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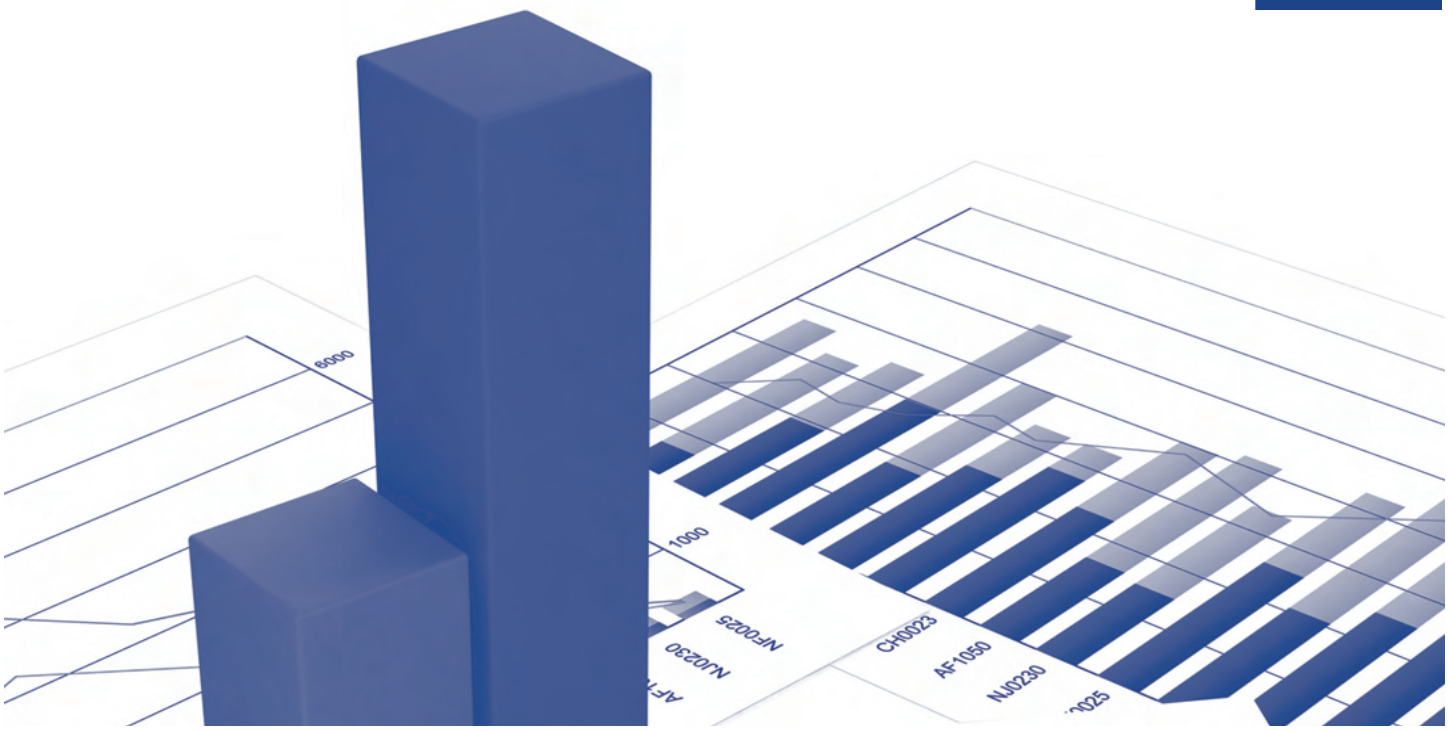

DATA BOOK

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 Mandy Zhou, Chuanyu Mu, 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. 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 provides information to the Congress on 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 and comments from interested parties. Commission members and staff also seek input on Medicare issues through frequent meetings with 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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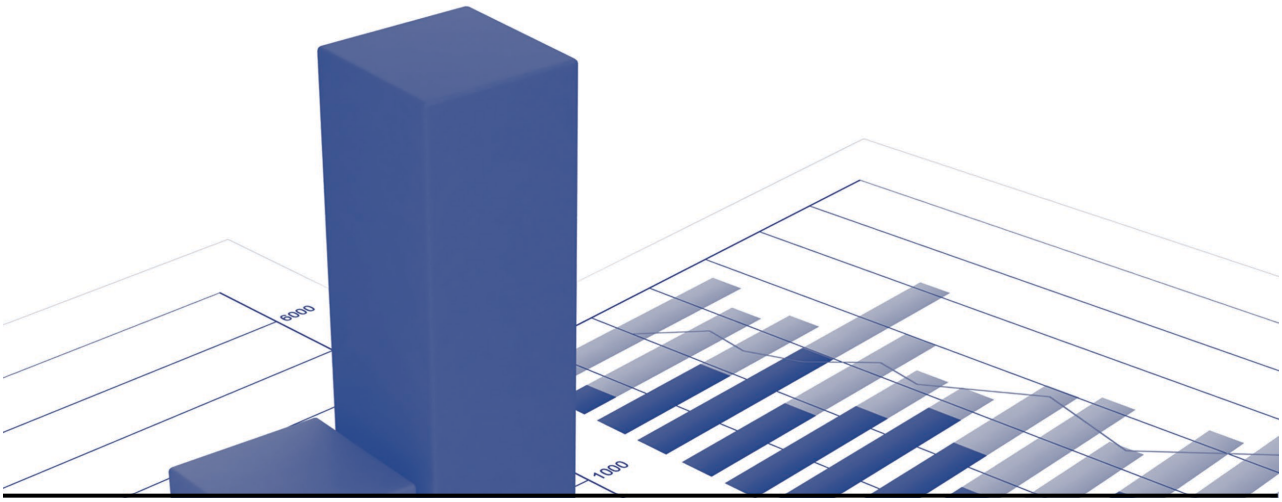
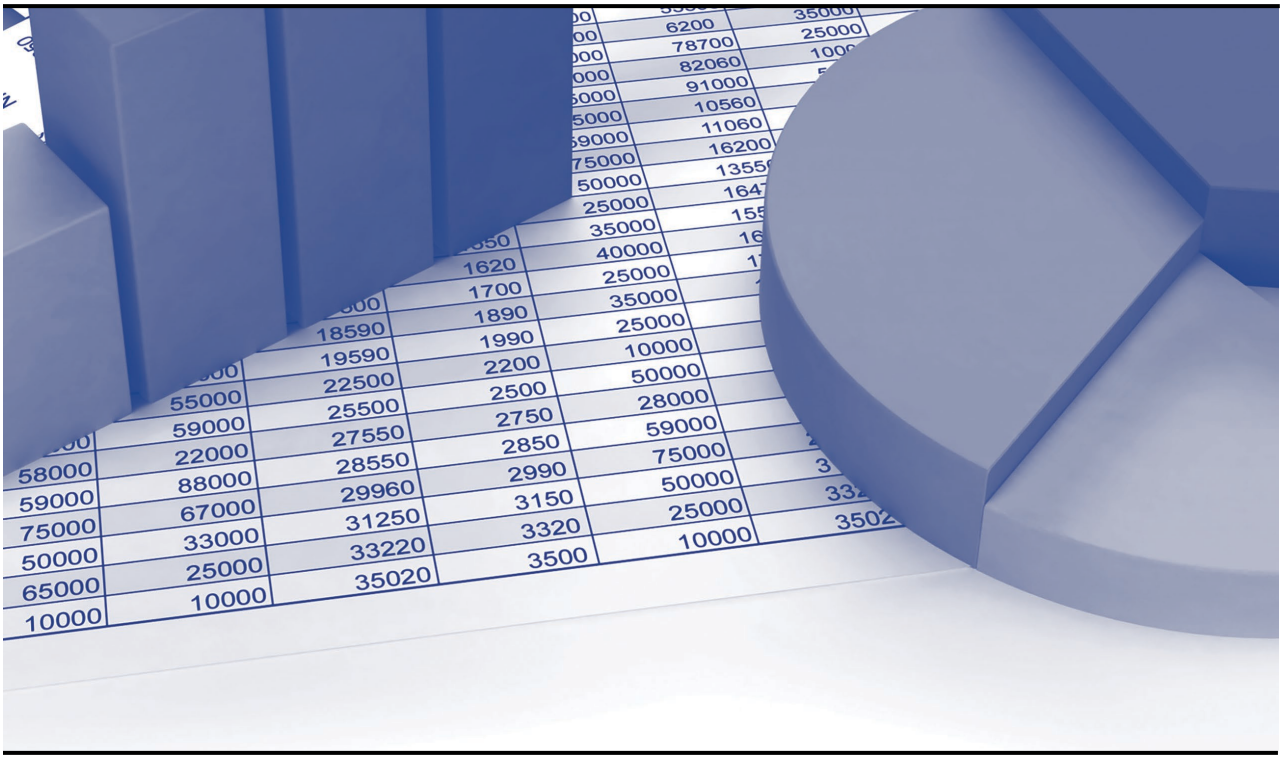


Introduction



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 programs creates barriers to coordination of care and the extent to which lack of coordination increases costs and leads to poor health outcomes. Because these issues are of concern to both commissions, we thought it prudent to combine resources and conduct a joint analysis of federal Medicare and Medicaid data. This data book is the latest in a series intended 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;
- utilization of and spending on Medicare and Medicaid services for dual-eligible beneficiaries;
- 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-eligible Medicare and Medicaid beneficiaries. In the case of Medicaid, our non-dual-eligible comparison group comprises 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-eligible comparison group includes all non-dual-eligible Medicare beneficiaries, who may qualify for coverage on the basis of age, disability, or end-stage renal disease (ESRD).

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, most notably LTSS. 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. Most Medicare payments are governed by formulas that allow for geographic variation but are determined at the national level. By contrast, in Medicaid, provider payment methodologies and payments are set at the state level. The programs also differ in their financing. Medicare is funded from sources such as general revenues, payroll taxes, premiums, 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 2023, the FMAP ranges from 50 percent to about 78 percent (Office of the Secretary, Department of Health and Human Services 2021).

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 receive assistance only 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 2022	Benefits
Medicare Savings Program (MSP) beneficiaries			
Qualified Medicare beneficiary (QMB)	Partial: QMB only	▪ At or below 100% FPL ▪ $8,400 / $12,600	Entitled to Medicare Part A, eligible for Medicaid only 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 ▪ $8,400 / $12,600	Entitled to Medicare Part A, eligible for Medicaid only 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 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 ▪ $8,400 / $12,600	Entitled to Medicare Part A, eligible for Medicaid only 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, eligible for Medicaid only 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, states have 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 2022b, 2022e, 2013a, 2013b; Medicaid and CHIP Payment and Access Commission 2015; Social Security Act; Social Security Administration 2019.*

States have the authority to expand eligibility for MSP benefits by using less restrictive methodologies for counting income and assets. As of November 2022, 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 2022

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%**	**$8,400**	**$12,600**	**120%**	**$8,400**	**$12,600**	**135%**	**$8,400**	**$12,600**
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
California	100	$130,000	$195,000	120	$130,000	$195,000	135	$130,000	$195,000
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	$8,400	$12,600	170	$8,400	$12,600	185	$8,400	$12,600
Louisiana	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
Maine[3]	150	$58,000 in liquid assets	$87,000 in liquid assets	170	$58,000 in liquid assets	$87,000 in liquid assets	185	$58,000 in liquid assets	$87,000 in liquid assets
Maryland[4]	100	$8,400	$12,600	135	$8,400	$12,600	N/A	N/A	N/A
Massachusetts	130	$16,800	$25,200	150	$16,800	$25,200	165	$16,800	$25,200
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 Mexico	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 shown in this table. All states except Connecticut have at least a $20 disregard for unearned income. Other income and asset disregards vary by state. The states that are not included in the table all follow the federal standards. This table does not include the Qualified Disabled and Working Individuals program.*

[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 2022; Arizona Health Care Cost Containment System 2022; Baltimore County Government 2022; California Department of Health Care Services 2022; Centers for Medicare & Medicaid Services 2022e; Delaware Health and Social Services 2022; District of Columbia Department of Health Care Finance 2022; District of Columbia Department of Health Care Finance 2013; Indiana Department of Insurance 2022; Louisiana Department of Health 2022; Maine Department of Health and Human Services 2022; MassHealth 2022; Minnesota Senior Linkage Line 2022; Mississippi Division of Medicaid 2022; New Mexico Human Services Department 2022; New York State Department of Health 2022; Oregon Department of Human Services 2022; United Way of Connecticut 2022; Vermont Agency of Human Services 2022.*

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 most individuals premium-free Part A, but Part B is a voluntary program requiring 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. Almost all 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 plans, or MA–PDs), 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. In addition, as part of a demonstration project, eight states have private plans known as Medicare–Medicaid Plans that provide the full range of Medicare and Medicaid services to certain full-benefit dual-eligible beneficiaries.

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 limit 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 FFS 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. States may contract with managed care plans to deliver LTSS, referred to as managed long-term services and supports programs.

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, preventive and screening services, 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, family planning services and supplies, and tobacco cessation counseling for pregnant women
		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: Non-emergency medical transportation
		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. We use the term "pregnant women" in this table, as this is the term used in the Medicaid statute and regulations. However, we recognize that not all individuals who become pregnant identify as women.*

Source: *Social Security Act and Centers for Medicare & Medicaid Services 2022c.*

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 limit 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 in which 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, 2023 and 2020

Part A	
Premium	Premium-free for insured individuals and their dependents and survivors; for uninsured individuals "buying in," $506 per month in 2023 or $278 for individuals with at least 30 quarters of coverage ($458 and $252, respectively, in 2020), plus the Part B premium (Part A cannot be purchased by itself)
Hospital stays	$1,600 deductible in 2023 for each benefit period ($1,408 in 2020)
	$400 per day in 2023 for days 61–90 of each benefit period (1/4 of hospital deductible each year) ($352 in 2020)
	$800 per "lifetime reserve day" in 2023 (1/2 of hospital deductible each year) after day 90 of each benefit period (up to 60 days over lifetime) ($704 in 2020)
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
	$200 per day in 2023 (1/8 of hospital deductible each year) for days 21–100 of each benefit period ($176 in 2020)
	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	$164.90 per month (the standard premium) in 2023 ($144.60 in 2020); Part B premiums have been higher for higher-income individuals since 2007
Deductible	The first $226 of Part B–covered services or items in 2023 ($198 in 2020)
Physician and other medical services	20% of the Medicare-approved amount for physician services and outpatient therapy (subject to limits); no cost sharing for annual wellness visits and many preventive services and screenings if the provider accepts payment of the Medicare fee schedule amount as payment in full (which is required for all Medicare claims for which Medicaid will be billed)
Outpatient hospital services	A coinsurance or copayment amount that varies by service, projected to average 20%; 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
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 the national average bid of sponsoring plans. The Part D basic beneficiary premium for 2023 is $34.71 ($32.74 in 2020); 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	$505 in 2023 ($435 in 2020); not applied to dual-eligible beneficiaries; dual-eligible beneficiaries pay only nominal copayments
Initial coverage limit	$4,660 in 2023 ($4,020 in 2020); dual-eligible beneficiaries pay only nominal copayments
Out-of-pocket threshold (catastrophic cap)	$7,400 in 2023 ($6,350 in 2020); 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, which in 2023 ranges from $1.45 for generic or preferred multisource drugs up to $10.35 for other drugs, depending on the person's subsidy category (a range of $1.30 to $8.95 in 2020).
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: *Centers for Medicare & Medicaid Services 2022d, 2022f, 2022g, 2019a, 2019b, 2019c.*

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, 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 people with disabilities 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 widow(er)s with disabilities 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 an entitlement program for individuals meeting eligibility criteria defined by population characteristics and financial criteria. As noted earlier, the MSP pathways to limited Medicaid coverage of Medicare premiums and cost sharing are 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 such as the Affordable Care Act's extension of eligibility to adults under age 65 with income below 138 percent of the FPL, 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 2020. When the analytic work for this data book began, calendar year (CY) 2020 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 Transformed Medicaid Statistical Information System (T-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 T-MSIS data submitted by states, which may not always be reflected in the research files from CMS) may lead to estimates of enrollment and spending that are 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 data sets was assigned a unique identification (ID) number using an algorithm that incorporates program-specific identifiers (such as the Medicare Beneficiary Identifier and T-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 T-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 was used to separate beneficiaries with disabilities 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, beneficiaries who are disabled and entitled to Medicare based on another individual's work history include adult children who are disabled and receive benefits through a disabled, retired, or deceased parent as well as individuals ages 50 and older who are disabled and receive benefits through a deceased spouse or deceased former (divorced) spouse.

- *Medicaid LTSS.* Medicaid LTSS is defined by FFS use of the following Medicaid services: institutional (nursing facility, intermediate care facility for individuals 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 those using services under the state plan 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.

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

- *Reporting of Medicaid data by states.* T-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, T-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 over 50 percent of Medicaid FFS spending on inpatient and outpatient hospital services (Medicaid and CHIP Payment and Access Commission 2022b). The T-MSIS data also exclude Medicaid payments for Medicare premiums ($21.4 billion in 2020, of which $14.1 billion was the federal share and $7.2 billion was the state share (Medicaid and CHIP

Payment and Access Commission 2022a)) that finance a portion of Medicare spending. Other known issues with state reporting of T-MSIS data, such as errors in coding individuals in the proper eligibility group or spending under the appropriate type of service, are documented in an interactive, web-based Data Quality (DQ) Atlas updated by CMS on an ongoing basis (Centers for Medicare & Medicaid Services 2022a). The DQ Atlas includes information on T-MSIS file usability, the share of values that are missing for specific variables, benchmark comparisons with other data sources, and data anomalies that may require special consideration. 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. In addition, T-MSIS figures shown in this year's data book may not be directly comparable with figures from earlier editions that were based on MSIS data. The new eligibility groups and expanded type-of-service categories in T-MSIS mean that enrollees and some spending may be classified differently than under MSIS, depending on how states map eligibility categories and types of service between the two systems.

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 T-MSIS spending reported by states. MACPAC adjusts the T-MSIS spending published in its MACStats data book by collapsing over 100 service types into just 7 broad categories of service that are more comparable between the T-MSIS and CMS–64 data. However, a similar adjustment may not be appropriate when analyzing spending for a particular subset of individuals such as dual-eligible beneficiaries.

- *Identification of Medicaid payments for Medicare cost sharing.* States are instructed to report Medicaid payments for Medicare deductibles and coinsurance in T-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 T-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 2020

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	**$2.7**	**$0.3**	**$1.7**	**$0.3**	**$0.3**	**$8.3**
Hospital deductible	1.1	0.1	0.5	0.2	0.2	5.7
Hospital per day copayments	0.3	<0.1	0.1	<0.1	<0.1	0.4
SNF-day copayments	1.3	0.2	1.1	0.1	0.1	2.2
Part B total	**5.6**	**0.5**	**2.2**	**1.2**	**1.0**	**36.2**
Deductible	0.6	<0.1	0.2	0.1	0.1	4.8
Coinsurance	5.0	0.4	2.0	1.1	0.9	31.4
Part A and Part B total	**8.2**	**0.8**	**3.9**	**1.5**	**1.3**	**44.5**

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. Components may not sum to totals 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 enrollment in Medicaid or Medicaid-expansion coverage under the State Children's Health Insurance Program (CHIP) enrollment. Individuals residing outside of the 50 states and the District of Columbia are excluded from the analysis.

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

beneficiaries, the status change can be from partial-benefit to full-benefit Medicaid coverage or vice versa.

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 90 percent of ever-enrolled counts) than the Medicare population (where average monthly counts were 97 percent of ever-enrolled counts) (Table 6). For dual-eligible beneficiaries, average monthly counts were 91 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 2020

	Number of beneficiaries (millions)		Average monthly as a percent of ever enrolled
	Ever enrolled	Average monthly	
Dual-eligible beneficiaries	**12.2**	**11.0**	**91%**
Under age 65	4.5	4.1	93
Ages 65 and older	7.7	6.9	89
Medicare beneficiaries with no dual-eligible enrollment	**52.3**	**50.6**	**97**
Under age 65	4.0	3.8	96
Ages 65 and older	48.3	46.8	97
Medicaid beneficiaries with no dual-eligible enrollment	**77.1**	**68.7**	**89**
Nondisabled under age 65	70.9	62.9	89
Disabled under age 65	5.2	5.0	95
Ages 65 and older	0.9	0.7	84
All Medicare beneficiaries	**64.5**	**62.4**	**97**
All Medicaid beneficiaries	**89.3**	**80.0**	**90**

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.* Spending and utilization are attributed to beneficiaries 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 2019 (Exhibit 13). Therefore, our method for attributing 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 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 a Medicare managed care plan (usually 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 were managed care enrollees for a portion of the year but who were in Medicare or Medicaid FFS status for the remaining portion of the year.

  About 52 percent of the dual-eligible population was enrolled in a Medicare managed care plan for all or part of the year in 2020 (Exhibit 11). Dual-eligible beneficiaries were more likely to have been managed care enrollees and more likely than non-dual Medicare beneficiaries to have had a mix of managed care and FFS enrollment in the year (11 percent vs. 4 percent). This difference reflects the ability of dual-eligible beneficiaries to enroll in or disenroll from managed care on a quarterly or monthly basis (whereas non-dual Medicare beneficiaries generally can make changes only 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 (41 percent vs. 72 percent, Exhibit 12).

- *Beneficiaries with ESRD.* About 1.0 percent of all Medicare beneficiaries and 2.2 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 were the only class of Medicare beneficiaries specifically prohibited from enrolling in MA plans (except in certain circumstances; this prohibition was lifted in 2021). This prohibition further skewed the utilization and expenditure statistics for the FFS population, which is the population examined in most of the exhibits.

Table 7. Beneficiaries with and without end-stage renal disease and their expenditures, CY 2020

	All beneficiaries	Non-ESRD	ESRD	ESRD as share of total
Population				
All Medicare beneficiaries (in millions)	64.5	63.8	0.6	1.0%
Dual-eligible beneficiaries (in millions)	12.2	11.9	0.3	2.2
Dual-eligible beneficiaries as share of category	19%	19%	44%	
Medicare expenditures				
Total spending (in billions)	$838.6	$791.2	$47.3	5.6
Per person per year	13,009	12,393	77,162	
Spending on dual-eligible beneficiaries (in billions)	287.2	262.2	25.1	8.7
Per person per year	23,552	21,988	92,220	
Spending on non-dual beneficiaries (in billions)	551.3	529.0	22.3	4.0
Per person per year	10,549	10,189	65,188	
Medicaid expenditures				
Spending on dual-eligible beneficiaries (in billions)	$169.0	$163.6	$5.4	3.2
Per person per year	13,854	13,717	19,861	

Note: *CY (calendar year), ESRD (end-stage renal disease). ESRD status is based on at least one month of having ESRD in the year. Components may not sum to totals 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 (beneficiaries with and without ESRD) are greater for Medicare expenditures than for Medicaid expenditures in the case of dual-eligible beneficiaries. In 2020, annual per capita Medicare spending for dual-eligible beneficiaries with ESRD was $92,220; per capita Medicaid spending for the same population was $19,861. With the ESRD population included, annual per capita Medicare spending for dual-eligible beneficiaries averaged $23,552 in 2020; excluding

beneficiaries with ESRD, per capita Medicare spending on dual-eligible beneficiaries averaged $21,988 for the year. In comparison, Medicaid per capita spending on dual-eligible beneficiaries including the ESRD population was $13,854; excluding these individuals, the amount was $13,717.

Table 8. Dual-eligible, Medicare, and Medicaid beneficiaries as a percent of population by state, CY 2020 (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	326,569	12,196	4%	8,829	72%	3,367	28%	64,459	20%	89,276	27%
Alabama	4,893	229	5	91	40	138	60	1,111	23	1,232	25
Alaska	737	21	3	20	94	1	6	110	15	245	33
Arizona	7,174	257	4	195	76	62	24	1,429	20	2,156	30
Arkansas	3,012	147	5	78	53	69	47	675	22	1,054	35
California	39,346	1,638	4	1,603	98	35	2	6,791	17	14,754	37
Colorado	5,685	131	2	90	68	42	32	984	17	1,487	26
Connecticut	3,571	202	6	78	39	124	61	729	20	1,094	31
Delaware	968	35	4	17	50	17	50	226	23	273	28
District of Columbia	702	39	6	27	69	12	31	101	14	269	38
Florida	21,217	958	5	464	48	494	52	4,877	23	4,647	22
Georgia	10,517	384	4	162	42	222	58	1,857	18	2,428	23
Hawaii	1,420	48	3	41	86	7	14	294	21	404	28
Idaho	1,754	54	3	32	59	22	41	364	21	409	23
Illinois	12,716	429	3	377	88	53	12	2,376	19	3,395	27
Indiana	6,697	236	4	166	70	70	30	1,347	20	1,795	27
Iowa	3,150	96	3	75	79	21	21	669	21	785	25
Kansas	2,913	75	3	48	65	27	35	573	20	468	16
Kentucky	4,462	216	5	130	60	86	40	985	22	1,739	39
Louisiana	4,665	254	5	151	60	102	40	937	20	1,825	39
Maine	1,341	94	7	56	60	37	40	362	27	381	28
Maryland	6,038	167	3	98	59	69	41	1,109	18	1,564	26
Massachusetts	6,873	347	5	314	91	33	9	1,422	21	2,017	29
Michigan	9,974	359	4	297	83	62	17	2,203	22	2,840	28
Minnesota	5,600	155	3	138	89	17	11	1,095	20	1,234	22
Mississippi	2,982	173	6	83	48	89	52	640	21	804	27
Missouri	6,124	201	3	164	82	37	18	1,305	21	1,097	18

State	Total population (thousands)	Dual-eligible beneficiaries						All Medicare beneficiaries		All Medicaid beneficiaries	
		All		Full		Partial					
		Number (thousands)	Percent of total population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of total population	Number (thousands)	Percent of total population
Montana	1,062	32	3	22	66	11	34	248	23	297	28
Nebraska	1,924	44	2	39	89	5	11	370	19	320	17
Nevada	3,030	78	3	30	39	47	61	571	19	790	26
New Hampshire	1,355	37	3	24	65	13	35	320	24	243	18
New Jersey	8,885	220	2	218	100	1	<1	1,692	19	1,992	22
New Mexico	2,097	108	5	64	59	44	41	452	22	915	44
New York	19,515	1,049	5	891	85	157	15	3,868	20	7,340	38
North Carolina	10,386	361	3	275	76	86	24	2,124	20	2,512	24
North Dakota	760	17	2	13	79	4	21	141	19	115	15
Ohio	11,675	426	4	296	69	130	31	2,497	21	3,156	27
Oklahoma	3,949	130	3	105	81	25	19	789	20	967	24
Oregon	4,176	119	3	59	50	60	50	888	21	1,191	29
Pennsylvania	12,795	513	4	425	83	88	17	2,909	23	3,265	26
Rhode Island	1,058	49	5	41	84	8	16	235	22	346	33
South Carolina	5,092	178	4	150	84	29	16	1,149	23	1,341	26
South Dakota	879	22	3	14	62	9	38	188	21	137	16
Tennessee	6,772	288	4	165	57	123	43	1,446	21	1,706	25
Texas	28,635	776	3	405	52	371	48	4,490	16	5,773	20
Utah	3,151	40	1	36	90	4	10	430	14	416	13
Vermont	624	30	5	22	73	8	27	158	25	185	30
Virginia	8,509	219	3	151	69	69	31	1,616	19	1,787	21
Washington	7,512	224	3	155	69	69	31	1,461	19	2,054	27
West Virginia	1,807	88	5	48	55	39	45	461	25	609	34
Wisconsin	5,807	196	3	178	91	18	9	1,257	22	1,354	23
Wyoming	581	12	2	8	67	4	33	119	20	73	13

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 analysis of ACS Demographic and Housing Estimates, 2019: ACS 1-Year Estimates Data Profiles"* (https://data.census.gov/cedsci/table?q=state%20population&g=0100000US%240400000&d=ACS%201-Year%20Estimates%20Data%20Profiles&tid=ACSDP1Y2019.DP05&hidePreview=true&tp=true) *and Medicare and Medicaid enrollment data for MedPAC and MACPAC.*

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Section

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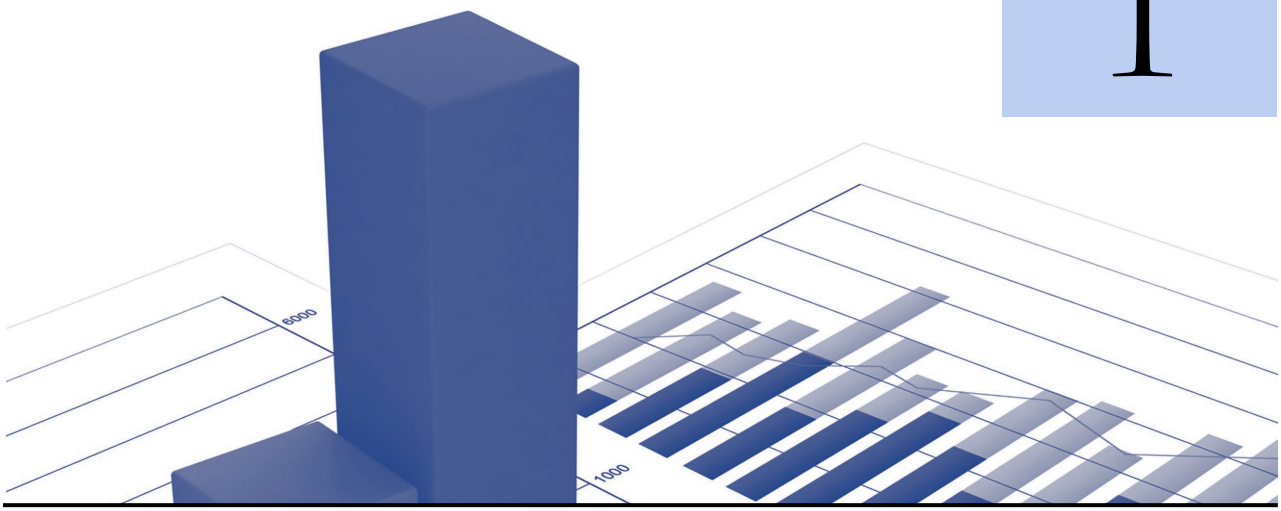


Overview of dual-eligible beneficiaries

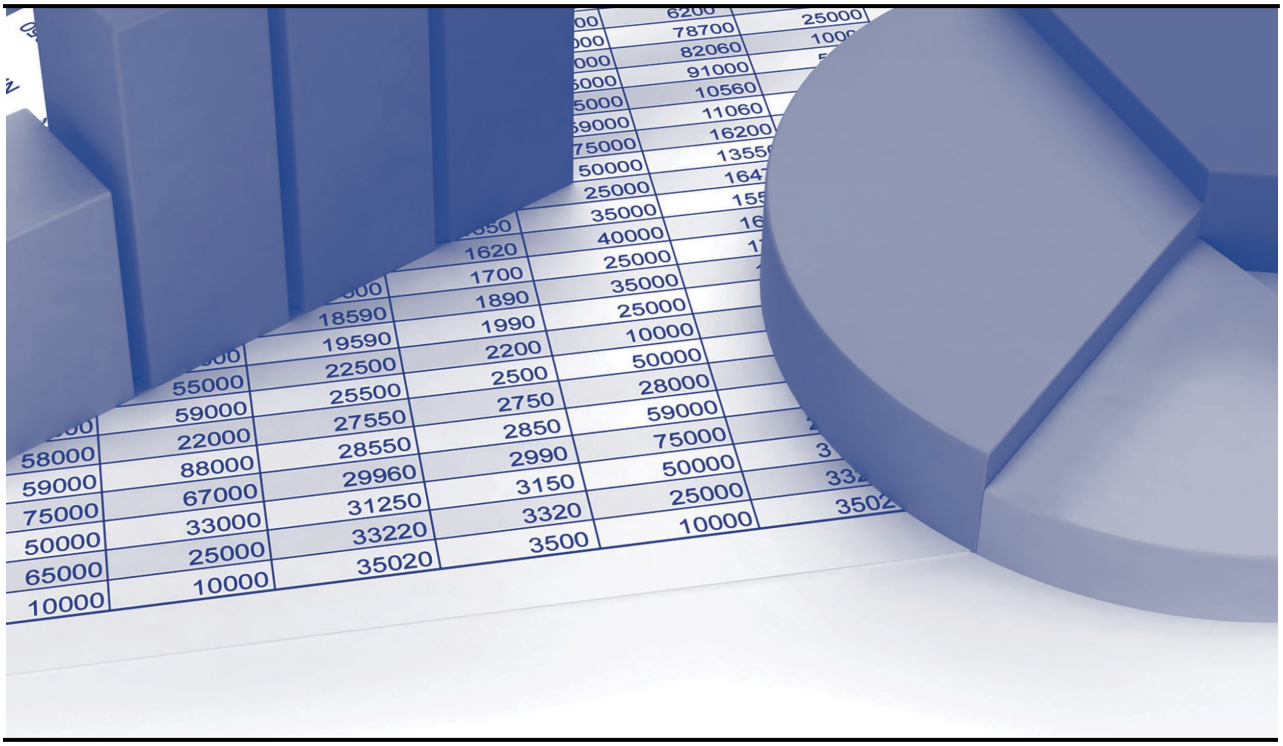
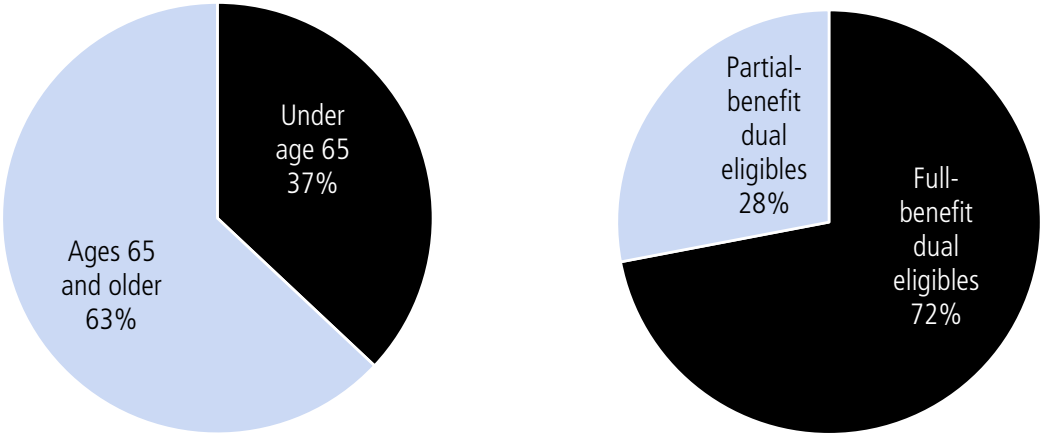


Exhibit 1

Snapshot of dual-eligible beneficiaries by age and type of benefit, CY 2020

12.2 million dual-eligible beneficiaries



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

- A total of 12.2 million individuals were dually eligible for Medicare and Medicaid benefits in at least one month of CY 2020. The majority (63 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 2020

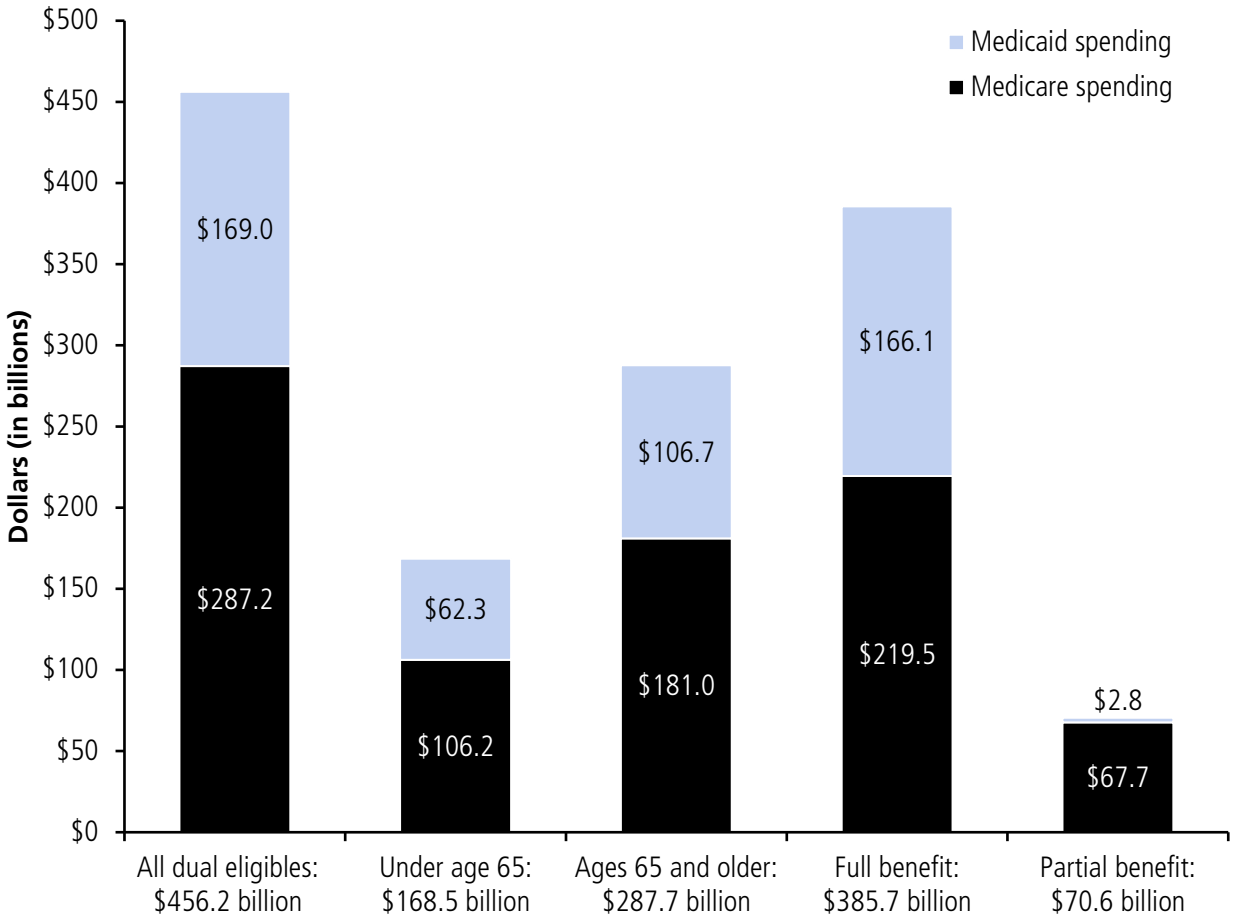
Benefit categories	Dual-eligible beneficiaries		
	All	Under age 65	Ages 65 and older
Full-benefit dual-eligible beneficiaries	**72%**	**73%**	**72%**
QMB plus	52	53	52
SLMB plus	3	3	3
Other full benefit	17	17	18
Partial-benefit dual-eligible beneficiaries	**28**	**27**	**28**
QMB only	14	14	14
SLMB only	9	8	9
QI	5	4	5
QDWI	<1	<1	<1

Note: *CY (calendar year), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (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. Beneficiaries in the QMB plus and SLMB plus categories qualify for QMB or SLMB benefits, respectively, and full Medicaid benefits. Beneficiaries in the QMB only and SLMB only categories are not eligible for full Medicaid benefits; their Medicaid coverage is limited to payment of Medicare premiums and sometimes cost sharing.*

- In CY 2020, almost 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 (14 percent) was in the QMB-only category.

Exhibit 3

Medicare and Medicaid spending on dual-eligible beneficiaries by age and type of benefit, CY 2020

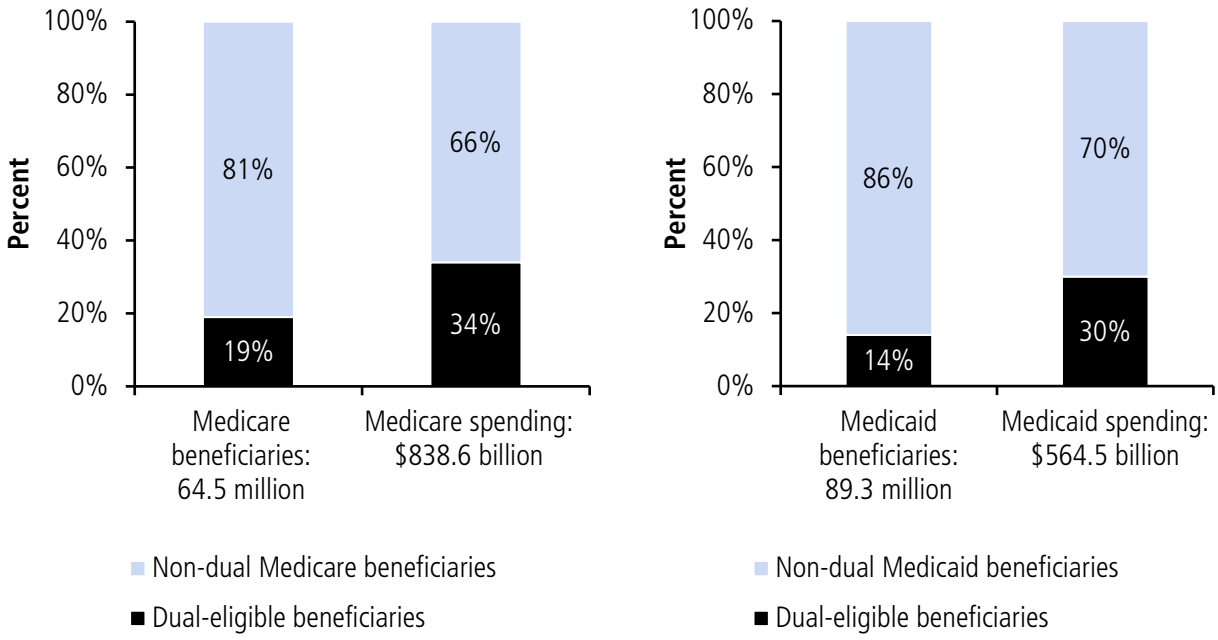


Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Components may not sum to totals due to rounding. Exhibit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

- Combined Medicare and Medicaid spending on individuals who were dually eligible for both Medicare and Medicaid was $456.2 billion in CY 2020. Medicare accounted for about 63 percent of combined spending, or $287.2 billion.
- By age group, combined Medicare and Medicaid spending on dual-eligible beneficiaries was higher for beneficiaries ages 65 and older ($287.7 billion in combined spending) than for beneficiaries under age 65 ($168.5 billion in combined spending).
- Combined Medicare and Medicaid spending was more than five times higher for full-benefit dual-eligible beneficiaries than for partial-benefit dual-eligible beneficiaries ($385.7 billion vs. $70.6 billion).

Exhibit 4

Dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2020



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 2020.
- Dual-eligible beneficiaries totaled 19 percent of the Medicare population in 2020 but accounted for 34 percent of Medicare spending.
- Similarly, dual-eligible beneficiaries comprised 14 percent of all Medicaid beneficiaries but accounted for 30 percent of Medicaid spending.

Exhibit 5

Selected subgroups of dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2020

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	7%	13%	5%	11%
Ages 65 and older	12	22	9	19
Type of benefit				
Full benefit	14%	26%	10%	29%
Partial benefit	5	8	4	1

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

- Certain subgroups of individuals dually eligible for Medicare and Medicaid benefits accounted for disproportionate shares of Medicare and Medicaid spending.
- Dual-eligible beneficiaries ages 65 and older made up 12 percent of the Medicare population in CY 2020 but accounted for 22 percent of Medicare spending. These beneficiaries also accounted for 9 percent of the Medicaid population but 19 percent of Medicaid spending.
- Full-benefit dual-eligible beneficiaries also incurred disproportionate spending, particularly in Medicaid. In Medicare, they accounted for 14 percent of all enrollment but 26 percent of all Medicare spending; in Medicaid, they made up 10 percent of all enrollment but 29 percent of all Medicaid spending.

Section

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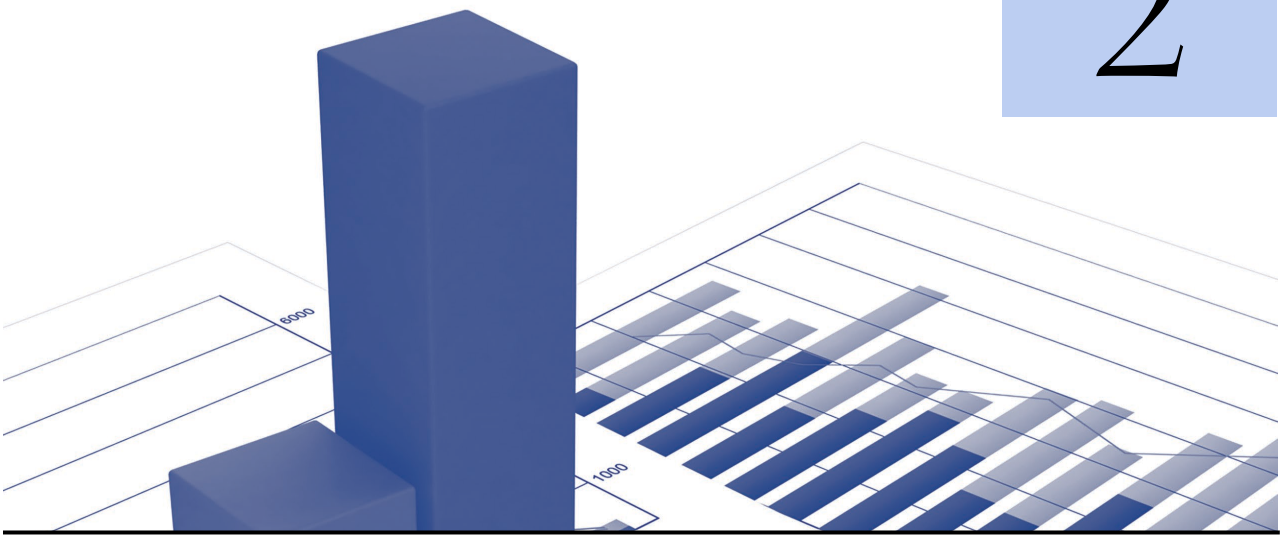

Characteristics of dual-eligible beneficiaries

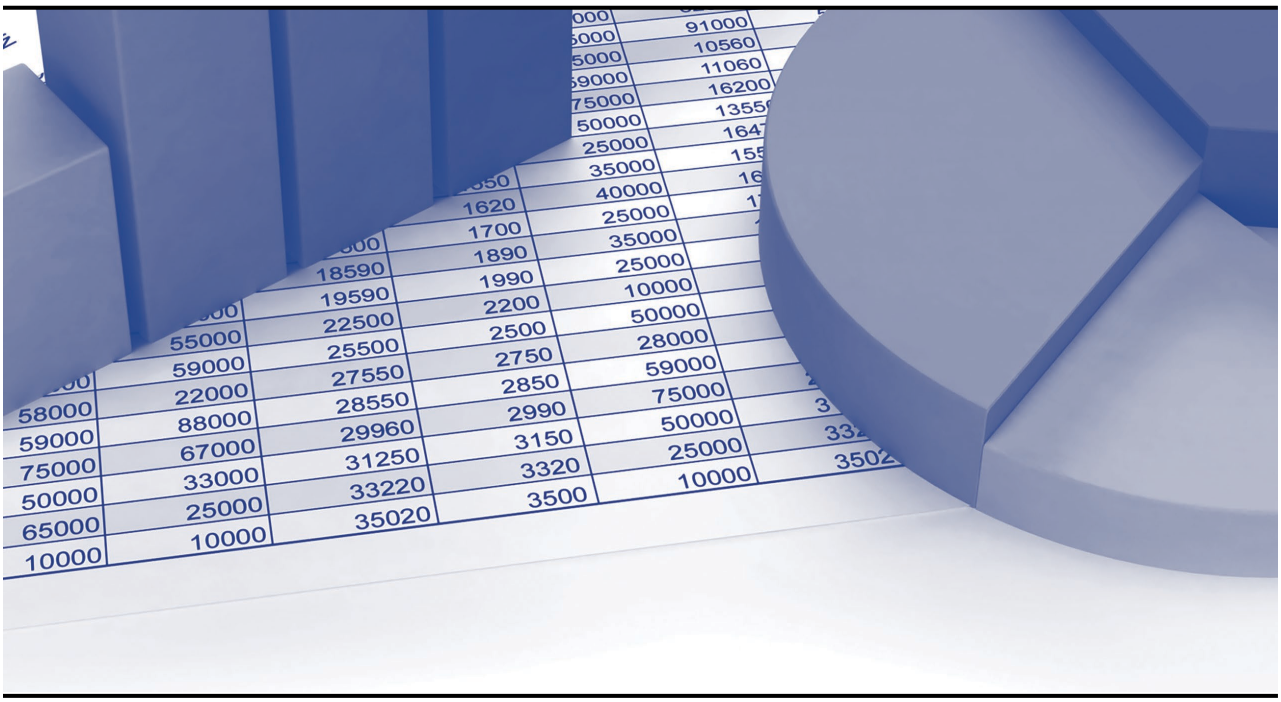

Exhibit 6

Demographic characteristics of dual-eligible and non-dual Medicare and Medicaid beneficiaries, CY 2020

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	41%	48%	37%	41%	41%	47%	56%
Female	59	52	63	59	59	53	44
Race/Ethnicity							
White/non-Hispanic	54%	60%	50%	52%	58%	82%	48%
Black/non-Hispanic	21	25	19	20	24	9	29
Hispanic	17	12	20	18	15	6	20
Other	8	3	11	9	3	3	4
Residence							
Urban	79%	76%	81%	81%	75%	80%	81%
Rural	21	24	19	19	25	20	19

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 3.2 percent or less for all statistics except race/ethnicity for non-dual disabled Medicaid beneficiaries, where the share of beneficiaries with missing information was 20.2 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 2020 were female (59 percent), White (54 percent), and lived in an urban area (79 percent).
- Dual-eligible beneficiaries were more likely to be White (54 percent) than non-dual Medicaid beneficiaries who were eligible on the basis of a disability (48 percent), but less likely than non-dual Medicare beneficiaries (82 percent). There were proportionately more Black (21 percent) and Hispanic (17 percent) dual-eligible beneficiaries than Black and Hispanic non-dual Medicare beneficiaries (9 percent and 6 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. 37 percent), White (60 percent vs. 50 percent), or Black (25 percent vs. 19 percent). Dual-eligible beneficiaries ages 65 and older were more likely to be Hispanic than dual-eligible beneficiaries under the age of 65 (20 percent vs. 12 percent, respectively).
- Comparing full-benefit and partial-benefit dual-eligible beneficiaries, more full-benefit beneficiaries were Hispanic (18 percent vs. 15 percent) or lived in an urban area (81 percent vs. 75 percent).

Exhibit 7

Additional characteristics of dual-eligible beneficiaries, CY 2020

Characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
Limitations in ADLs						
None	54%	46%	58%	48%	68%	82%
1–2 ADL limitations	23	28	19	23	22	12
3–6 ADL limitations	24	25	23	29	11	6
Self-reported health status						
Excellent or very good	21%	17%	24%	19%	26%	52%
Good or fair	59	62	58	60	57	40
Poor	13	18	9	13	12	4
Unknown	7	3	9	8	5	4
Living arrangement						
Institution	12%	7%	15%	17%	1%	3%
Alone	35	32	37	31	44	27
Spouse	15	10	18	12	21	54
Children, nonrelatives, others	38	51	30	40	34	16
Education						
No high school diploma	34%	25%	39%	36%	29%	8%
High school diploma only	31	39	27	30	35	24
Some college	30	34	28	27	36	67
Other	5	3	7	7	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 (MCBS). Non-dual disabled Medicaid beneficiaries are not included because data are not available for these beneficiaries through the MCBS. The figures for living arrangement exclude beneficiaries with unknown living arrangements. Percentages may not sum to 100 due to rounding.*
Source: *2020 Medicare Current Beneficiary Survey.*

- Nearly half (46 percent) of individuals dually eligible for Medicare and Medicaid benefits in CY 2020 had at least one ADL limitation.
- Dual-eligible beneficiaries were more likely than non-dual Medicare beneficiaries to report being in poor health (13 percent vs. 4 percent). They were also more likely to live in an institution (12 percent vs. 3 percent).
- Dual-eligible beneficiaries ages 65 and older were more likely than younger dual-eligible beneficiaries to live in an institution (15 percent vs. 7 percent). However, older dual-eligible beneficiaries were more likely to report having no ADL limitations (58 percent vs. 46 percent) and less likely to report being in poor health (9 percent vs. 18 percent).
- Dual-eligible beneficiaries with partial benefits were more likely than those with full benefits to report having no ADL limitations (68 percent vs. 48 percent). Partial-benefit dual-eligible beneficiaries were also less likely to live in an institution (1 percent vs. 17 percent).
- About a third of all dually eligible individuals (34 percent) did not graduate from high school, compared with 8 percent of non-dual Medicare beneficiaries.

Exhibit 8

Selected chronic conditions for FFS dual-eligible beneficiaries by age group, CY 2020

Condition	FFS dual-eligible beneficiaries	
	Under age 65	Ages 65 and older
Cognitive impairment		
Alzheimer's disease or related dementia	4%	19%
Intellectual disabilities and related conditions	11	2
Physical health conditions		
Diabetes	23%	32%
Heart failure	8	19
Hypertension	38	60
Ischemic heart disease	13	28
Behavioral health conditions		
Anxiety disorders	34%	21%
Bipolar disorder	15	4
Depression	33	24
Schizophrenia and other psychotic disorders	13	5

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 differed 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 (19 percent vs. 4 percent). More dual-eligible beneficiaries under age 65 had an intellectual disability (11 percent vs. 2 percent).
- Compared with the population under age 65, those ages 65 and older generally had higher rates of physical health 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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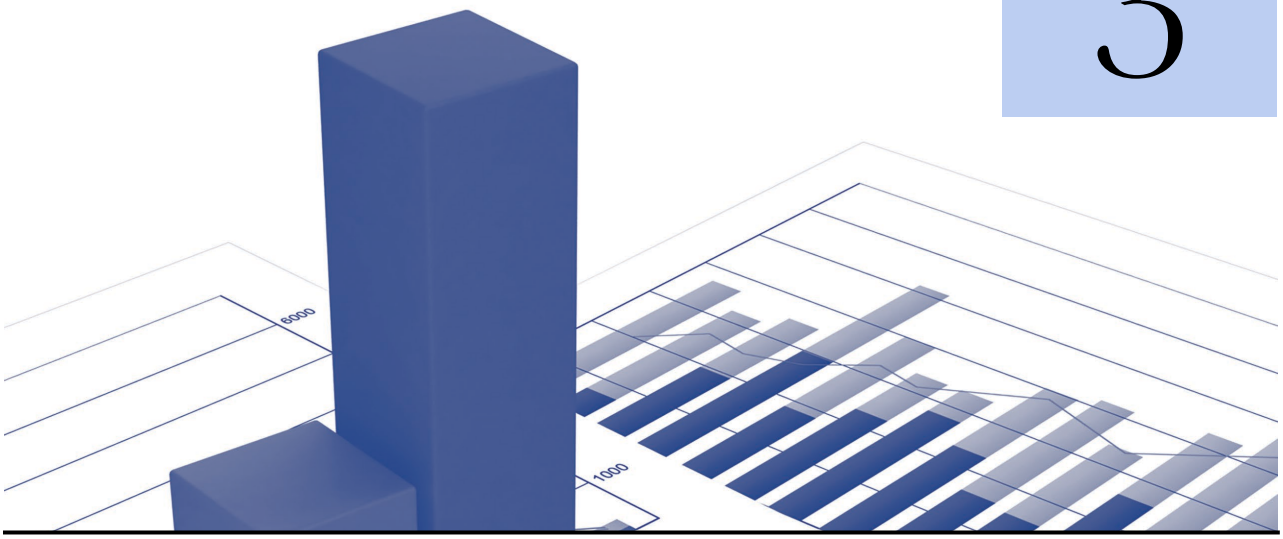

Eligibility pathways, managed care enrollment, and continuity of enrollment

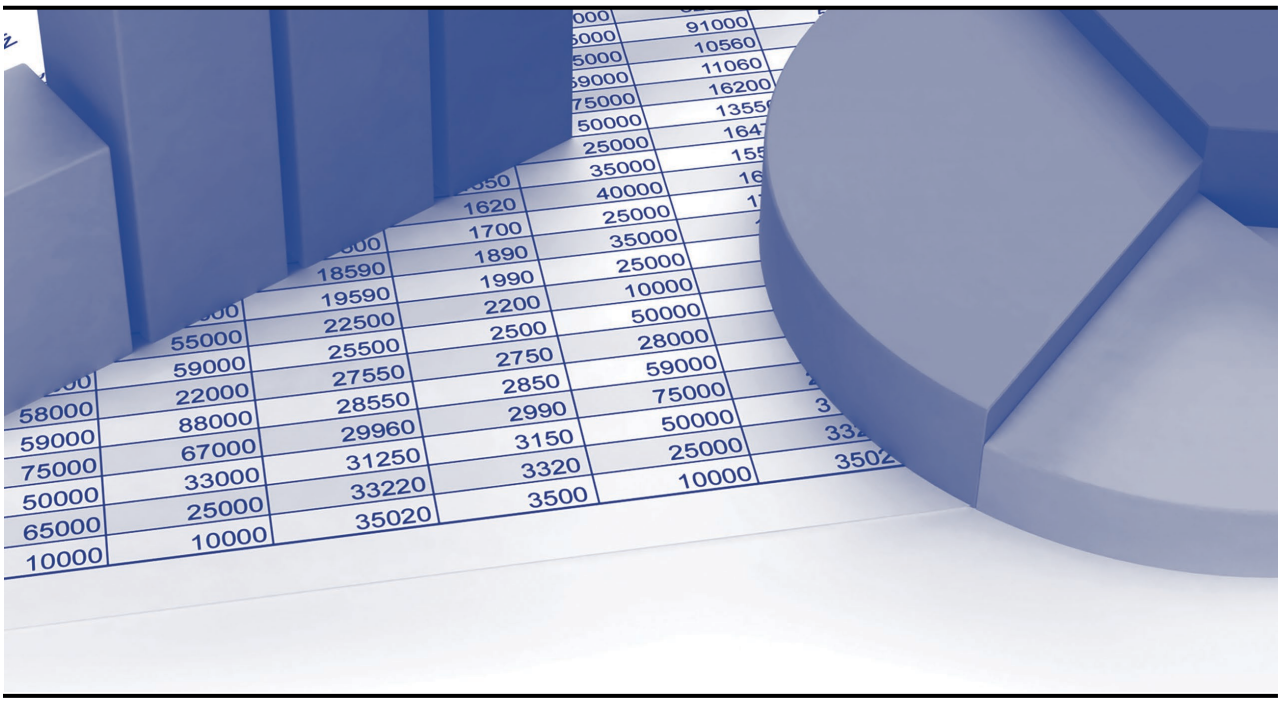

Exhibit 9

Medicare eligibility pathways, CY 2020

Original reason for entitlement to Medicare	Dual-eligible beneficiaries			Non-dual Medicare beneficiaries
	All	Full benefit	Partial benefit	
Age	48%	49%	46%	85%
ESRD	1	1	1	<1
Disability	51	50	53	15
Based on own record	81	76	93	96
Based on another's record	19	24	7	4

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).*

- Overall, individuals dually eligible for Medicare and Medicaid benefits in CY 2020 were nearly evenly split between those who originally qualified for Medicare benefits based on age (48 percent) and those who qualified for Medicare benefits based on disability (51 percent).
- In contrast to dual-eligible beneficiaries, most non-dual Medicare beneficiaries (85 percent) originally qualified for Medicare benefits based on their age.
- Most (76 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 (93 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 (24 percent among those with full benefits and 7 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 2020

Medicaid eligibility group	Dual-eligible beneficiaries			Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	
SSI	36%	36%	36%	85%
Poverty related	43	42	43	5
Medically needy	6	5	7	4
Section 1115 waiver	<1	<1	<1	<1
Special income limit and other	14	17	13	5

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 2020 qualified for Medicaid benefits through receipt of SSI benefits (36 percent) or through poverty-related eligibility pathways (43 percent).
- In contrast to dual-eligible beneficiaries, most non-dual Medicaid beneficiaries eligible on the basis of a disability (85 percent) qualified for Medicaid benefits based on receipt of SSI benefits.
- Compared with those under age 65, dual-eligible beneficiaries ages 65 and older were more likely to have been eligible for Medicaid because they have high medical costs (medically needy group) and less likely to qualify because they require an institutional level of care (special income limit and other group).

Exhibit 11

Medicare fee-for-service and managed care enrollment, CY 2020

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	48%	53%	45%	52%	38%	60%
Managed care only	41	35	45	36	54	35
Both FFS and managed care	11	12	10	12	8	4
Among beneficiaries in managed care only						
Enrolled in a D–SNP	51	56	49	57	40	<1
Enrolled in other plan type	49	44	51	43	60	100

Note: *CY (calendar year), FFS (fee-for-service), D–SNP (dual-eligible special needs plan). Managed care includes all types of Medicare Advantage plans, Medicare–Medicaid Plans, and the Program of All-Inclusive Care for the Elderly. 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 2020, slightly less than half of individuals dually eligible for Medicare and Medicaid services (48 percent) were enrolled only in Medicare FFS.
- Dual-eligible beneficiaries were more likely to be exclusively enrolled in managed care (either a Medicare Advantage (MA) plan or other type of Medicare health plan) than non-dual Medicare beneficiaries (41 percent vs. 35 percent).
- Dual-eligible beneficiaries ages 65 and older were more likely to be exclusively enrolled in managed care than those under age 65 (45 percent vs. 35 percent).
- Partial-benefit dual-eligible beneficiaries were more likely to be exclusively enrolled in managed care than full-benefit beneficiaries (54 percent vs. 36 percent), while full-benefit beneficiaries were more likely to be in FFS only (52 percent vs. 38 percent).
- Among those exclusively enrolled in managed care, about half of dual-eligible beneficiaries were enrolled in D–SNPs, which are specialized MA plans that exclusively serve dual-eligible beneficiaries. Full-benefit dual-eligible beneficiaries were more likely to enroll in D–SNPs while those with partial-benefit dual eligibility were more likely to enroll in other types of plans.

Exhibit 12

Medicaid fee-for-service and managed care enrollment, CY 2020

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	40%	40%	40%	22%	89%	9%
FFS and limited-benefit managed care only	19	22	18	26	1	19
At least one month of comprehensive managed care	41	38	42	52	10	72

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.*

- Most individuals dually eligible for Medicare and Medicaid services in CY 2020 were either enrolled only in Medicaid FFS (40 percent) or in Medicaid FFS with a limited-benefit Medicaid managed care plan (19 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 (72 percent vs. 41 percent) and less likely to be enrolled in Medicaid FFS only (9 percent vs. 40 percent).
- Dual-eligible beneficiaries ages 65 and older were more likely to be in comprehensive managed care than those under age 65 (42 percent vs. 38 percent).
- More than three-quarters (78 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 2020

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	81%	85%	79%	81%	82%
Enrolled 12 months, some with Medicare or Medicaid only	13	13	13	12	14
Enrolled fewer than 12 months	6	3	8	7	4
Consistency of full and partial dual-eligible status during the year					
Exclusively full or exclusively partial	97	96	97	97	97
Switched between full and partial	3	4	3	3	3
Attainment of dual-eligible status during the year					
Was previously dually eligible	90	91	89	89	91
Became dually eligible	10	9	11	11	9
Of those who became dually eligible during the year, the share who were:					
Medicare beneficiaries who gained Medicaid coverage	52	33	61	43	82
Medicaid beneficiaries who gained Medicare coverage	47	66	39	57	18
Individuals who gained Medicare and Medicaid coverage simultaneously	<1	<1	<1	<1	1

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

- Overall, most individuals dually eligible for Medicare and Medicaid benefits (81 percent) were dual-eligible beneficiaries during every month of CY 2020.
- Only 3 percent of all dual-eligible beneficiaries in 2020 switched between full-benefit and partial-benefit dual-eligible status.
- Ten percent of dual-eligible beneficiaries first became dually eligible during 2020. Among those individuals, more than half (52 percent) were non-dual-eligible Medicare beneficiaries who subsequently gained Medicaid coverage.
- Among beneficiaries who became dually eligible during 2020, 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 (61 percent).
- Full-benefit beneficiaries who became dually eligible during the year were more likely to be non-dual Medicaid beneficiaries first (57 percent) than non-dual Medicare beneficiaries (43 percent).

Section

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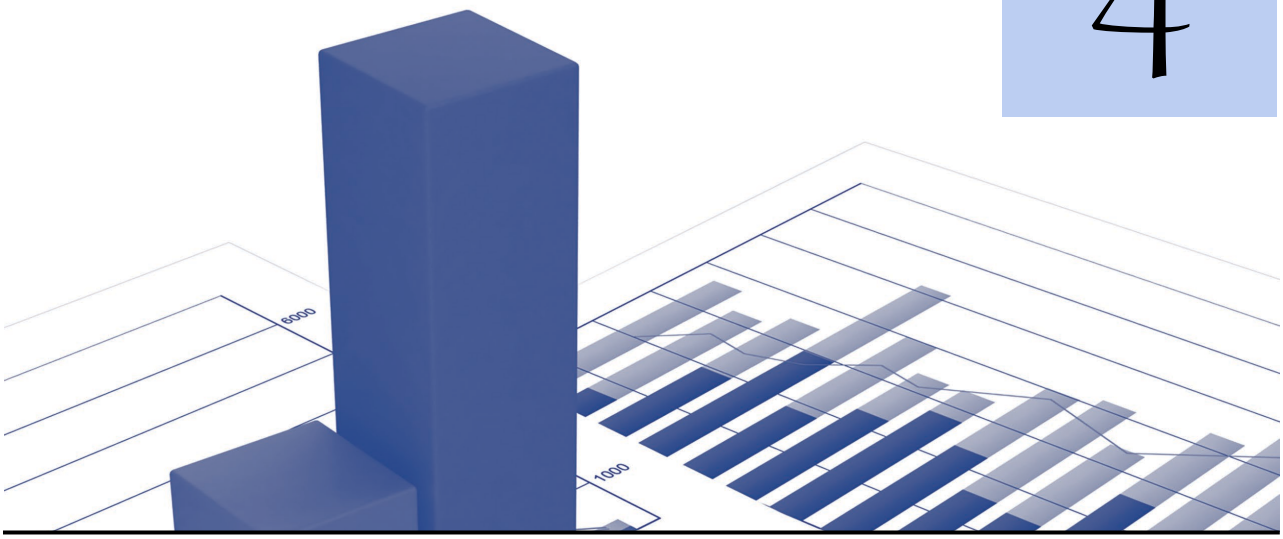

Utilization of and spending on Medicare and Medicaid services for dual-eligible beneficiaries

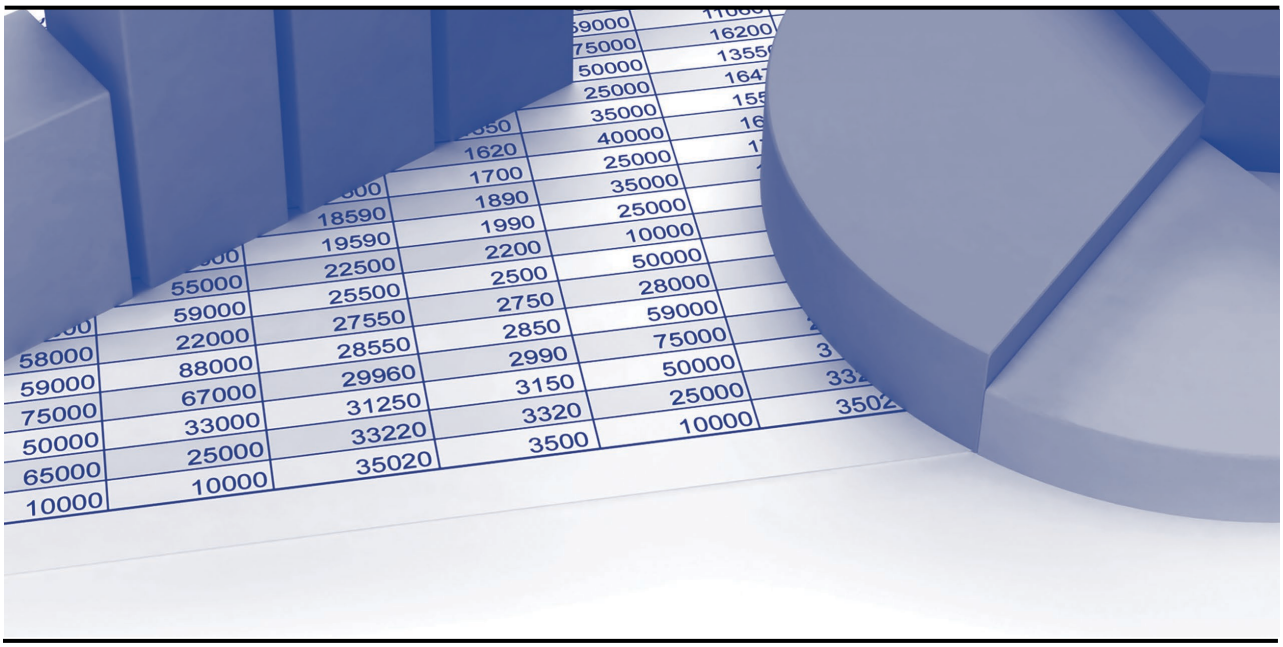

Exhibit 14

Use of Medicare services and per user Medicare spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2020

Selected Medicare services	Full-benefit FFS dual-eligible beneficiaries			FFS non-dual Medicare beneficiaries		
	Percent using service	Spending per user	Percent of total spending	Percent using service	Spending per user	Percent of total spending
Part A and Part B						
Inpatient hospital	23%	$25,946	36%	13%	$21,018	30%
Skilled nursing facility	12	23,046	16	3	16,492	5
Home health	11	5,857	4	8	4,817	5
Other outpatient	93	7,132	41	92	5,641	57
Part D						
Prescription drugs	92	7,943		94	2,341	

Note: *FFS (fee-for-service), CY (calendar year). Dual-eligible beneficiaries are limited to full-benefit dual-eligible beneficiaries 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 prescription drugs are based only on beneficiaries who were covered by a Part D plan.*

- Individuals enrolled in FFS Medicare who were dually eligible for Medicaid in CY 2020 had higher use of certain Medicare-covered services (inpatient hospital, skilled nursing facility, home health, and other outpatient services) than did their non-dual FFS counterparts.
- Per user Medicare FFS spending for each type of service was higher for dual-eligible beneficiaries than for non-dual Medicare beneficiaries.
- Skilled nursing facility services accounted for a higher portion of Medicare FFS spending on dual-eligible beneficiaries than of Medicare FFS spending on non-dual Medicare beneficiaries (16 percent vs. 5 percent).

Exhibit 15

Use of Medicaid services and per user Medicaid spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2020

Selected Medicaid services	Full-benefit FFS dual-eligible beneficiaries			Full-benefit FFS non-dual Medicaid beneficiaries (disabled, under age 65)		
	Percent using service	Spending per user	Percent of total spending	Percent using service	Spending per user	Percent of total spending
Inpatient hospital	10%	$2,413	1%	14%	$24,622	13%
Outpatient	86	2,416	8	82	6,860	21
Institutional LTSS	17	53,471	36	4	84,361	12
HCBS state plan	12	10,766	5	12	9,791	4
HCBS waiver	20	45,343	36	20	34,816	26
Prescription drugs	27	249	<1	68	6,306	16
Managed care capitation	49	7,117	14	71	2,979	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-eligible beneficiaries 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. Exhibit excludes administrative spending.*

- Compared with non-dual Medicaid beneficiaries who are eligible on the basis of a disability, individuals dually eligible for Medicare and Medicaid were more likely to use Medicaid-covered institutional LTSS under FFS (17 percent utilization among dual-eligible beneficiaries vs. 4 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 (36 percent vs. 12 percent).
- However, per user FFS spending on institutional LTSS was higher for non-dual disabled Medicaid beneficiaries ($84,361) than for dual-eligible beneficiaries ($53,471).
- More FFS dual-eligible beneficiaries used Medicaid HCBS services through an HCBS waiver than through a state plan (20 percent vs. 12 percent), and Medicaid FFS spending per user was also more than four times higher for HCBS waiver services than for state plan HCBS services ($45,343 vs. $10,766). As a result, HCBS waiver services accounted for a much higher portion of Medicaid FFS spending on dual-eligible beneficiaries than state plan HCBS services (36 percent vs. 5 percent).

Exhibit 16

Use of Medicare and Medicaid services and per user Medicare and Medicaid spending for FFS dual-eligible beneficiaries by age, CY 2020

Selected services	Full-benefit FFS dual-eligible beneficiaries under age 65			Full-benefit FFS dual-eligible beneficiaries ages 65 and older		
	Percent using service	Spending per user	Percent of total spending	Percent using service	Spending per user	Percent of total spending
Medicare services						
Inpatient hospital	18%	$26,796	23%	27%	$25,480	27%
Skilled nursing facility	4	22,914	4	18	23,070	16
Home health	7	5,956	2	15	5,818	3
Other outpatient	92	6,148	27	94	7,952	29
Prescription drugs	90	9,665	42	91	6,500	23
Medicaid services						
Inpatient hospital	8%	$2,898	1%	12%	$2,117	1%
Outpatient	89	2,697	9	83	2,160	7
Institutional LTSS	7	81,081	21	25	47,192	48
HCBS state plan	11	10,482	4	12	10,978	5
HCBS waiver	25	54,647	54	15	32,162	20
Prescription drugs	26	274	<1	29	230	<1
Managed care capitation	50	5,027	10	48	8,957	18

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. Medicare "prescription drugs" reflects beneficiaries who filled Part D prescriptions. Medicaid "outpatient" includes all Medicaid services that are not inpatient, LTSS (institutional or HCBS), prescription 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. Administrative spending is excluded. In the "percent of total spending" columns, the Medicare figures do not sum to 100 percent because spending is shown only for selected services, and the Medicaid figures may not sum to 100 percent due to rounding.*

- Among individuals dually eligible for Medicare and Medicaid services in CY 2020, those who were ages 65 and older had higher use of FFS Medicare–covered inpatient hospital, skilled nursing facility, and home health services. However, their average spending per user for these services was similar to the amount spent for individuals under 65. Similar shares of FFS dual-eligible beneficiaries over and under age 65 used prescription drugs, but spending per user was higher for those under age 65.
- Among FFS dual-eligible beneficiaries, those under age 65 had lower use of Medicaid-covered institutional LTSS (7 percent vs. 25 percent for those ages 65 and older). Institutional LTSS also accounted for a lower portion of Medicaid spending on FFS dual-eligible beneficiaries under age 65 (21 percent vs. 48 percent).

Section

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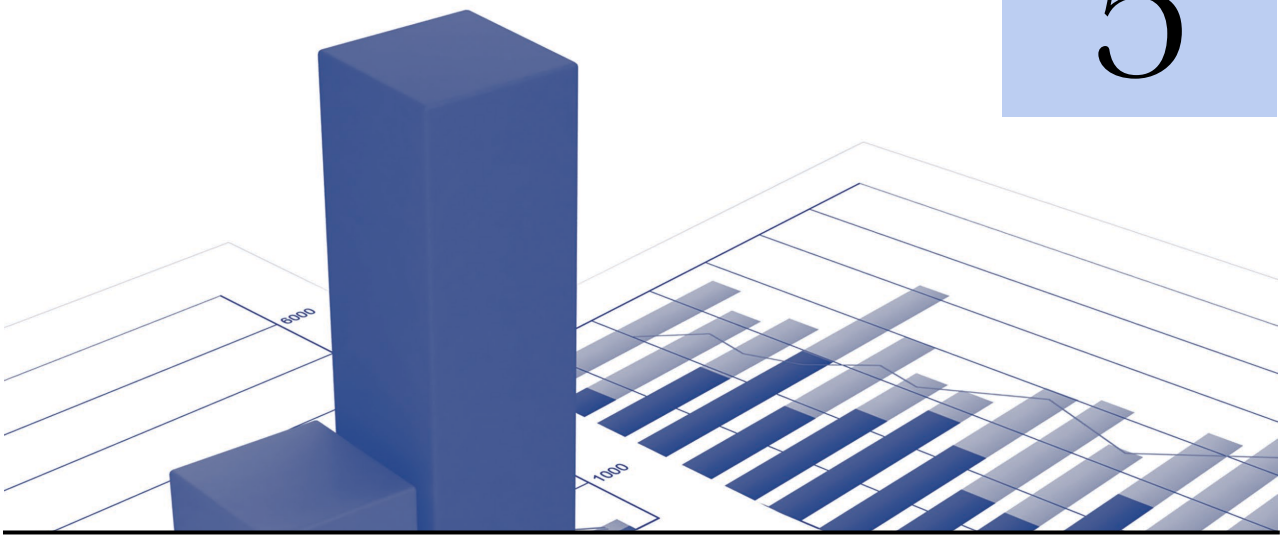


Medicare and Medicaid spending for dual-eligible beneficiaries by LTSS use

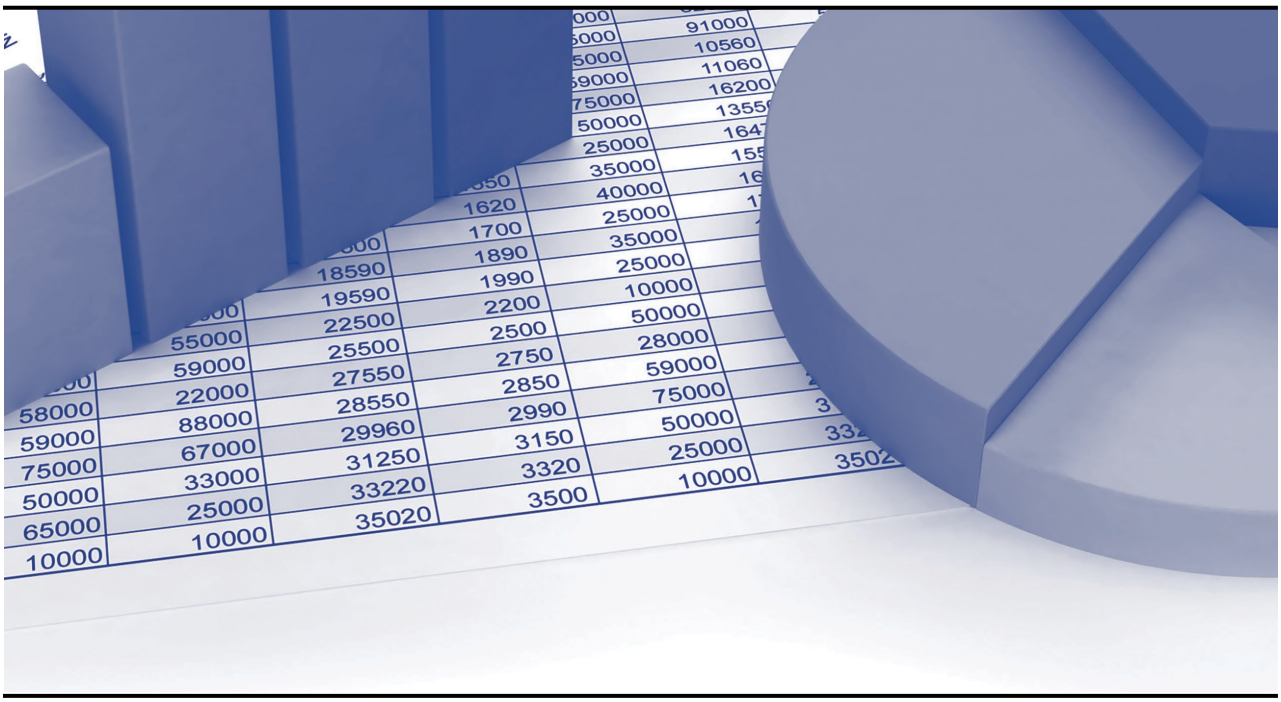
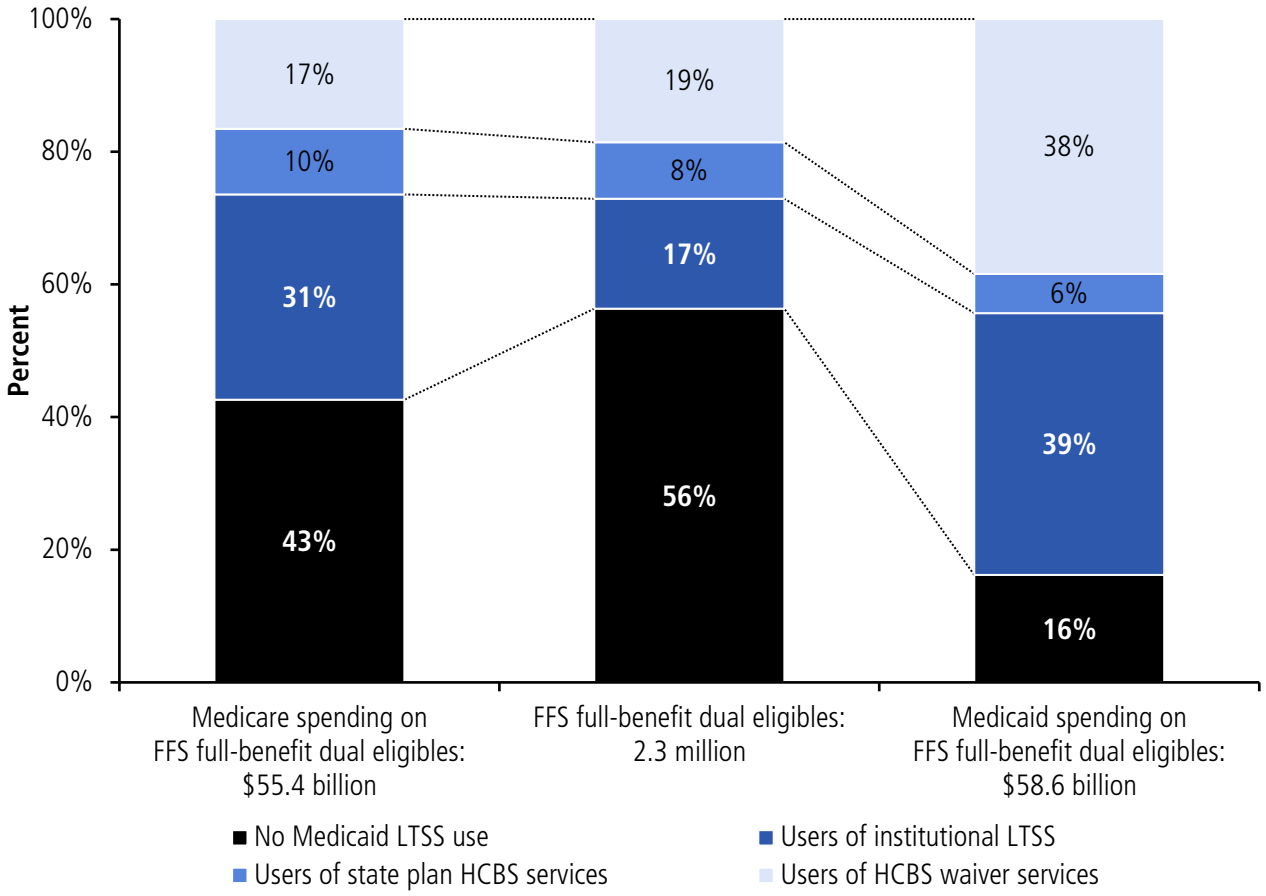


Exhibit 17

Medicare and Medicaid spending on FFS full-benefit dual-eligible beneficiaries by type of Medicaid LTSS, CY 2020

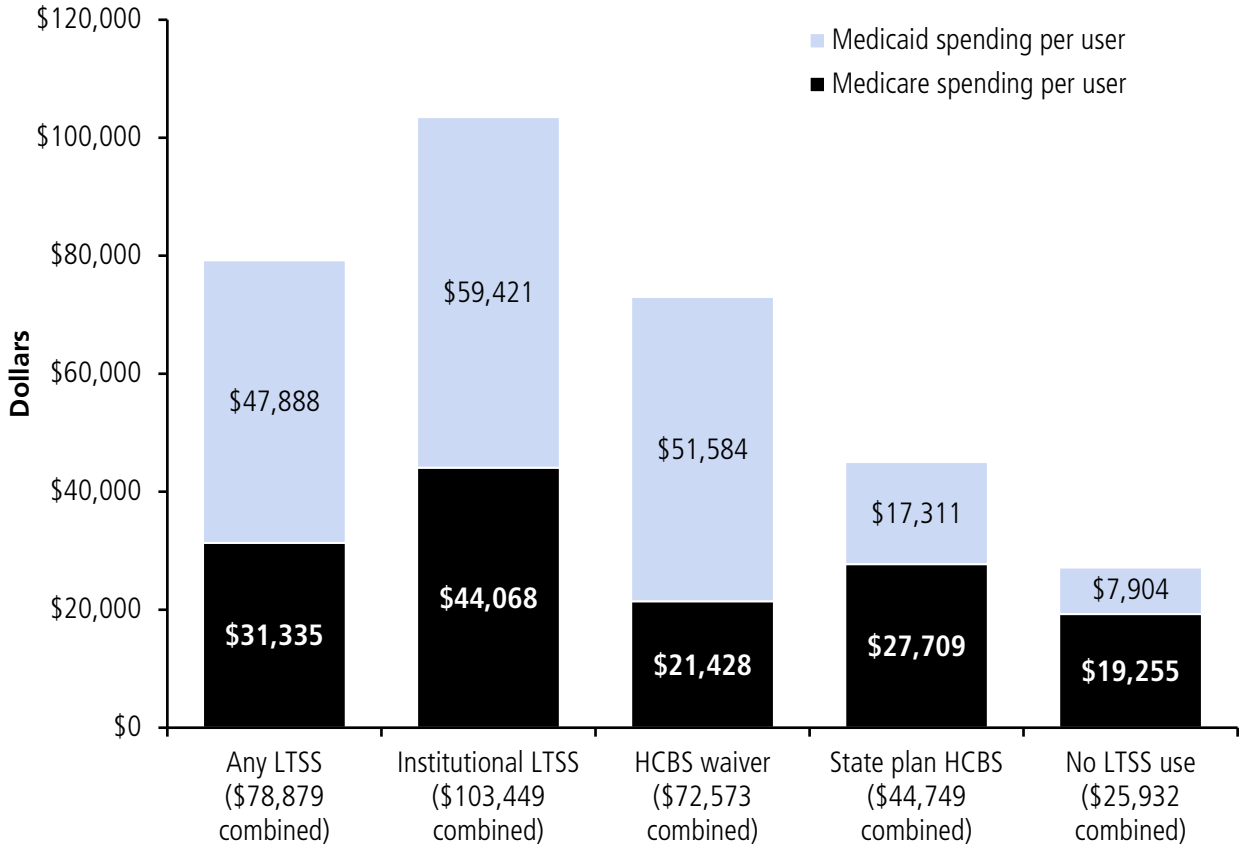


Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible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

- In CY 2020, the majority (56 percent) of FFS full-benefit dual-eligible beneficiaries used no 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. Users of institutional LTSS made up 17 percent of FFS full-benefit dual-eligible beneficiaries, but they accounted for 31 percent of Medicare spending and 39 percent of Medicaid spending on this population.
- Over the last two decades, federal and state policymakers have focused on shifting LTSS use from institutional settings toward HCBS. In CY 2020, the share of FFS full-benefit dual-eligible beneficiaries who used HCBS was larger than the share who used institutional LTSS (27 percent vs. 17 percent), and HCBS accounted for a larger share of Medicaid spending than institutional LTSS (44 percent vs. 39 percent).

Exhibit 18

Medicare and Medicaid spending per user on FFS full-benefit dual-eligible Medicaid LTSS users and non-users, CY 2020

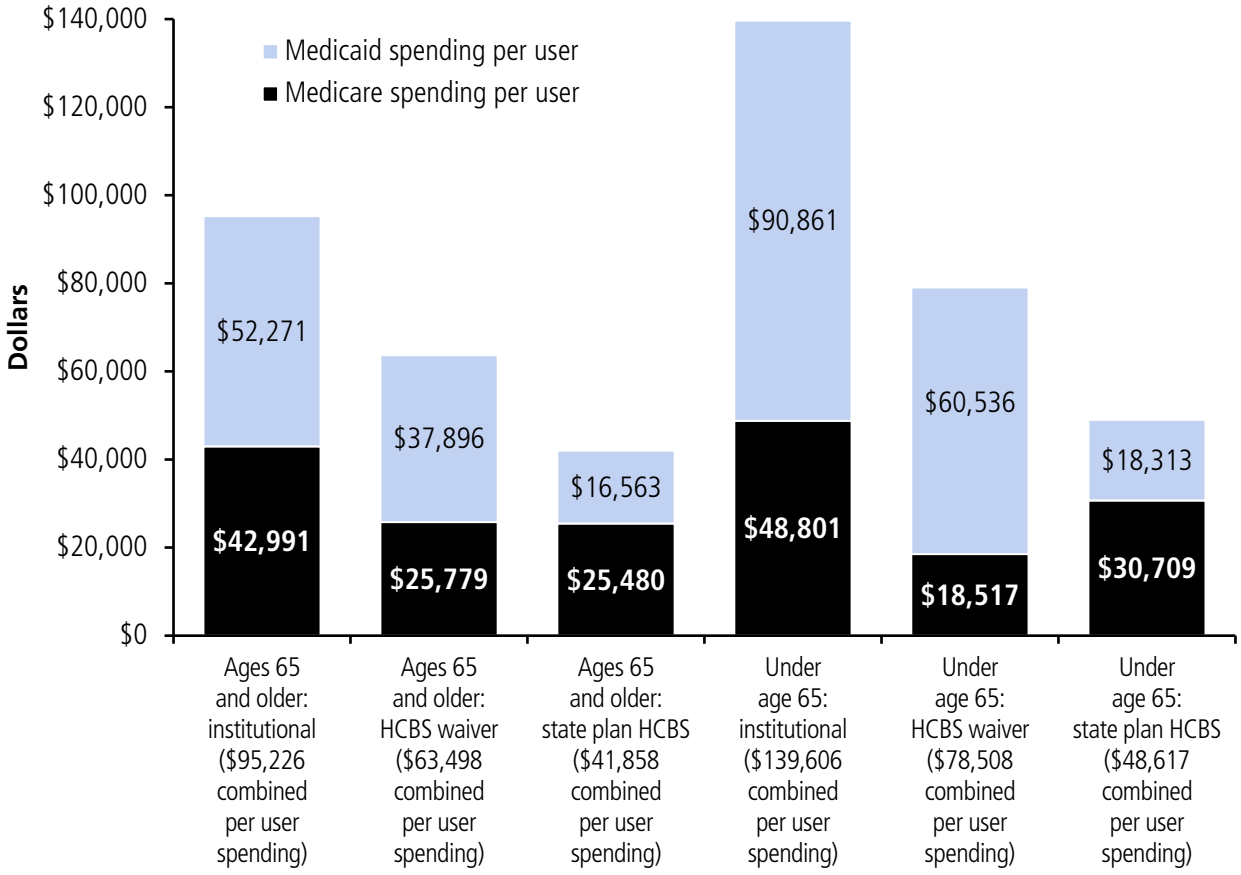


Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible 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 spending per user includes a small number of individuals who used either Medicare or Medicaid services, but not both.*

- Users of Medicaid-covered institutional LTSS had the highest Medicare and Medicaid spending per user in CY 2020 ($44,068 and $59,421, respectively) compared with users of other types of Medicaid LTSS and with non-LTSS users.
- Medicare and Medicaid spending per user for any type of Medicaid LTSS (institutional, HCBS waiver, or state plan HCBS) was almost three times higher than spending per user on non-LTSS users ($78,879 vs. $25,932).
- Medicaid spending per user was generally higher than Medicare's for Medicaid LTSS users, except for users of state plan HCBS. However, Medicare spending per user exceeded Medicaid's for non-LTSS users.

Exhibit 19

Medicare and Medicaid spending per user on FFS full-benefit dual-eligible Medicaid LTSS users by age, CY 2020



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 spending per user 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, combined Medicare and Medicaid spending per user was higher for those who received Medicaid LTSS in an institution ($95,226) than for those who received Medicaid LTSS through HCBS waivers ($63,498) or through state plan HCBS ($41,858).
- Among Medicaid LTSS users under age 65, Medicare spending per user was substantially higher for those who received Medicaid institutional LTSS compared with Medicare spending per user for those receiving Medicaid LTSS through HCBS waivers or through state plan HCBS ($48,801 vs. $18,517 and $30,709).
- Medicaid spending per user on Medicaid institutional LTSS users under age 65 ($90,861) was higher than spending per user on any other subgroup of Medicaid LTSS users. It was also substantially higher than spending per user on Medicaid institutional LTSS users who were ages 65 and older ($52,271).

Section

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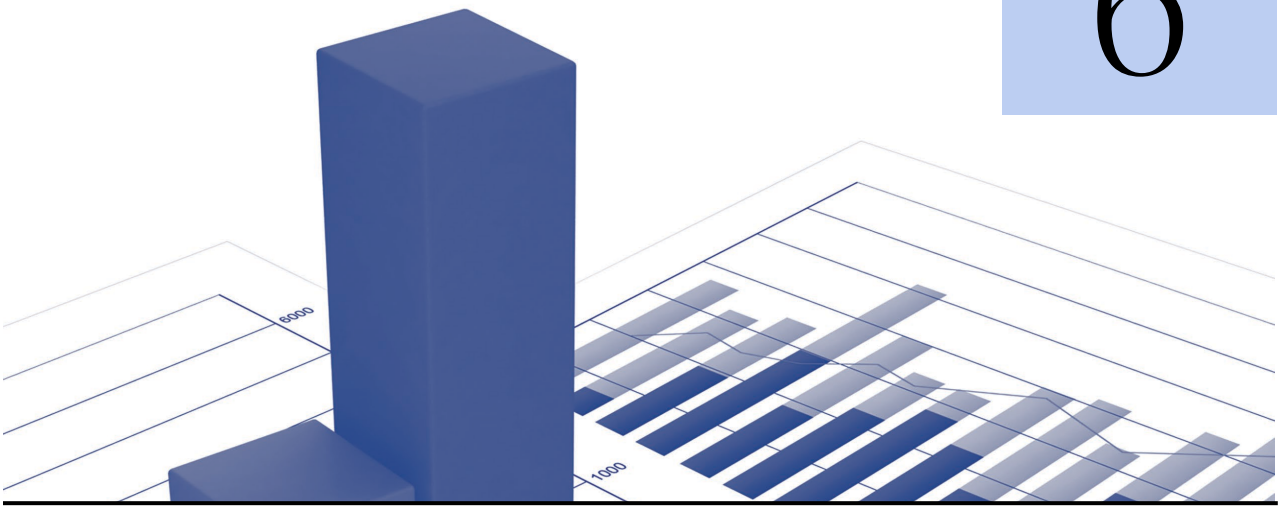


Trends in dual-eligible population composition, spending, and service use

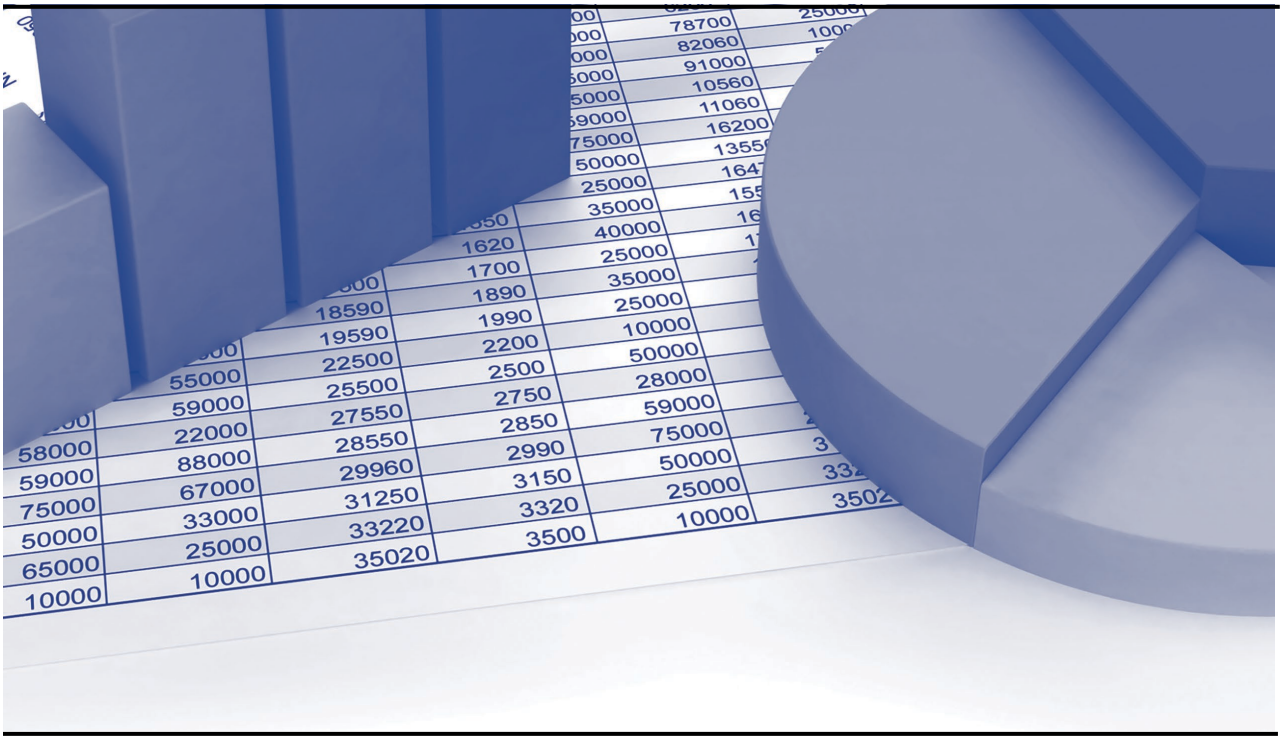
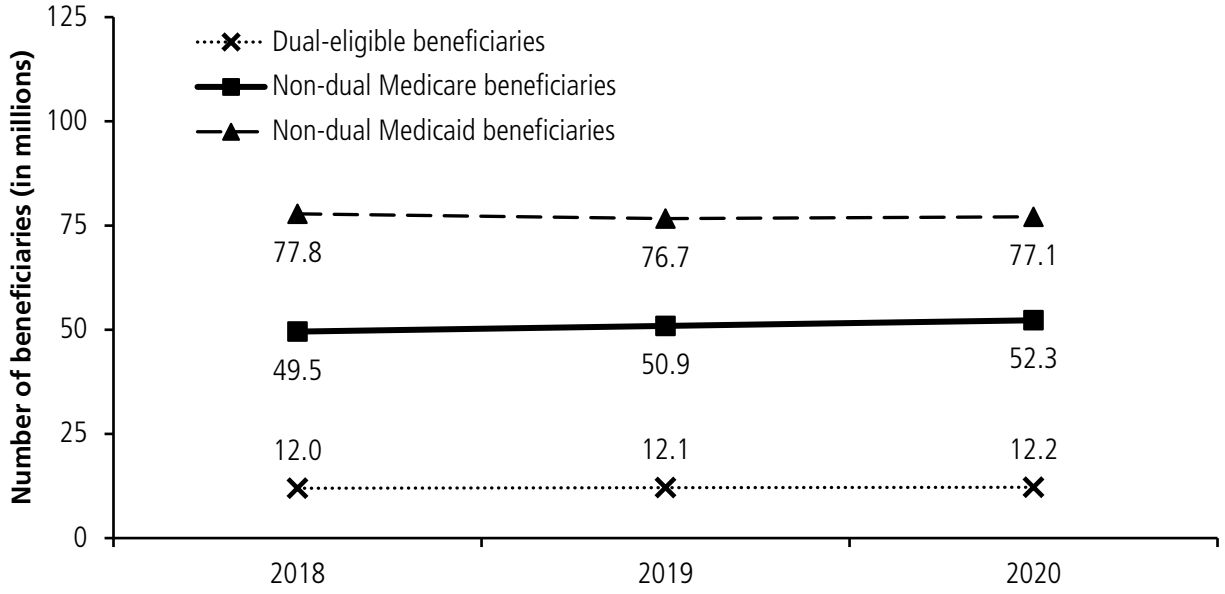


Exhibit 20

Number of dual-eligible and non-dual Medicare and Medicaid beneficiaries, CY 2018–2020



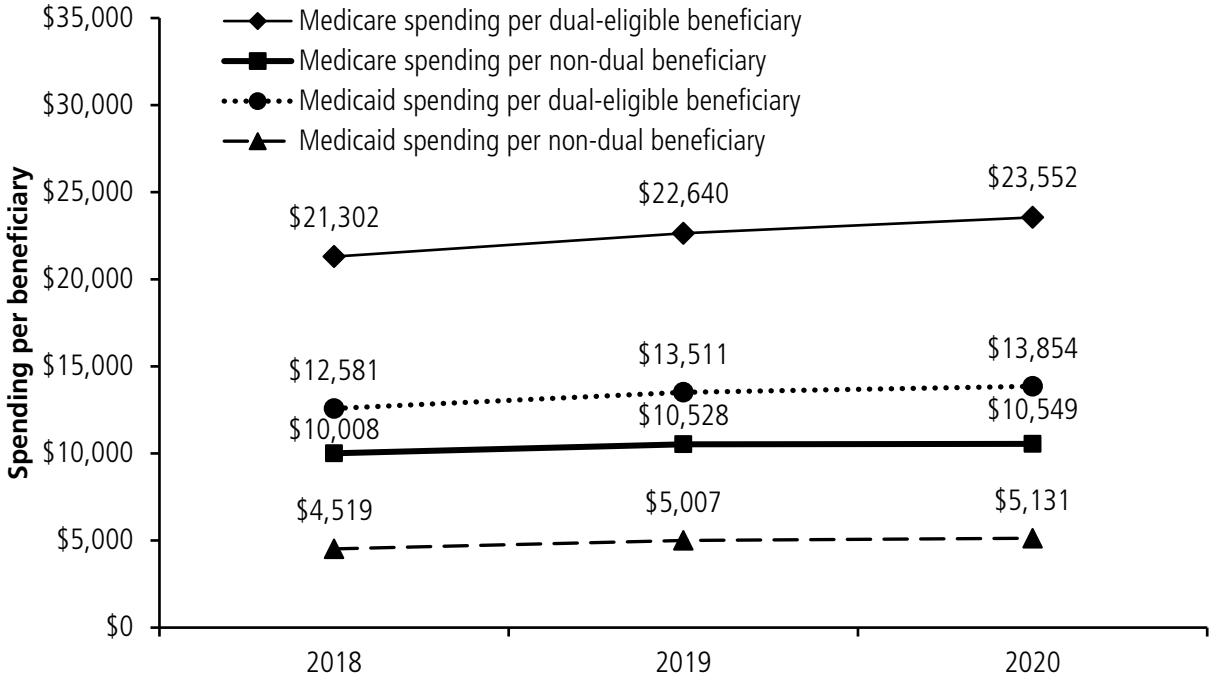
Category	Annual percentage growth in the number of beneficiaries		Cumulative growth	Average annual growth rate
	2019	2020		
Dual-eligible beneficiaries	1.2%	0.7%	1.9%	1.0%
Non-dual Medicare beneficiaries	2.7	2.7	5.5	2.7
Non-dual Medicaid beneficiaries	-1.5	0.5	-0.9	-0.5

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

- The number of individuals dually eligible for Medicare and Medicaid grew from 12.0 million in 2018 to 12.2 million in 2020—cumulative growth of 1.9 percent over the period and an average annual growth rate of 1.0 percent.
- The number of non-dual-eligible Medicaid beneficiaries declined somewhat, from 77.8 million in 2018 to 77.1 million in 2020, for a cumulative decrease of 0.9 percent.
- The non-dual-eligible Medicare population grew the fastest, from 49.5 million in 2018 to 52.3 million in 2020—cumulative growth of 5.5 percent and an average annual growth of 2.7 percent.

Exhibit 21

Medicare and Medicaid spending per dual-eligible and non-dual beneficiary, CY 2018–2020



Category	Annual percentage growth in the number of beneficiaries		Cumulative growth	Average annual growth rate
	2019	2020		
Medicare spending per dual-eligible beneficiary	6.3%	4.0%	10.6%	5.1%
Medicare spending per non-dual beneficiary	5.2	0.2	5.4	2.7
Medicaid spending per dual-eligible beneficiary	7.4	2.5	10.1	4.9
Medicaid spending per non-dual beneficiary	10.8	2.5	13.5	6.6

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

(Continued next page)

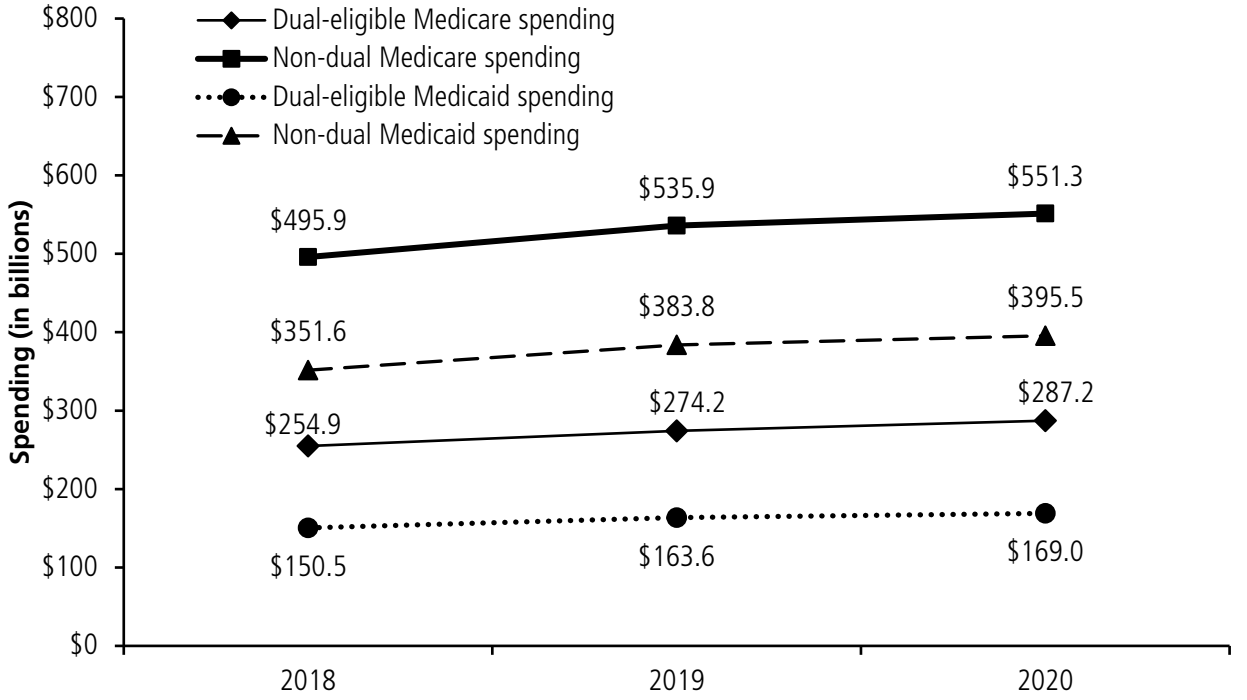
Exhibit 21

Medicare and Medicaid spending per dual-eligible and non-dual beneficiary, CY 2018–2020 (continued)

- Medicare spending per dual-eligible beneficiary grew between 2018 and 2020 (10.6 percent cumulative growth and 5.1 percent average annual growth).
- Medicaid spending per dual-eligible beneficiary increased at a similar rate between 2018 and 2020 (10.1 percent cumulative growth and 4.9 percent average annual growth).
- Comparing Medicare spending per beneficiary on dual-eligible beneficiaries and non-dual beneficiaries, spending per dual-eligible beneficiary increased at a faster rate than spending per non-dual beneficiary. Cumulative growth in Medicare per beneficiary spending between 2018 and 2020 was 10.6 percent for dual-eligible beneficiaries and 5.4 percent for non-dual beneficiaries; average annual growth was 5.1 percent for dual-eligible beneficiaries compared with 2.7 percent for non-dual beneficiaries.
- In contrast, Medicaid spending per dual-eligible beneficiary increased more slowly than spending per non-dual beneficiary (10.1 percent cumulative growth and 4.9 percent average annual growth for dual-eligible beneficiaries compared with 13.5 percent cumulative growth and 6.6 percent average annual growth for non-dual beneficiaries).

Exhibit 22

Medicare and Medicaid spending for dual-eligible and non-dual beneficiaries, CY 2018–2020



Category	Annual percentage growth in the number of beneficiaries		Cumulative growth	Average annual growth rate
	2019	2020		
Dual-eligible Medicare spending	7.6%	4.8%	12.7%	6.2%
Non-dual Medicare spending	8.1	2.9	11.2	5.4
Dual-eligible Medicaid spending	8.7	3.3	12.3	6.0
Non-dual Medicaid spending	9.2	3.1	12.5	6.1

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 using unrounded numbers.*

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Exhibit 22

Medicare and Medicaid spending for dual-eligible and non-dual beneficiaries, CY 2018–2020 (continued)

- Medicare spending on dual-eligible beneficiaries increased from $254.9 billion in 2018 to $287.2 billion in 2020—cumulative growth of 12.7 percent and an average annual growth of 6.2 percent.
- Medicaid spent less than Medicare on dual-eligible beneficiaries between 2018 and 2020. Medicaid spending on dual-eligible beneficiaries was $150.5 billion in 2018 and $169.0 billion in 2020. 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 slightly lower (12.3 percent and 6.0 percent, respectively).
- Medicaid spending on non-dual beneficiaries grew at a rate very similar to the rate of Medicaid spending on dual-eligible beneficiaries, with cumulative growth of 12.5 percent and an average annual growth rate of 6.1 percent.
- Although total Medicare spending was higher for non-dual beneficiaries than for dual-eligible beneficiaries between 2018 and 2020, 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 12.7 percent compared with 11.2 percent for non-dual beneficiaries; average annual growth was 6.2 percent for dual-eligible beneficiaries compared with 5.4 percent for non-dual beneficiaries.

Exhibit 23

Share of dual-eligible beneficiaries by selected beneficiary characteristics, CY 2018 and CY 2020

Beneficiary characteristic	2018	2020	2018–2020 percentage point change
Age			
65 and older	61.0%	63.3%	2.3%
Under 65	39.0	36.7	–2.3
Benefit level			
Full benefit	71.5%	72.4%	0.9%
Partial benefit	28.5	27.6	–0.9
Original reason for entitlement to Medicare			
Age	46.9%	47.9%	1.0%
ESRD	1.4	1.3	–<0.1
Disability	51.8	50.8	–1.0
Medicaid eligibility pathway			
SSI	37.4%	36.3%	–1.2%
Poverty related	41.7	42.8	1.1
Medically needy	6.8	6.4	–0.4
Section 1115 waiver	0.2	0.2	<0.1
Special income limit and other	13.6	14.1	0.5
FFS Medicare and managed care			
FFS only	55.8%	48.1%	–7.7%
MA only	32.6	41.2	8.6
Both FFS and MA	11.6	10.7	–0.9
FFS Medicaid and managed care			
FFS only	44.0%	40.3%	–3.7%
FFS and limited-benefit managed care only	21.0	19.1	–1.9
At least one month of comprehensive managed care	35.0	40.6	5.6

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

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Exhibit 23

Share of dual-eligible beneficiaries by selected beneficiary characteristics, CY 2018 and CY 2020 (continued)

- Between CY 2018 and CY 2020, there was an increase in the share of dual-eligible beneficiaries who were 65 and older (2.3 percentage point increase) and in the share who originally qualified for Medicare on the basis of age (1.0 percentage point increase). The share of dual-eligible beneficiaries who received full benefits also increased (0.9 percentage point increase).
- The share of dual-eligible beneficiaries who qualified for Medicaid through poverty-related pathways increased by 1.1 percentage points, from 41.7 percent of the dual-eligible population in 2018 to 42.8 percent of the population in 2020.
- The share of dual-eligible beneficiaries who were enrolled in FFS Medicare and the share who were enrolled in FFS Medicaid declined between 2018 and 2020 (decreases of 7.7 percentage points and 3.7 percentage points, respectively). The share whose only Medicaid enrollment was in FFS and a limited-benefit Medicaid managed care plan also decreased by 1.9 percentage points.
- The share of dual-eligible beneficiaries whose only Medicare enrollment was in Medicare Advantage increased by 8.6 percentage points over the period, while the share of dual-eligible beneficiaries with at least one month of comprehensive Medicaid managed care enrollment increased by 5.6 percentage points.

Exhibit 24

Use of Medicare services and spending per user for FFS beneficiaries, CY 2018 and CY 2020

Select Medicare services	Full-benefit FFS dual-eligible beneficiaries			FFS non-dual Medicare beneficiaries		
	2018	2020	2018–2020	2018	2020	2018–2020
Share using service in each year and percentage point change during period						
Inpatient hospital	24.9%	22.8%	–2.0%	15.0%	12.8%	–2.1%
Skilled nursing facility	9.4	11.6	2.2	3.9	2.9	–0.9
Home health	12.5	11.5	–1.1	9.1	8.5	–0.7
Other outpatient	94.6	93.2	–1.4	92.1	91.6	–0.6
Part D drugs	92.8	91.6	–1.2	94.8	94.2	–0.6
FFS spending per user in each year and average annual growth during period						
Inpatient hospital	$22,429	$25,946	7.6%	$18,543	$21,018	6.5%
Skilled nursing facility	18,711	23,046	11.0	14,733	16,492	5.8
Home health	5,271	5,857	5.4	4,815	4,817	<0.1
Other outpatient	6,994	7,132	1.0	5,517	5,641	1.1
Part D drugs	7,097	7,943	5.8	2,106	2,341	5.4

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

- The share of full-benefit dual-eligible beneficiaries using skilled nursing facility services increased by 2.2 percentage points between 2018 and 2020. The share of full-benefit dual-eligible beneficiaries using inpatient hospital services decreased by 2.0 percentage points, and the share using other outpatient services decreased by 1.4 percentage points.
- Medicare FFS spending per user for full-benefit dual-eligible beneficiaries increased between 2018 and 2020 for inpatient hospital services (7.6 percent average annual growth), skilled nursing facility services (11.0 percent average annual growth), home health (5.4 percent average annual growth), other outpatient services (1.0 percent average annual growth) and prescription drugs under Medicare Part D (5.8 percent average annual growth).
- Comparing full-benefit dual-eligible beneficiaries with non-dual Medicare beneficiaries, FFS spending per user in 2018 and 2020 was higher for dual-eligible beneficiaries for each type of service. Growth in spending per user was faster for dual-eligible beneficiaries compared with non-dual Medicare beneficiaries for inpatient hospital services, skilled nursing facility services, and home health; it was similar for other outpatient services and Part D drugs.
- In 2018 and 2020, 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. The only exception was Part D drugs, where the share of dual-eligible beneficiaries who filled a prescription was slightly lower.

Exhibit 25

Use of Medicaid services and spending per user for FFS beneficiaries, CY 2018 and CY 2020

Select Medicaid services	Full-benefit FFS dual-eligible beneficiaries			Full-benefit FFS non-dual Medicaid beneficiaries (disabled, under age 65)		
	2018	2020	2018–2020	2018	2020	2018–2020
Share using service in each year and percentage point change during period						
Inpatient hospital	11.3%	10.2%	–1.1%	14.7%	13.8%	–0.9%
Outpatient	87.7	86.0	–1.7	81.5	81.9	0.4
Institutional LTSS	17.5	16.6	–0.9	4.2	3.9	–0.3
HCBS state plan	10.6	11.5	0.9	11.3	12.0	0.7
HCBS waiver	19.1	19.8	0.6	16.2	19.7	3.4
Prescription drugs	29.0	27.3	–1.8	67.7	67.9	0.2
Managed care capitation	48.3	49.0	0.8	65.8	71.1	5.3
Spending per user in each year and average annual growth during period						
Inpatient hospital	$2,380	$2,413	0.7%	$24,321	$24,622	0.6%
Outpatient	2,457	2,416	–0.8	6,943	6,860	–0.6
Institutional LTSS	49,043	53,471	4.4	77,979	84,361	4.0
HCBS state plan	9,592	10,766	5.9	8,446	9,791	7.7
HCBS waiver	39,588	45,343	7.0	37,962	34,816	–4.2
Prescription drugs	214	249	7.8	5,579	6,306	6.3
Managed care capitation	5,983	7,117	9.1	2,499	2,979	9.2

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-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid "outpatient" includes all Medicaid services that are not inpatient, LTSS (institutional or HCBS), drugs, or managed care 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. Exhibit excludes administrative spending. Percentage point change is calculated using unrounded numbers.*

- Medicaid FFS spending per user on full-benefit individuals dually eligible for Medicare and Medicaid increased between 2018 and 2020 for inpatient hospital, institutional LTSS, HCBS state plan and waiver services, prescription drugs, and Medicaid managed care capitation payments.
- The share of full-benefit dual-eligible beneficiaries using institutional LTSS declined between 2018 and 2020 by 0.9 percentage points while the share of dual-eligible beneficiaries using HCBS waiver services increased by 0.6 percentage points over this period.
- Medicaid spending per user on managed care had the largest percentage increase between 2018 and 2020 for both dual-eligible beneficiaries and non-dual disabled Medicaid beneficiaries (9.1 percent and 9.2 percent average annual growth, respectively). The share of beneficiaries in these groups with managed care capitation payments increased between 2018 and 2020 by 0.8 percentage point for dual-eligible beneficiaries and 5.3 percentage points for non-dual disabled beneficiaries.

Exhibit 26

Average annual growth in dual-eligible enrollment by state, CY 2018–2020 (continued on next page)

State	Average annual growth in number of dual-eligible beneficiaries			Number of dual-eligible beneficiaries (in thousands)					
	CY 2018–2020			CY 2018			CY 2020		
	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit
National	1.0%	1.6%	–0.6%	11,964	8,553	3,411	12,196	8,829	3,367
Alabama	0.2	0.2	0.3	228	91	137	229	91	138
Alaska	1.7	1.8	1.0	20	19	1	21	20	1
Arizona	2.0	3.0	–0.7	247	184	63	257	195	62
Arkansas	1.3	2.8	–0.4	143	74	69	147	78	69
California	0.5	1.0	–17.4	1,622	1,571	51	1,638	1,603	35
Colorado	1.6	5.6	–5.6	127	80	47	131	90	42
Connecticut	2.0	–0.5	3.7	194	79	115	202	78	124
Delaware	2.9	8.2	–1.7	33	15	18	35	17	17
District of Columbia	0.8	1.9	–1.6	38	26	13	39	27	12
Florida	2.7	4.2	1.3	908	427	481	958	464	494
Georgia	2.7	0.1	4.6	364	161	203	384	162	222
Hawaii	2.5	2.5	2.7	45	39	7	48	41	7
Idaho	2.2	2.2	2.3	52	31	21	54	32	22
Illinois	1.5	1.6	0.8	417	365	52	429	377	53
Indiana	1.3	4.4	–5.1	230	152	78	236	166	70
Iowa	0.7	1.6	–2.2	95	73	22	96	75	21
Kansas	0.5	4.8	–6.1	74	44	30	75	48	27
Kentucky	4.9	10.1	–1.8	196	107	89	216	130	86
Louisiana	1.8	6.3	–3.8	245	134	111	254	151	102
Maine	–<0.1	0.2	–0.4	94	56	38	94	56	37
Maryland	0.3	1.4	–1.1	166	96	70	167	98	69
Massachusetts	0.1	–1.3	16.4	346	322	24	347	314	33
Michigan	–0.3	–<0.1	–1.7	361	297	64	359	297	62
Minnesota	–1.2	–0.6	–5.6	159	139	19	155	138	17
Mississippi	–0.3	–0.3	–0.4	174	84	90	173	83	89
Missouri	0.4	3.1	–9.4	200	155	45	201	164	37
Montana	0.4	3.6	–5.0	32	20	12	32	22	11
Nebraska	0.4	0.1	3.4	44	39	5	44	39	5
Nevada	0.9	2.0	0.2	76	29	47	78	30	47
New Hampshire	–1.5	0.5	–4.8	38	24	14	37	24	13
New Jersey	1.0	1.4	–37.0	215	213	3	220	218	1
New Mexico	–2.2	–8.9	10.8	113	77	36	108	64	44
New York	2.0	2.9	–2.9	1,009	842	167	1,049	891	157
North Carolina	–0.3	–0.2	–0.4	363	276	87	361	275	86
North Dakota	2.1	2.6	0.4	16	13	4	17	13	4
Ohio	0.8	1.5	–0.8	419	287	132	426	296	130

State	Average annual growth in number of dual-eligible beneficiaries			Number of dual-eligible beneficiaries (in thousands)					
	CY 2018–2020			CY 2018			CY 2020		
	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit
Oklahoma	0.3	0.1	0.8	129	105	25	130	105	25
Oregon	1.4	3.5	–0.5	116	55	60	119	59	60
Pennsylvania	–0.1	1.3	–6.3	514	414	101	513	425	88
Rhode Island	0.6	–0.3	5.3	48	41	7	49	41	8
South Carolina	2.7	1.0	13.1	169	147	22	178	150	29
South Dakota	–1.2	–0.8	–1.9	23	14	9	22	14	9
Tennessee	0.4	2.2	–2.0	286	158	128	288	165	123
Texas	–0.3	–0.7	<0.1	781	411	371	776	405	371
Utah	1.0	0.9	2.0	39	35	4	40	36	4
Vermont	–1.3	–0.1	–4.5	31	22	9	30	22	8
Virginia	1.8	3.1	–0.9	212	142	70	219	151	69
Washington	0.9	2.4	–2.5	220	148	72	224	155	69
West Virginia	–2.0	–1.8	–2.3	91	50	41	88	48	39
Wisconsin	1.4	4.4	–19.1	190	164	27	196	178	18
Wyoming	–1.5	–6.2	11.0	12	9	3	12	8	4

Note: *CY (calendar year). 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. Components may not sum to totals due to rounding.*

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

- Between CY 2018 and 2020, national average annual growth in total dual-eligible enrollment was 1.0 percent: an increase of 1.6 percent for the full-benefit population and a decrease of 0.6 percent for the partial-benefit population.
- At the state level, average annual growth in total dual-eligible enrollment ranged from a decrease of 2.2 percent in New Mexico to an increase of 4.9 percent in Kentucky.
- No state had average annual growth in full-benefit dual-eligible enrollment of more than 10.1 percent. The number of full-benefit dual-eligible beneficiaries increased in 37 states and the District of Columbia and declined in 13 states.
- In contrast, partial-benefit enrollment grew in 19 states while declining in 31 states and the District of Columbia.

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