	7,672	3,013
Alabama	2.2	–0.3	4.3	201	95	106	219	94	125
Alaska	4.3	3.9	16.6	14	14	*	17	16	1
Arizona	4.2	3.6	6.1	161	125	36	189	144	46
Arkansas	2.7	0.2	6.0	123	73	50	136	74	63
California	2.7	2.6	7.1	1,226	1,195	31	1,364	1,324	41
Colorado	5.8	4.7	9.0	85	63	21	106	76	30
Connecticut	12.2	0.9	32.5	109	80	29	173	82	90
Delaware	4.0	2.5	5.2	25	12	13	29	13	16
District of Columbia	10.4	6.8	23.0	22	18	4	33	23	9
Florida	6.1	2.0	10.8	626	352	274	794	381	413
Georgia	4.7	1.8	7.9	267	144	123	322	154	167
Hawaii	3.7	3.1	8.4	34	30	3	39	34	5
Idaho	6.4	3.6	11.9	33	23	10	42	26	16
Illinois	3.5	3.7	2.3	330	285	44	379	330	49
Indiana	4.4	4.4	4.4	159	105	54	190	125	65
Iowa	2.9	1.4	9.4	82	68	14	91	72	19
Kansas	3.1	0.2	9.6	64	46	18	72	47	26
Kentucky	2.0	–0.3	5.0	177	105	71	191	104	87
Louisiana	3.6	1.3	6.6	186	109	77	214	115	99
Maine	0.7	1.6	–0.5	99	53	46	101	57	45
Maryland	5.3	3.5	8.9	113	76	37	139	87	52
Massachusetts	7.9	7.6	11.2	222	205	17	301	275	26
Michigan	3.8	3.0	9.3	275	241	34	319	271	48
Minnesota	2.8	2.5	5.6	133	118	15	149	130	19
Mississippi	2.5	0.8	4.5	153	83	70	169	86	83
Missouri	1.0	–0.4	9.4	176	155	21	183	152	31
Montana	4.3	2.4	8.3	22	15	7	27	17	10
Nebraska	2.1	1.7	5.3	42	37	4	45	40	5
Nevada	6.8	3.3	11.0	39	22	17	51	26	26
New Hampshire	4.9	2.3	10.2	30	21	9	36	23	13
New Jersey	2.0	2.1	1.2	207	181	26	224	197	28
New Mexico	4.5	2.8	6.8	66	39	26	78	44	34
New York	3.8	1.9	14.4	765	665	99	888	717	170
North Carolina	2.4	1.6	5.4	315	248	66	346	264	82
North Dakota	0.9	1.3	–0.3	15	12	3	16	13	3
Ohio	3.9	2.5	6.8	318	219	99	370	241	129
Oklahoma	2.1	1.5	4.7	115	95	20	125	101	24
Oregon	6.1	3.2	11.4	95	64	31	120	72	48

State	Average annual growth in number of dual-eligible beneficiaries			Number of dual-eligible beneficiaries (in thousands)					
	CY 2009–2013			CY 2009			CY 2013		
	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit
Pennsylvania	3.7	2.8	8.2	399	338	61	461	377	84
Rhode Island	*	–0.4	2.5	40	34	6	40	33	7
South Carolina	2.6	1.3	10.9	148	131	17	164	137	26
South Dakota	2.0	0.2	5.2	21	14	7	22	14	9
Tennessee	0.4	–4.7	8.5	283	185	98	288	153	135
Texas	3.8	1.4	7.3	626	390	236	725	412	313
Utah	5.1	3.5	15.9	31	28	3	38	32	6
Vermont	2.2	1.8	3.1	29	20	8	31	22	9
Virginia	3.4	2.3	5.8	175	120	55	200	131	68
Washington	5.1	3.1	10.7	158	120	38	193	135	58
West Virginia	2.1	0.8	4.0	81	49	32	88	50	37
Wisconsin	3.9	3.4	7.9	152	134	18	177	153	24
Wyoming	3.6	0.7	8.9	10	7	3	12	7	5

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. Alaska, Kansas, and Rhode Island had not submitted complete Medicaid data for 2013, so we used their 2012 data instead.*

** Indicates an increase of fewer than 500 beneficiaries or less than 0.1 percent.*

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

- Between CY 2009 and 2013, national average annual growth in total dual-eligible enrollment was 3.7 percent: 2.2 percent for the full-benefit population and 8.1 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 12 percent (Connecticut).
- No state had average annual growth in full-benefit dual-eligible enrollment of more than 8 percent. The number of full-benefit dual eligibles declined in five states (Alabama, Kentucky, Missouri, Rhode Island, and Tennessee).
- In contrast, partial-benefit enrollment growth rates exceeded 5 percent in all but 11 states, and exceeded 15 percent in 4 states. The number of partial-benefit dual eligibles decreased in Maine and North Dakota.

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