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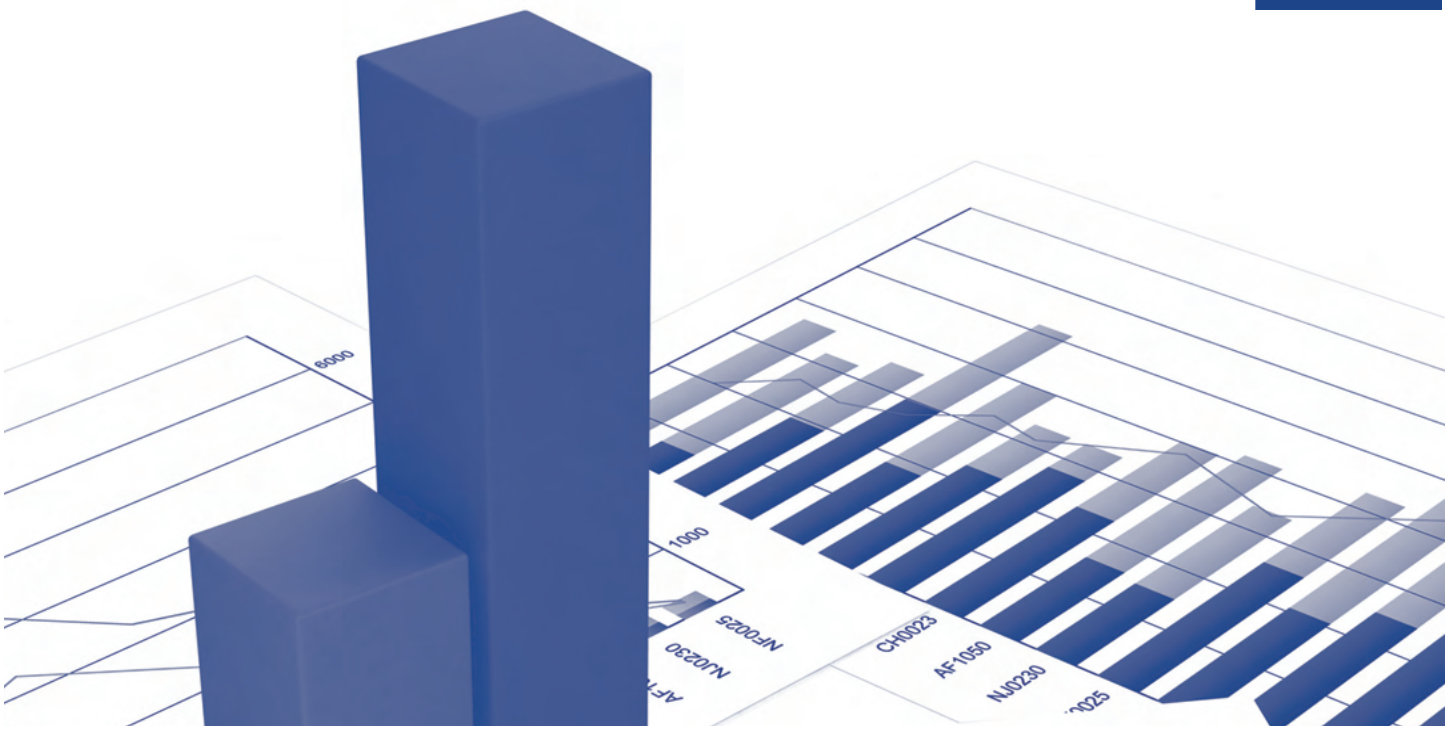

DATA BOOK

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. The Commission's statutory mandate is quite broad: In addition to advising the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

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

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

About MACPAC

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

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

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

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

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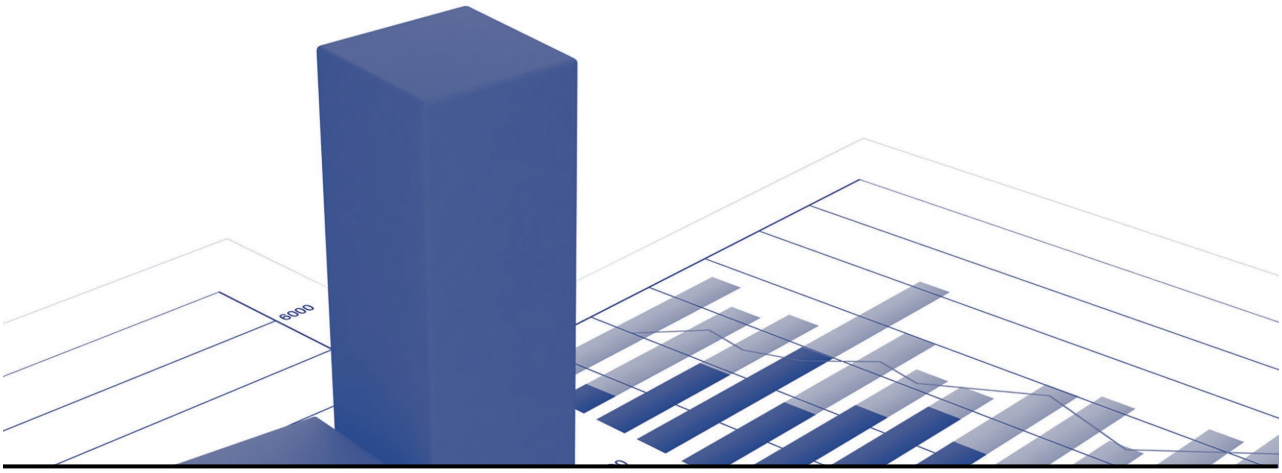
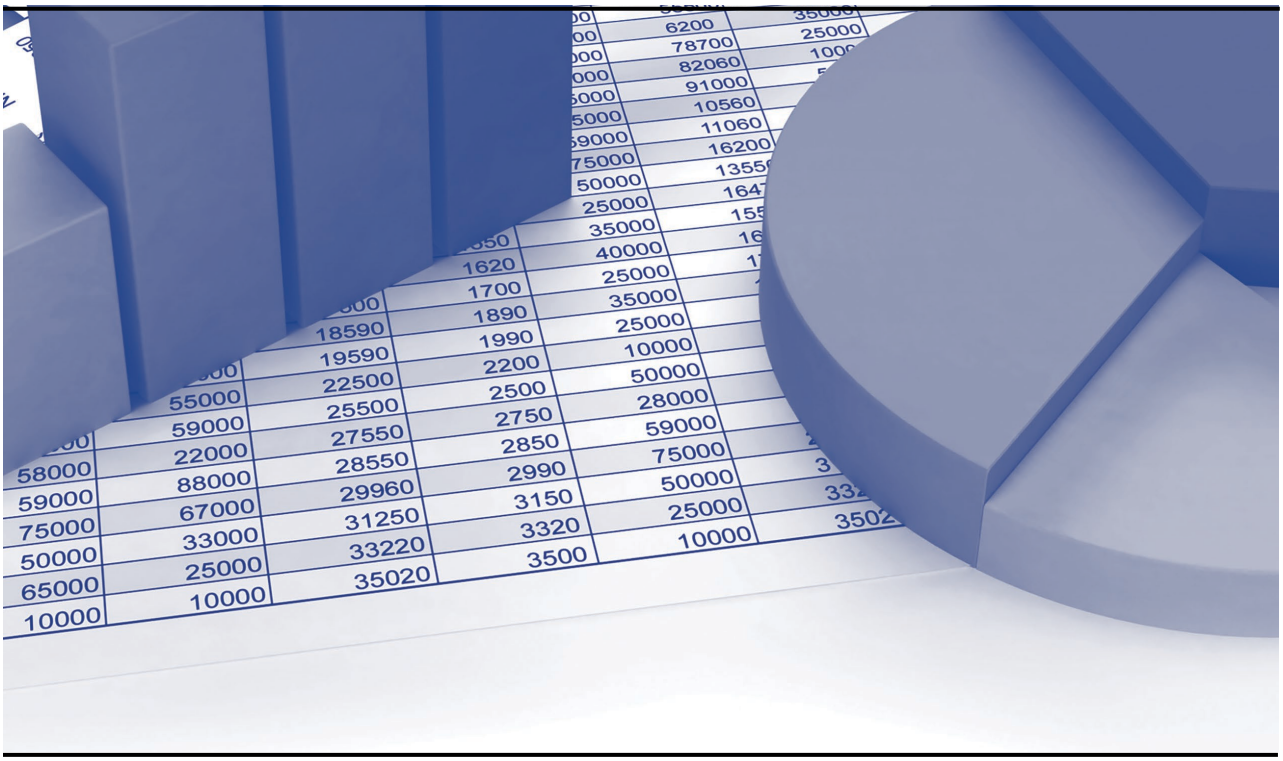


Introduction



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

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

Policymakers have expressed particular interest in dual-eligible beneficiaries because of the relatively large expenditures by both Medicare and Medicaid for this relatively small group of individuals. Concerns have also been raised as to how the existence of separate 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; and
- Medicare and Medicaid spending for dual-eligible beneficiaries by LTSS 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. 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 2022, the FMAP ranges from 50 percent to about 78 percent (Office of the Secretary, Department of Health and Human Services 2020).

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 2021	Benefits
Medicare Savings Program (MSP) beneficiaries			
Qualified Medicare beneficiary (QMB)	Partial: QMB only	▪ At or below 100% FPL ▪ $7,970 / $11,960	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 ▪ $7,970 / $11,960	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 ▪ $7,970 / $11,960	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[2]	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 2021b, 2021e, 2013a, 2013b; Medicaid and CHIP Payment and Access Commission 2015; Social Security Act; Social Security Administration 2019.*

In addition, states have the authority to expand eligibility for MSP benefits by using less restrictive methodologies for counting income and assets. As of November 2021, 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 2021

State	QMB monthly income (percent of FPL)	QMB assets		SLMB monthly income (percent of FPL)	SLMB assets		QI monthly income (percent of FPL)	QI assets	
		Single	Couple		Single	Couple		Single	Couple
Federal standard	**100%**	**$7,790**	**$11,960**	**120%**	**$7,790**	**$11,960**	**135%**	**$7,790**	**$11,960**
Alabama	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
Arizona	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
Connecticut[1]	211	No limit	No limit	231	No limit	No limit	246	No limit	No limit
Delaware	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
District of Columbia[2]	300	No limit	No limit	N/A	N/A	N/A	N/A	N/A	N/A
Indiana	150	$7,970	$11,960	170	$7,970	$11,960	185	$7,790	$11,960
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	$7,970	$11,960	135	$7,970	$11,960	N/A	N/A	N/A
Massachusetts	130	$15,940	$23,920	150	$15,940	$23,920	165	$15,940	$23,920
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 Agency 2021; Arizona Health Care Cost Containment System 2021; Baltimore County Government 2021; Centers for Medicare & Medicaid Services 2021e; Connecticut Department of Social Services 2021; Delaware Health and Social Services 2021; District of Columbia Department of Health Care Finance 2021; District of*

Columbia Department of Health Care Finance 2013; Indiana Family and Social Services Administration 2021; Louisiana Department of Health 2021; Maine Department of Health and Human Services 2021; MassHealth 2021; Minnesota Department of Human Services 2021; Mississippi Division of Medicaid 2021; New Mexico Department of Health 2021; New York State Department of Health 2021; Oregon Department of Human Services 2021; Vermont Green Mountain Care 2018.

Medicare and Medicaid benefits for dual-eligible beneficiaries

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

The Medicare entitlement gives individuals premium-free Part A, but Part B is a voluntary program 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. Most Medicare beneficiaries, including dual-eligible beneficiaries, have the choice of receiving their Medicare Part A and Part B benefits through private health plans (Medicare Advantage (MA) plans) if those plans are available in the beneficiaries' geographic area. MA plans are required to provide the Part A and Part B benefit following Medicare coverage rules, but the cost-sharing structure of such plans can differ from that of traditional fee-for-service (FFS) Medicare. Enrollees in MA plans who have Part D coverage must receive their Part D benefits through the MA plan (referred to as MA prescription drug 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, nine 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 fee-for-service or a limited-benefit managed care plan. In states with limited-benefit Medicaid managed care, the plans most often provide transportation, behavioral health care, or dental services. 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. MACPAC uses the term "pregnant women" as this is the term used in the Medicaid statute and regulations. However, the term "birthing people" is being used increasingly, as it is more inclusive and recognizes that not all individuals who become pregnant and give birth identify as women.*
Source: *Social Security Act and Centers for Medicare & Medicaid Services 2021c.*

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, 2022 and 2019

Part A	
Premium	Premium-free for insured individuals and their dependents and survivors; for uninsured individuals "buying in," $499 per month in 2022 or $274 for individuals with at least 30 quarters of coverage ($437 and $240, respectively, in 2019), plus the Part B premium (Part A cannot be purchased by itself)
Hospital stays	$1,556 deductible in 2022 for each benefit period ($1,364 in 2019)
	$389 per day in 2022 for days 61–90 of each benefit period (1/4 of hospital deductible each year) ($341 in 2019)
	$778 per "lifetime reserve day" in 2022 (1/2 of hospital deductible each year) after day 90 of each benefit period (up to 60 days over lifetime) ($682 in 2019)
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
	$194.50 per day in 2022 (1/8 of hospital deductible each year) for days 21–100 of each benefit period ($170.50 in 2019)
	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	$170.10 per month (the standard premium) in 2022 ($135.50 in 2019, but about 3.5 percent of beneficiaries paid a lower premium because the hold-harmless provision kept their premium from increasing by more than the cost-of-living adjustment to their Social Security benefits); Part B premiums have been higher for higher income individuals since 2007
Deductible	The first $233 of Part B–covered services or items in 2022 ($185 in 2019)
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 national average bid of sponsoring plans. The Part D basic beneficiary premium for 2022 is $33.37 ($33.19 in 2019); 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	$480 in 2022 ($415 in 2019); not applied to dual-eligible beneficiaries; dual-eligible beneficiaries pay only nominal copayments
Initial coverage limit	$4,430 in 2022 ($3,820 in 2019); dual-eligible beneficiaries pay only nominal copayments
Out-of-pocket threshold (catastrophic cap)	$7,050 in 2022 ($5,100 in 2019); after this amount, dual-eligible beneficiaries have no financial obligation for covered drugs
Copayment rules	Copayments vary from plan to plan, but minimum copayment amounts are required for beneficiaries who have reached the out-of-pocket threshold. For dual-eligible beneficiaries, there are no copayments for institutionalized beneficiaries at any level of utilization. For other dual-eligible beneficiaries, maximum copayment limits are set for utilization up to the out-of-pocket threshold: ranging, in 2022, from $1.35 for generic or preferred multisource drugs up to $9.85 for other drugs, depending on the person's subsidy category (a range of $1.25 to $8.50 in 2019).
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 2021d, 2021f, 2021g 2018a, 2018b, 2018c.*

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

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

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

The share of each state's population that is covered by Medicaid varies greatly as a result of differences in states' use of optional eligibility pathways such as the Patient Protection and Affordable Care Act's (P.L. 111-148) 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 2019. When the analytic work for this data book began, calendar year (CY) 2019 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 that 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 contained in an individual's Medicare health insurance claim (HIC) number 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 are defined by FFS use of the following Medicaid services: institutional (nursing facility, intermediate care facility for persons with intellectual disabilities, and mental health facility for individuals ages 65 and older or age 21 and under), HCBS under a waiver (including any type of service provided under such a waiver), or HCBS under a state plan (nonwaiver home health and personal care services). We separate these groups because HCBS waiver users are required to meet an institutional level of care and may receive a wide array of services, whereas 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 2021b). The T-MSIS data also exclude Medicaid payments for Medicare premiums—$19.7 billion in 2019, of which

$11.8 billion was the federal share and $7.9 billion was the state share (Medicaid and CHIP Payment and Access Commission 2021a)—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 2021a). 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 seven 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 2019

Type of cost sharing	Full-benefit dual-eligible beneficiaries			Limited-benefit dual-eligible beneficiaries		Non-dual Medicare beneficiaries
	QMB plus	SLMB plus	Other full benefit	QMB only	SLMB only, QI, and QDWI	
Part A total	**$2.6**	**$0.3**	**$1.5**	**$0.4**	**$0.4**	**$9.7**
Hospital deductible	1.3	0.1	0.5	0.3	0.3	6.6
Hospital per-day copayments	0.3	<0.1	0.1	0.1	<0.1	0.5
SNF-day copayments	1.0	0.2	0.8	0.1	0.1	2.6
Part B total	**6.4**	**0.5**	**2.5**	**1.4**	**1.2**	**39.4**
Deductible	0.6	<0.1	0.2	0.1	0.1	4.6
Coinsurance	5.9	0.5	2.3	1.3	1.1	34.8
Part A and Part B total	**9.0**	**0.8**	**4.0**	**1.8**	**1.6**	**49.1**

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 86 percent of ever-enrolled counts) than the Medicare population (where average monthly counts were 95 percent of ever-enrolled counts) (Table 6). For dual-eligible beneficiaries, average monthly counts were 89 percent of ever-enrolled counts.

Table 6. Comparison of dual-eligible and non-dual Medicare and Medicaid beneficiary counts using ever-enrolled and average monthly measures, CY 2019

	Number of beneficiaries (millions)		Average monthly as a percent of ever enrolled
	Ever enrolled	Average monthly	
Dual-eligible beneficiaries	**12.2**	**10.9**	**89%**
Under age 65	4.6	4.2	90
Ages 65 and older	7.6	6.7	88
Medicare beneficiaries with no dual-eligible enrollment	**50.9**	**48.6**	**95**
Under age 65	4.1	3.9	95
Ages 65 and older	46.8	44.7	96
Medicaid beneficiaries with no dual-eligible enrollment	**77.7**	**66.0**	**85**
Nondisabled under age 65	71.0	60.0	84
Disabled under age 65	5.4	5.1	93
Ages 65 and older	0.9	0.7	77
All Medicare beneficiaries	**63.1**	**60.2**	**95**
All Medicaid beneficiaries	**89.8**	**77.2**	**86**

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 attribution method for counting beneficiaries, spending, and utilization likely does not have a large impact on our results.

- *Fee-for-service and managed care enrollment status.* Many of the tables in this data book provide information about expenditures and utilization for particular categories of services. Since managed care plans are paid 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 in Medicare or Medicaid FFS status for the remaining portion of the year.

  About 45 percent of the dual-eligible population was enrolled in a Medicare managed care plan for all or part of the year in 2019 (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 (8 percent vs. 2 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 (37 percent vs. 71 percent, Exhibit 12).

- *Beneficiaries with ESRD.* About 1.0 percent of all Medicare beneficiaries and 2.3 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 2019

	All beneficiaries	Non-ESRD	ESRD	ESRD as percent of total
Population				
All Medicare beneficiaries (in millions)	63.1	62.5	0.6	1.0%
Dual-eligible beneficiaries (in millions)	12.2	11.9	0.3	2.3
Dual-eligible beneficiaries as percent of category	19%	19%	45%	
Medicare expenditures				
Total spending (in billions)	$811.8	$764.5	$47.3	5.8
Per person per year	12,868	12,236	77,361	
Spending on dual-eligible beneficiaries (in billions)	275.9	250.7	25.2	9.1
Per person per year	22,647	21,048	92,071	
Spending on non-dual beneficiaries (in billions)	535.9	513.8	22.1	4.1
Per person per year	10,528	10,161	65,421	
Medicaid expenditures				
Spending on dual-eligible beneficiaries (in billions)	$164.3	$157.4	$6.9	4.2
Per person per year	13,483	13,213	25,220	

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 2019, annual per capita Medicare spending for dual-eligible beneficiaries with ESRD was $92,071; per capita Medicaid spending for the same population was $25,220. With the ESRD population included, annual per capita Medicare spending for dual-eligible beneficiaries averaged $22,647 in 2019; excluding

beneficiaries with ESRD, per capita Medicare spending on dual-eligible beneficiaries averaged $21,048 for the year. In comparison, Medicaid per capita spending on dual-eligible beneficiaries including the ESRD population was $13,483; excluding these individuals, the amount was $13,213.

Table 8. Dual-eligible, Medicare, and Medicaid beneficiaries as a percent of population by state, CY 2019 (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	328,240	12,184	4%	8,667	71%	3,518	29%	63,088	19%	89,836	27%
Alabama	4,903	231	5	92	40	139	60	1,096	22	1,277	26
Alaska	732	21	3	20	93	1	7	106	14	251	34
Arizona	7,279	258	4	192	75	65	25	1,386	19	2,234	31
Arkansas	3,018	147	5	76	52	71	48	667	22	1,093	36
California	39,512	1,637	4	1,583	97	54	3	6,654	17	15,477	39
Colorado	5,759	137	2	93	68	44	32	952	17	1,552	27
Connecticut	3,565	201	6	78	39	123	61	717	20	1,099	31
Delaware	974	35	4	17	48	18	52	218	22	288	30
District of Columbia	706	39	6	27	67	13	33	101	14	282	40
Florida	21,478	943	4	446	47	497	53	4,751	22	4,618	22
Georgia	10,617	386	4	167	43	219	57	1,814	17	2,508	24
Hawaii	1,416	46	3	39	85	7	15	286	20	393	28
Idaho	1,787	53	3	32	59	22	41	350	20	342	19
Illinois	12,672	428	3	367	86	61	14	2,341	18	3,412	27
Indiana	6,732	239	4	159	66	80	34	1,325	20	1,746	26
Iowa	3,155	96	3	74	77	22	23	657	21	804	25
Kansas	2,913	76	3	45	60	31	40	562	19	491	17
Kentucky	4,468	198	4	108	54	90	46	972	22	1,650	37
Louisiana	4,649	256	6	144	56	113	44	923	20	1,862	40
Maine	1,344	95	7	57	60	38	40	356	26	344	26
Maryland	6,046	170	3	100	59	71	41	1,088	18	1,581	26
Massachusetts	6,893	347	5	323	93	24	7	1,399	20	2,088	30
Michigan	9,987	363	4	294	81	69	19	2,162	22	2,862	29
Minnesota	5,640	157	3	138	88	19	12	1,070	19	1,283	23
Mississippi	2,976	176	6	85	48	91	52	632	21	837	28
Missouri	6,137	202	3	157	78	45	22	1,285	21	1,162	19
Montana	1,069	33	3	20	61	13	39	242	23	322	30

State	Total population (thousands)	Dual-eligible beneficiaries						All Medicare beneficiaries		All Medicaid beneficiaries	
		All		Full		Partial					
		Number (thousands)	Percent of total population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of dual-eligible population	Number (thousands)	Percent of total population	Number (thousands)	Percent of total population
Nebraska	1,934	45	2	40	89	5	11	362	19	300	16
Nevada	3,080	81	3	32	39	49	61	555	18	823	27
New Hampshire	1,360	38	3	24	63	14	37	311	23	242	18
New Jersey	8,882	219	2	217	99	2	1	1,663	19	2,064	23
New Mexico	2,097	112	5	67	60	45	40	442	21	935	45
New York	19,454	1,035	5	867	84	168	16	3,811	20	7,416	38
North Carolina	10,488	370	4	278	75	91	25	2,077	20	2,524	24
North Dakota	762	17	2	13	78	4	22	138	18	117	15
Ohio	11,689	429	4	295	69	134	31	2,458	21	3,221	28
Oklahoma	3,957	132	3	107	81	26	19	775	20	970	25
Oregon	4,218	121	3	57	47	64	53	867	21	1,185	28
Pennsylvania	12,802	522	4	420	80	102	20	2,865	22	3,319	26
Rhode Island	1,059	50	5	41	82	9	18	231	22	360	34
South Carolina	5,149	178	3	152	85	27	15	1,115	22	1,402	27
South Dakota	885	23	3	14	62	9	38	184	21	144	16
Tennessee	6,829	296	4	164	55	132	45	1,421	21	1,731	25
Texas	28,996	792	3	417	53	375	47	4,361	15	5,558	19
Utah	3,206	39	1	33	85	6	15	415	13	412	13
Vermont	624	31	5	22	71	9	29	154	25	190	30
Virginia	8,536	217	3	144	66	73	34	1,577	18	1,731	20
Washington	7,615	223	3	151	68	72	32	1,427	19	2,093	27
West Virginia	1,792	87	5	47	54	39	46	457	26	631	35
Wisconsin	5,822	195	3	172	89	22	11	1,230	21	1,350	23
Wyoming	579	12	2	9	69	4	31	115	20	77	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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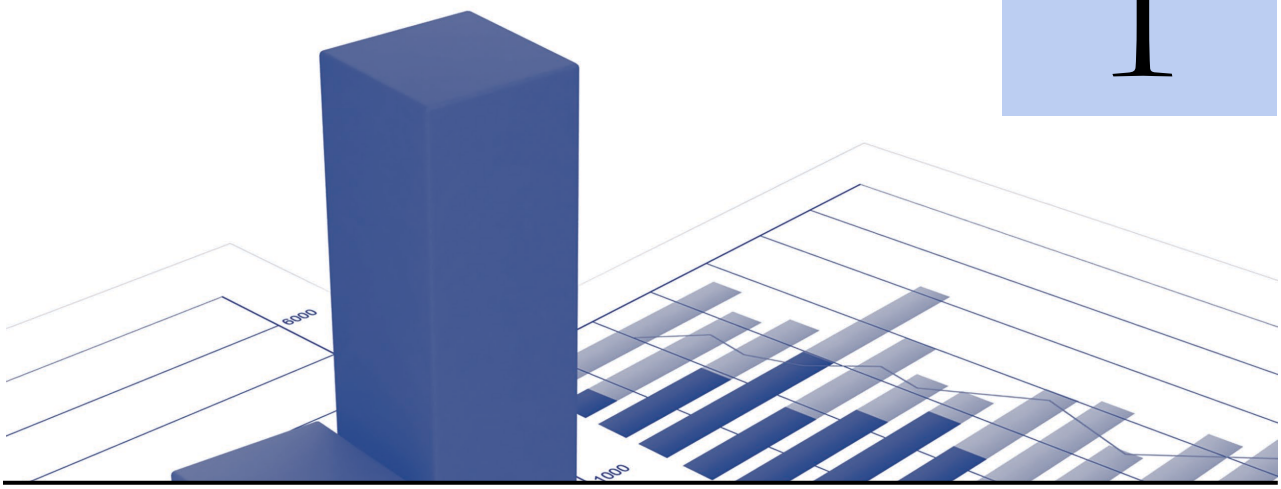


Overview of dual-eligible beneficiaries

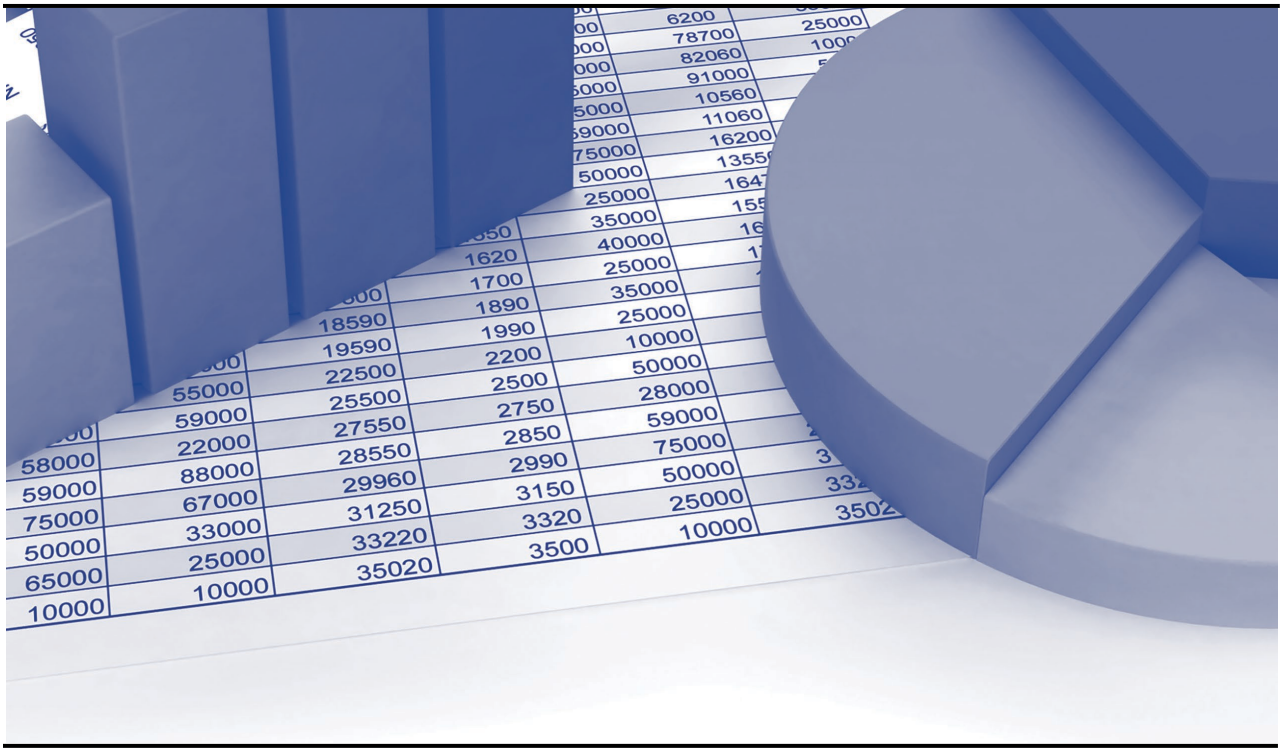
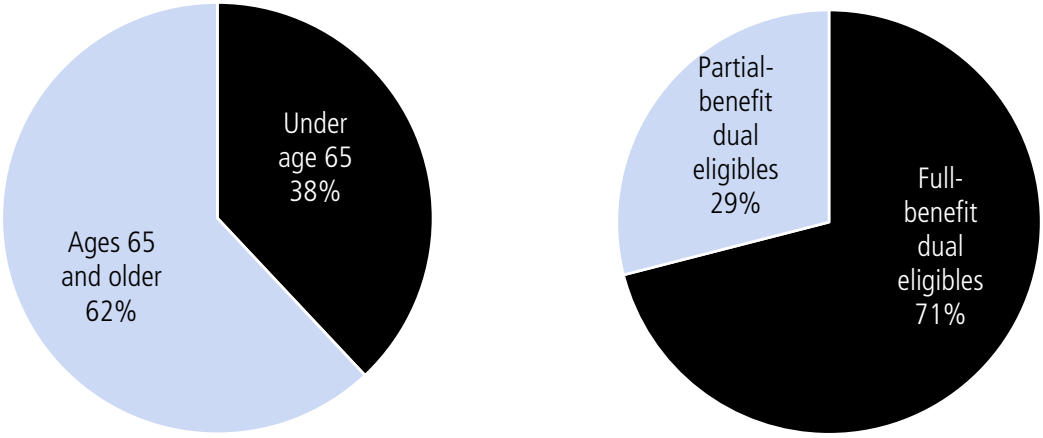


Exhibit 1

Snapshot of dual-eligible beneficiaries by age and type of benefit, CY 2019

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 2019. The majority (62 percent) of dual-eligible beneficiaries were ages 65 and older.
- Most dual-eligible beneficiaries (71 percent) were eligible for full Medicaid benefits.

Exhibit 2

Dual-eligible beneficiary enrollment in full- and partial-benefit categories, CY 2019

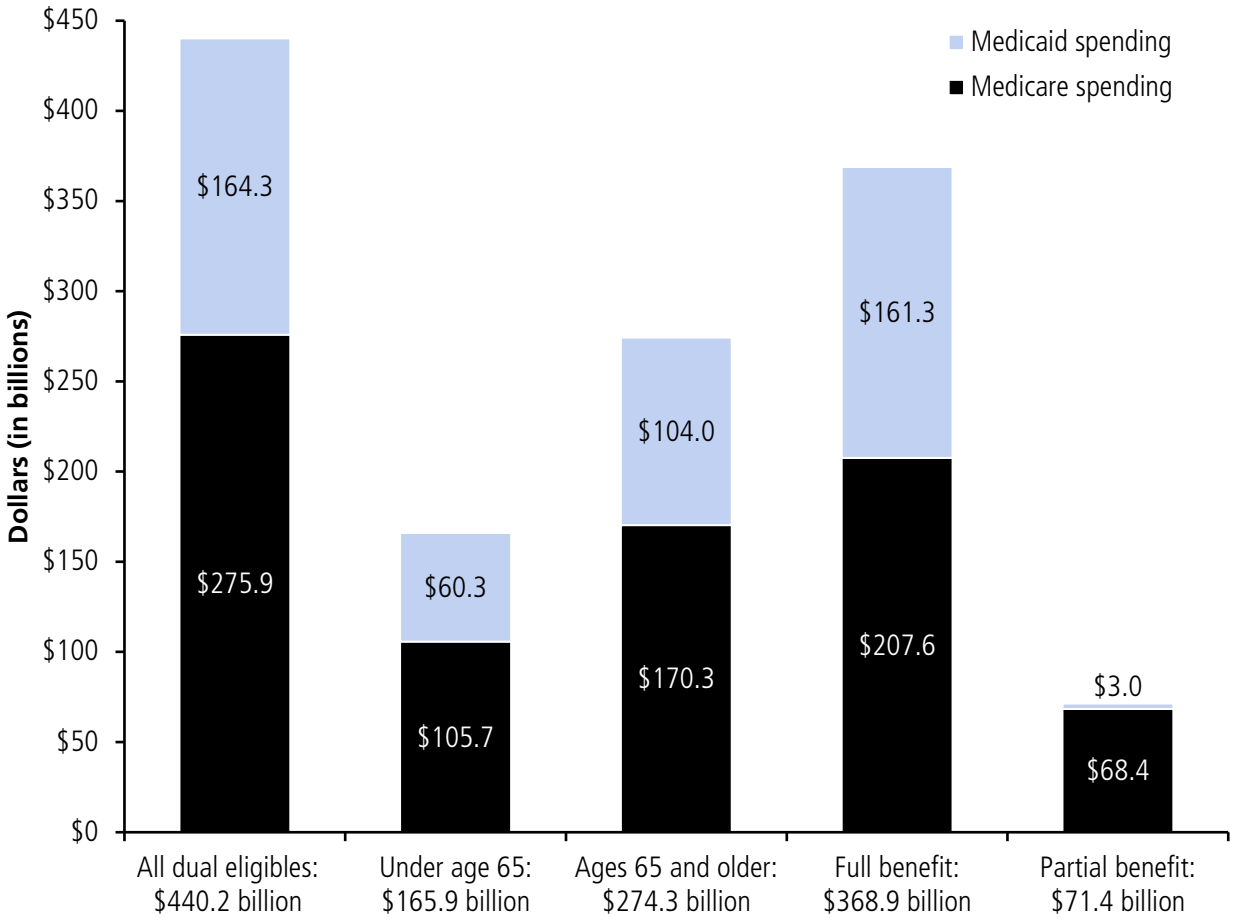
Benefit categories	Dual-eligible beneficiaries		
	All	Under age 65	Ages 65 and older
Full-benefit dual-eligible beneficiaries	**71%**	**71%**	**71%**
QMB plus	51	51	51
SLMB plus	3	3	3
Other full benefit	18	17	18
Partial-benefit dual-eligible beneficiaries	**29**	**29**	**29**
QMB only	14	15	14
SLMB only	9	9	9
QI	5	5	6
QDWI	<1	<1	<1

Note: *CY (calendar year), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual), QDWI (qualified disabled and working 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 both QMB or SLMB benefits 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 2019, almost three-quarters (71 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 2019

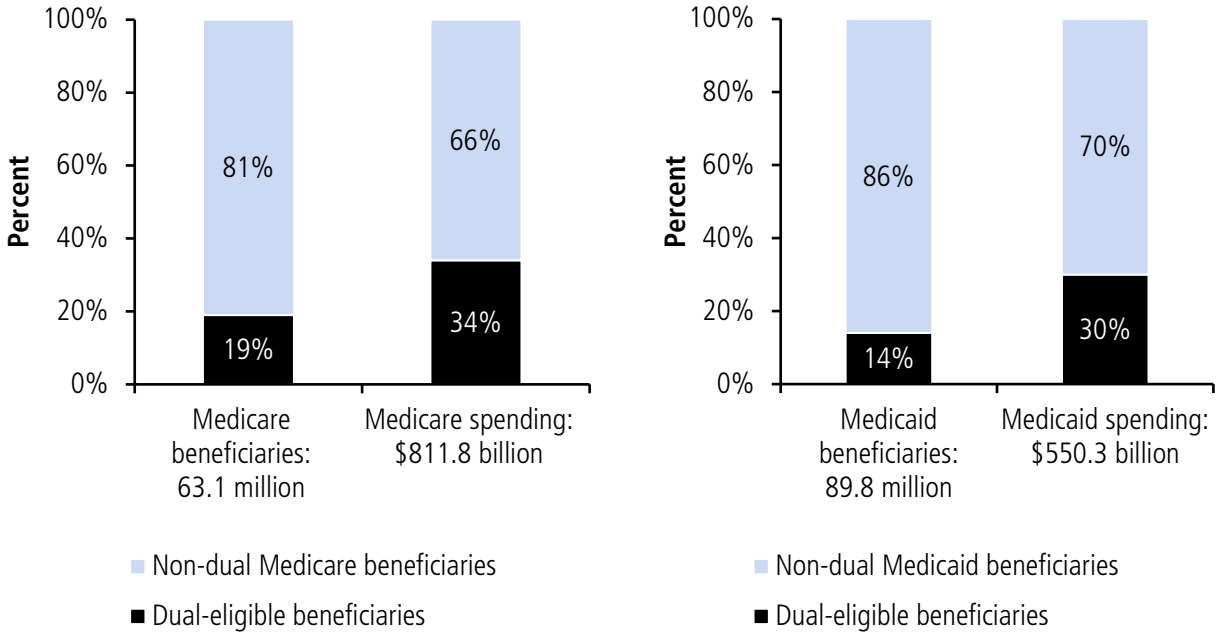


Note: *CY (calendar year). Exhibit includes all dual-eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Components may not sum to totals due to rounding. Exhibit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

- Combined Medicare and Medicaid spending on individuals who were dually eligible for both Medicare and Medicaid was $440.2 billion in CY 2019. Medicare accounted for about 63 percent of combined spending, or $275.9 billion.
- By age group, combined Medicare and Medicaid spending on dual-eligible beneficiaries was higher for beneficiaries ages 65 and older ($274.3 billion in combined spending) than for beneficiaries under age 65 ($165.9 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 ($368.9 billion vs. $71.4 billion).

Exhibit 4

Dual-eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2019



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 2019.
- Dual-eligible beneficiaries totaled 19 percent of the Medicare population in 2019 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 2019

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	21	8	19
Type of benefit				
Full benefit	14%	26%	10%	29%
Partial benefit	6	8	4	1

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

- Certain subgroups of individuals dually eligible for Medicare and Medicaid benefits accounted for disproportionate shares of Medicare and Medicaid spending.
- Dual-eligible beneficiaries ages 65 and older were 12 percent of the Medicare population in CY 2019 but accounted for 21 percent of Medicare spending. These beneficiaries also accounted for 8 percent of the Medicaid population but 19 percent of Medicaid spending.
- Full-benefit dual-eligible beneficiaries also incurred disproportionate spending, particularly in Medicaid. They accounted for 14 percent of all Medicare enrollment but 26 percent of all Medicare spending and 10 percent of all Medicaid enrollment but 29 percent of all Medicaid spending.

Section

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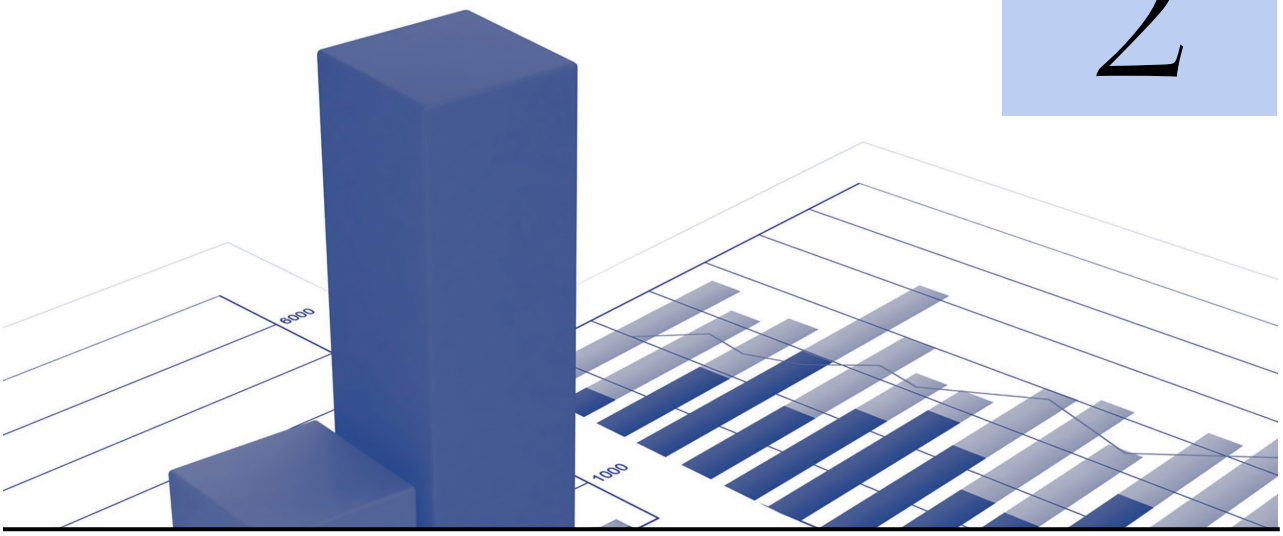

Characteristics of dual-eligible beneficiaries

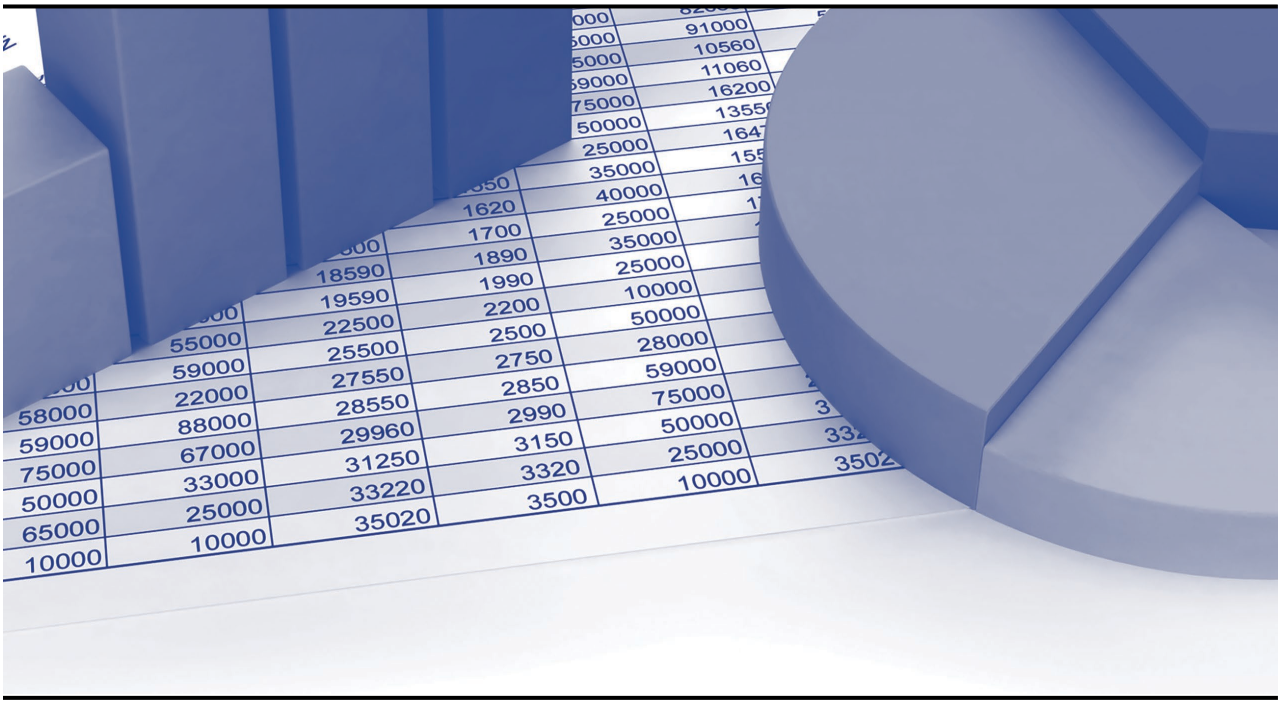

Exhibit 6

Demographic characteristics of dual-eligible and non-dual Medicare and Medicaid beneficiaries, CY 2019

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%	36%	40%	41%	47%	55%
Female	59	52	64	60	59	53	45
Race/Ethnicity							
White/non-Hispanic	54%	60%	50%	52%	58%	82%	46%
Black/non-Hispanic	21	25	19	20	23	9	28
Hispanic	17	12	20	18	15	6	21
Other	8	3	11	9	3	3	4
Residence							
Urban	79%	76%	81%	81%	75%	80%	80%
Rural	21	24	19	19	25	20	20

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 3.3 percent or less for all statistics except race/ethnicity for non-dual disabled Medicaid beneficiaries, where the share of beneficiaries with missing information was 31.9 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 2019 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 (46 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. 36 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 2019

Characteristic	Dual-eligible beneficiaries					Non-dual Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
Limitations in ADLs						
None	51	45%	55%	46%	63%	80%
1–2 ADL limitations	24	32	19	23	25	13
3–6 ADL limitations	25	23	26	30	12	7
Self-reported health status						
Excellent or very good	20%	18%	22%	19%	24%	50%
Good or fair	60	59	61	60	61	42
Poor	13	19	9	14	12	4
Unknown	6	3	8	8	3	4
Living arrangement						
Institution	13%	6%	18%	18%	3%	3%
Alone	33	32	34	29	40	26
Spouse	14	11	15	12	17	54
Children, nonrelatives, others	40	51	33	41	39	17
Education						
No high school diploma	36%	27%	42%	38%	32%	9%
High school diploma only	30	38	25	29	34	24
Some college	28	33	25	26	34	66
Other	5	2	8	8	<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: *2019 Medicare Current Beneficiary Survey.*

- Nearly half (49 percent) of individuals dually eligible for Medicare and Medicaid benefits in CY 2019 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 (13 percent vs. 3 percent).
- Dual-eligible beneficiaries ages 65 and older were more likely than younger dual-eligible beneficiaries to live in an institution (18 percent vs. 6 percent). However, older dual-eligible beneficiaries were more likely to report having no ADL limitations (55 percent vs. 45 percent) and less likely to report being in poor health (9 percent vs. 19 percent).
- Dual-eligible beneficiaries with partial benefits were more likely than those with full benefits to report having no ADL limitations (63 percent vs. 46 percent). Partial-benefit dual-eligible beneficiaries were also less likely to live in an institution (3 percent vs. 18 percent).
- About a third of dually eligible individuals (36 percent) did not graduate from high school, compared with 9 percent of non-dual Medicare beneficiaries.

Exhibit 8

Selected chronic conditions for FFS dual-eligible beneficiaries by age group, CY 2019

Condition	FFS dual-eligible beneficiaries	
	Under age 65	Ages 65 and older
Cognitive impairment		
Alzheimer's disease or related dementia	4%	20%
Intellectual disabilities and related conditions	10	2
Physical health conditions		
Diabetes	23%	33%
Heart failure	8	20
Hypertension	40	64
Ischemic heart disease	13	29
Behavioral health conditions		
Anxiety disorders	33%	21%
Bipolar disorder	15	4
Depression	35	25
Schizophrenia and other psychotic disorders	13	6

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 (20 percent vs. 4 percent). More dual-eligible beneficiaries under age 65 had an intellectual disability (10 percent vs. 2 percent).
- Compared with the under age 65 population, 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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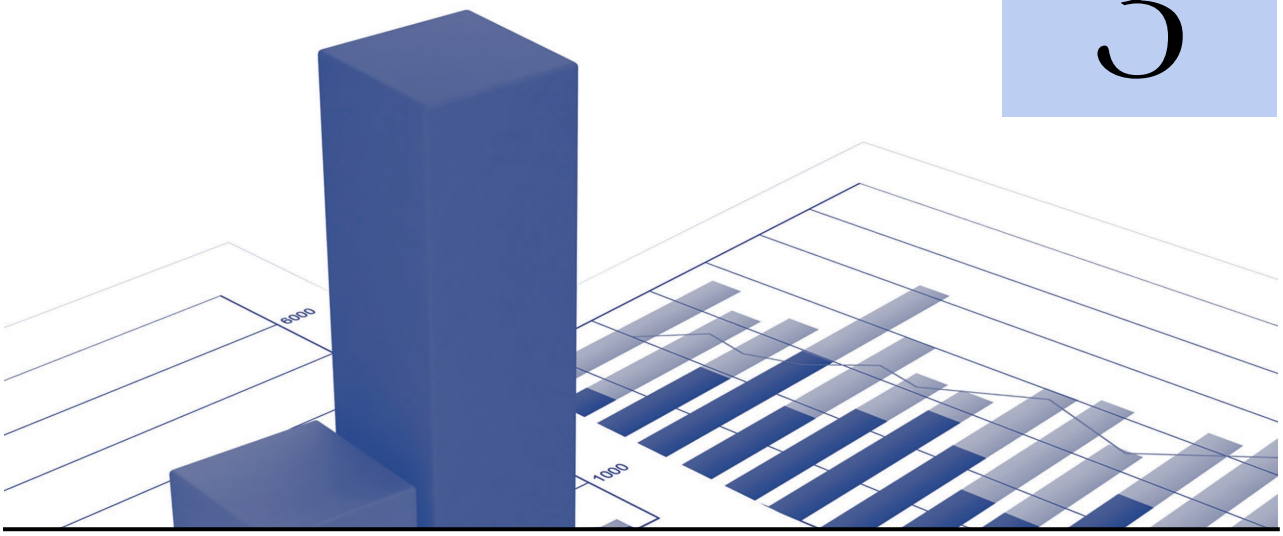

Eligibility pathways, managed care enrollment, and continuity of enrollment

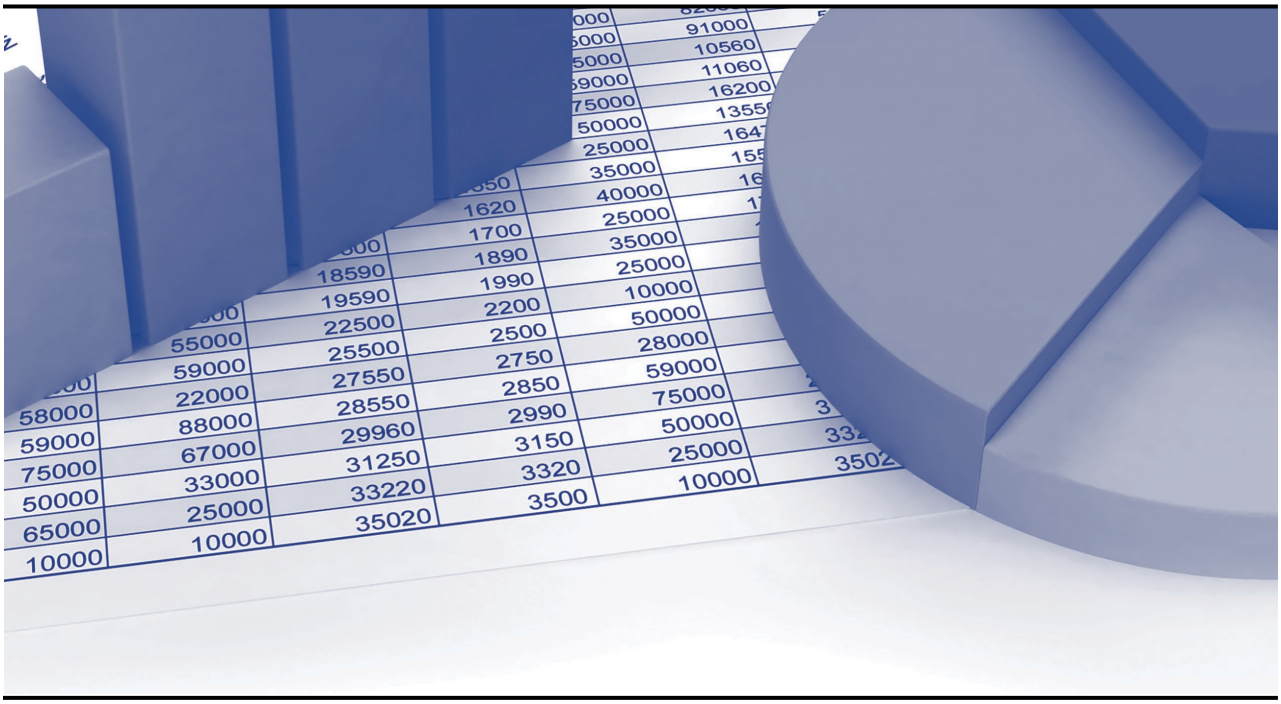

Exhibit 9

Medicare eligibility pathways, CY 2019

Original reason for entitlement to Medicare	Dual-eligible beneficiaries			Non-dual Medicare beneficiaries
	All	Full benefit	Partial benefit	
Age	47%	48%	45%	84%
ESRD	1	1	1	<1
Disability	51	50	54	15
Based on own record	80	75	92	95
Based on another's record	20	25	8	5

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

- Overall, individuals dually eligible for Medicare and Medicaid benefits in CY 2019 were evenly split between those who originally qualified for Medicare benefits based on age (47 percent) and those who qualified for Medicare benefits based on disability (51 percent).
- In contrast to dual-eligible beneficiaries, most non-dual Medicare beneficiaries (84 percent) originally qualified for Medicare benefits based on their age.
- Most (75 percent) full-benefit dual-eligible beneficiaries who originally qualified for Medicare because of disability were individuals with sufficient employment history to be eligible based on their own work record. A higher portion (92 percent) of partial-benefit dual-eligible beneficiaries who originally qualified for Medicare benefits because of disability did so based on their own employment record.
- The remaining dual-eligible beneficiaries (25 percent among those with full benefits and 8 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 2019

Medicaid eligibility group	Dual-eligible beneficiaries			Non-dual Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	
SSI	34%	34%	34%	86%
Poverty related	44	44	44	5
Medically needy	7	5	8	4
Section 1115 waiver	<1	<1	<1	<1
Special income limit and other	14	16	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 2019 qualified for Medicaid benefits through receipt of SSI benefits (34 percent) or through poverty-related eligibility pathways (44 percent).
- In contrast to dual-eligible beneficiaries, most non-dual Medicaid beneficiaries eligible on the basis of a disability (86 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 2019

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	55%	62%	52%	60%	45%	64%
Managed care only	37	30	41	32	48	34
Both FFS and managed care	8	8	7	8	8	2
Among beneficiaries in managed care only						
Enrolled in a D–SNP	49	54	47	55	38	<1
Enrolled in other plan type	51	46	53	45	62	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 2019, slightly over half of individuals dually eligible for Medicare and Medicaid services (55 percent) were enrolled only in Medicare FFS.
- Dual-eligible beneficiaries were somewhat 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 (37 percent vs. 34 percent).
- Dual-eligible beneficiaries ages 65 and older were more likely to be exclusively enrolled in managed care than those under age 65 (41 percent vs. 30 percent).
- Partial-benefit dual-eligible beneficiaries were more likely to be exclusively enrolled in managed care than full-benefit beneficiaries (48 percent vs. 32 percent), while full-benefit beneficiaries were more likely to be in FFS only (60 percent vs. 45 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 eligibles were more likely to enroll in D–SNPs while partial-benefit dual eligibles were more likely to enroll in other types of plans.

Exhibit 12

Medicaid fee-for-service and managed care enrollment, CY 2019

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	42%	42%	43%	24%	89%	10%
FFS and limited-benefit managed care only	20	23	18	27	3	19
At least one month of comprehensive managed care	37	35	39	49	8	71

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

- Most individuals dually eligible for Medicare and Medicaid services in CY 2019 were either enrolled only in Medicaid FFS (42 percent) or in Medicaid FFS with a limited-benefit Medicaid managed care plan (20 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 (71 percent vs. 37 percent) and less likely to be enrolled in Medicaid FFS only (10 percent vs. 42 percent).
- Dual-eligible beneficiaries ages 65 and older were more likely to be in comprehensive managed care than those under age 65.
- More than three-quarters (76 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 2019

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	78%	79%	76%	79%	75%
Enrolled 12 months, some with Medicare or Medicaid only	16	18	16	15	21
Enrolled fewer than 12 months	6	3	8	7	5
Consistency of full and partial dual-eligible status during the year					
Exclusively full or exclusively partial	95	94	96	97	92
Switched between full and partial	5	6	4	3	8

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 (78 percent) were dual-eligible beneficiaries during every month of CY 2019.
- Only 5 percent of all dual-eligible beneficiaries in 2019 switched between full-benefit and partial-benefit dual-eligible status.

Section

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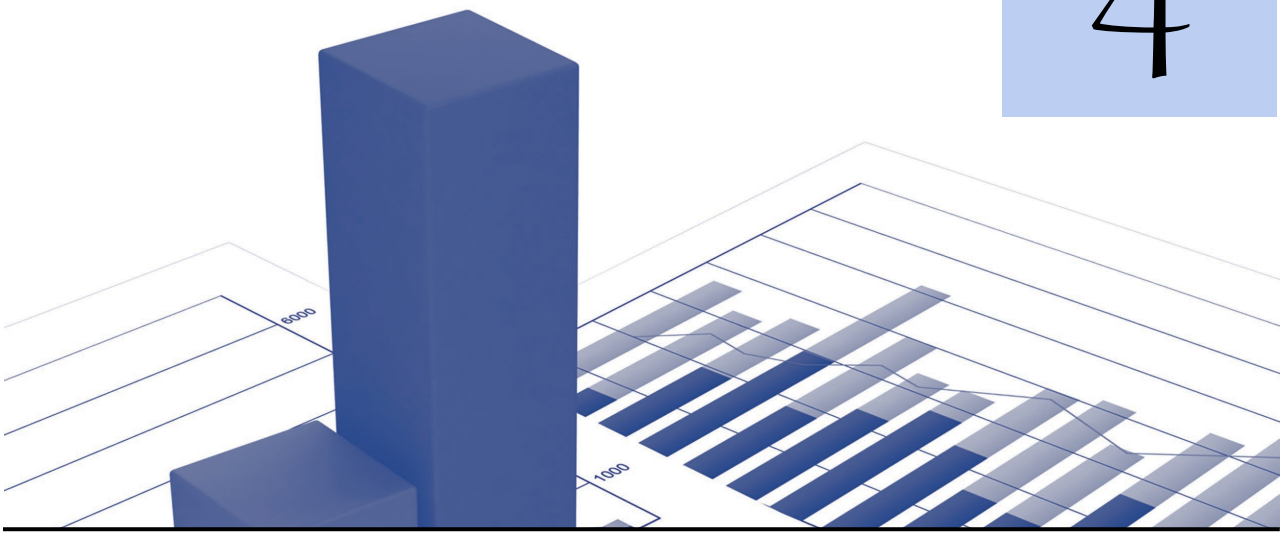

Utilization of and spending on Medicare and Medicaid services for dual-eligible beneficiaries

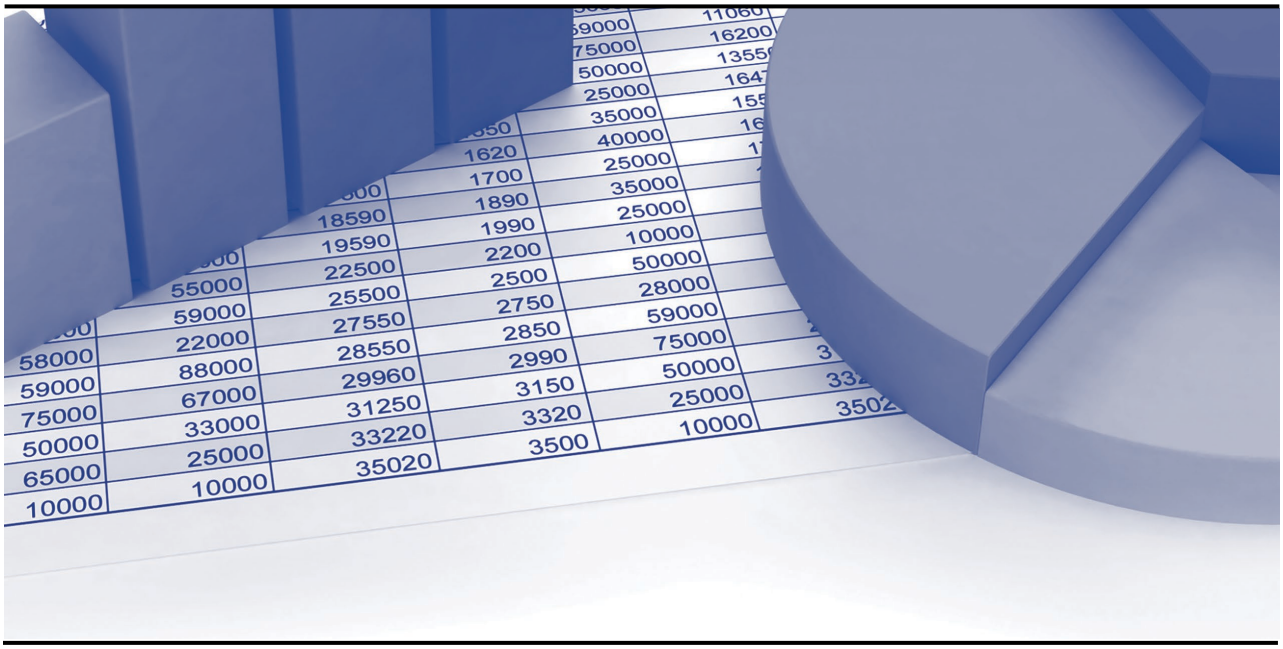

Exhibit 14

Use of Medicare services and per user Medicare spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2019

Selected Medicare services	Full-benefit FFS dual-eligible beneficiaries			FFS non-dual Medicare beneficiaries		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
Part A and Part B						
Inpatient hospital	24%	$23,652	37%	15%	$19,398	30%
Skilled nursing facility	9	19,705	12	4	14,931	6
Home health	12	5,361	4	9	4,877	5
Other outpatient	94	7,350	44	92	5,789	57
Part D						
Prescription drugs	92	7,468		94	2,178	

Note: *FFS (fee-for-service), CY (calendar year). Dual-eligible beneficiaries are limited to full-benefit dual eligibles in Medicare and Medicaid FFS. End-stage renal disease is excluded. "Inpatient hospital" includes psychiatric hospital services. "Other outpatient" includes physician services, hospice, durable medical equipment, hospital outpatient, emergency room not preceding an inpatient stay, and other outpatient facilities. The "percent of total spending" columns apply only to Part A and Part B services and do not sum to 100 because spending is shown only for selected services. The figures for 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 2019 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 (12 percent vs. 6 percent).

Exhibit 15

Use of Medicaid services and per user Medicaid spending for FFS dual-eligible beneficiaries and non-dual beneficiaries, CY 2019

Selected Medicaid services	Full-benefit FFS dual-eligible beneficiaries			FFS non-dual Medicaid beneficiaries (disabled, under age 65)		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
Acute hospital	44%	$1,606	3%	55%	$9,223	20%
Other acute	86	2,427	9	81	5,804	18
Institutional LTSS	17	51,571	37	4	77,934	12
HCBS state plan	11	9,995	5	11	9,307	4
HCBS waiver	19	42,050	33	16	37,787	23
Prescription drugs	29	429	1	69	5,735	15
Managed care capitation	50	6,122	13	71	2,959	8

Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Dual-eligible beneficiaries are limited to full-benefit dual eligibles in Medicare and Medicaid FFS. End-stage renal disease is excluded. "Acute hospital" includes inpatient and outpatient services performed at a hospital. "Other acute" includes all Medicaid services that are not part of the other service categories shown in this exhibit. The "acute hospital" and "other acute" service categories do not correspond to the "inpatient hospital" and "outpatient" service categories used in previous versions of this exhibit. 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. The population used for this exhibit includes individuals enrolled in limited-benefit managed care plans, so their total spending includes a small amount of capitation payments. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Percentages may not sum to 100 due to rounding. Exhibit excludes administrative spending.*

- Compared with non-dual Medicaid beneficiaries eligible on the basis of a disability, individuals dually eligible for Medicare and Medicaid used more 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 (37 percent vs. 12 percent).
- However, per user FFS spending on institutional LTSS was higher for non-dual disabled Medicaid beneficiaries ($77,934) than for dual-eligible beneficiaries ($51,571).
- More FFS dual-eligible beneficiaries used Medicaid HCBS services through an HCBS waiver than through a state plan (19 percent vs. 11 percent), and Medicaid FFS per user spending was also more than four times higher for HCBS waiver services than for state plan HCBS services ($42,050 vs. $9,995). 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 (33 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 2019

Selected services	Full-benefit FFS dual-eligible beneficiaries under age 65			Full-benefit FFS dual-eligible beneficiaries ages 65 and older		
	Percent using service	Per user spending	Percent of total spending	Percent using service	Per user spending	Percent of total spending
Medicare services						
Inpatient hospital	19%	$24,655	24%	29%	$23,064	27%
Skilled nursing facility	3	19,011	3	14	19,850	12
Home health	7	5,141	2	16	5,449	4
Other outpatient	93	6,337	29	95	8,226	32
Prescription drugs	90	8,930	40	92	6,212	23
Medicaid services						
Acute hospital	48%	$1,697	3%	40%	$1,507	2%
Other acute	89	2,742	10	84	2,129	7
Institutional LTSS	7	75,537	22	26	46,173	50
HCBS state plan	10	9,962	4	12	10,020	5
HCBS waiver	24	51,013	51	15	29,328	18
Prescription drugs	28	572	1	30	314	<1
Managed care capitation	52	3,818	8	49	8,274	17

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 "acute hospital" includes inpatient and outpatient services. Medicaid "other acute" includes all Medicaid services that are not part of the other service categories shown in this exhibit. The "acute hospital" and "other acute" service categories do not correspond to the "inpatient hospital" and "outpatient" service categories used in previous versions of this exhibit. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. The population used for this exhibit includes individuals enrolled in limited-benefit Medicaid managed care plans, so their total spending includes a small amount of capitation payments. Administrative spending is excluded. Components may not sum to 100 percent due to rounding.*

- Among individuals dually eligible for Medicare and Medicaid services in CY 2019, those who were ages 65 and older had higher use of Medicare FFS-covered inpatient hospital, skilled nursing facility, and home health services. However, their average per-user spending for these services was similar to that of individuals under 65. Similar shares of FFS dual-eligible beneficiaries over and under age 65 used prescription drugs, but per-user spending 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. 26 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 (22 percent vs. 50 percent).

Section

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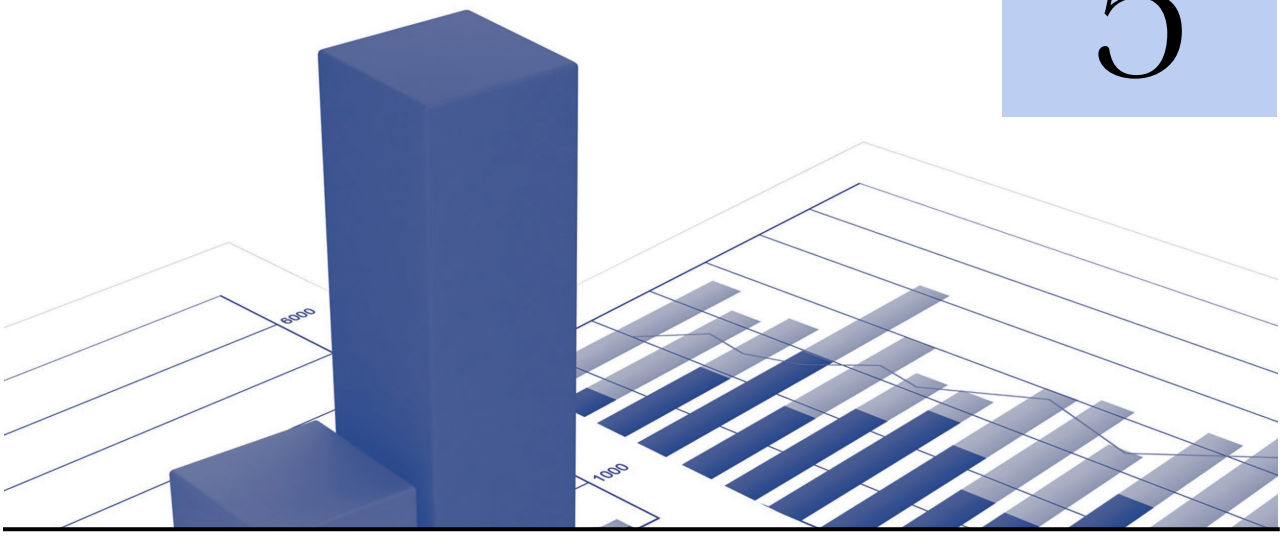


Medicare and Medicaid spending for dual-eligible beneficiaries by LTSS use

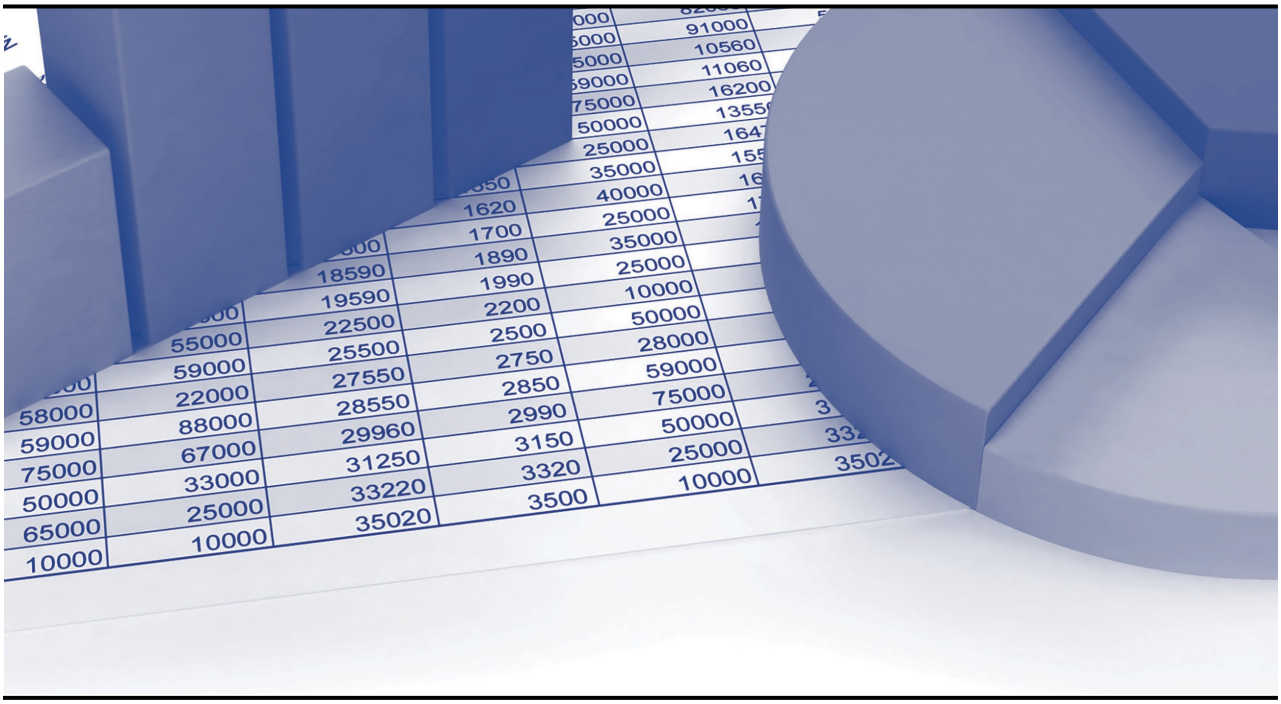
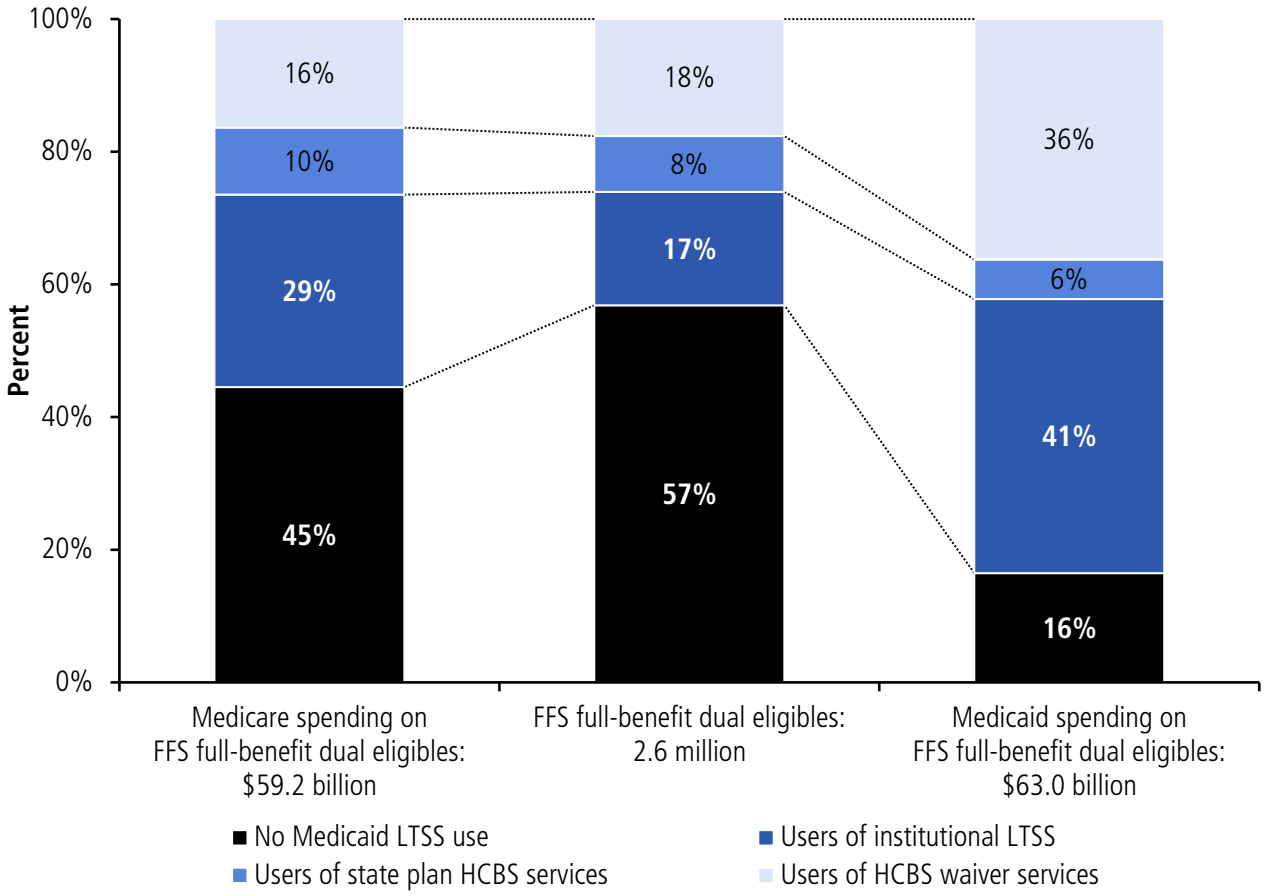


Exhibit 17

Medicare and Medicaid spending on FFS full-benefit dual-eligibles by type of Medicaid LTSS, CY 2019

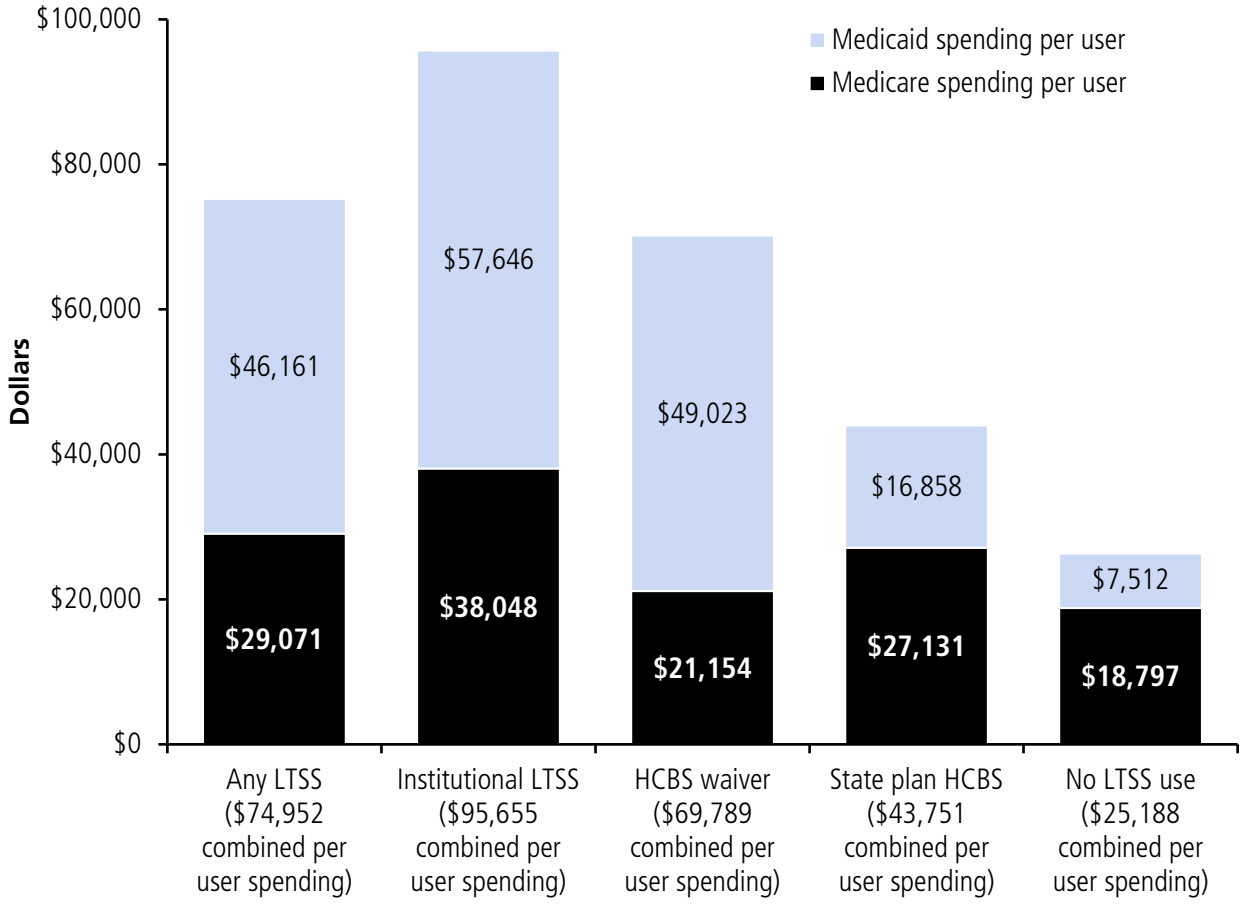


Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible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

- In CY 2019, the majority (57 percent) of FFS full-benefit dual-eligible beneficiaries did not use Medicaid LTSS.
- Use of Medicaid-covered institutional LTSS among individuals dually eligible for Medicare and Medicaid services resulted in disproportionately high Medicare and Medicaid spending. Users of institutional LTSS made up 17 percent of FFS full-benefit dual-eligible beneficiaries, but they accounted for 29 percent of Medicare spending and 41percent 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 2019, the share of FFS full-benefit dual-eligible beneficiaries who used HCBS was higher than the share who used institutional LTSS (26 percent vs. 17 percent). However, institutional LTSS and HCBS represented similar shares of Medicaid spending on FFS full-benefit dual-eligible beneficiaries (42 percent vs. 41 percent).

Exhibit 18

Per user Medicare and Medicaid spending on FFS full-benefit dual-eligible Medicaid LTSS users and non-users, CY 2019

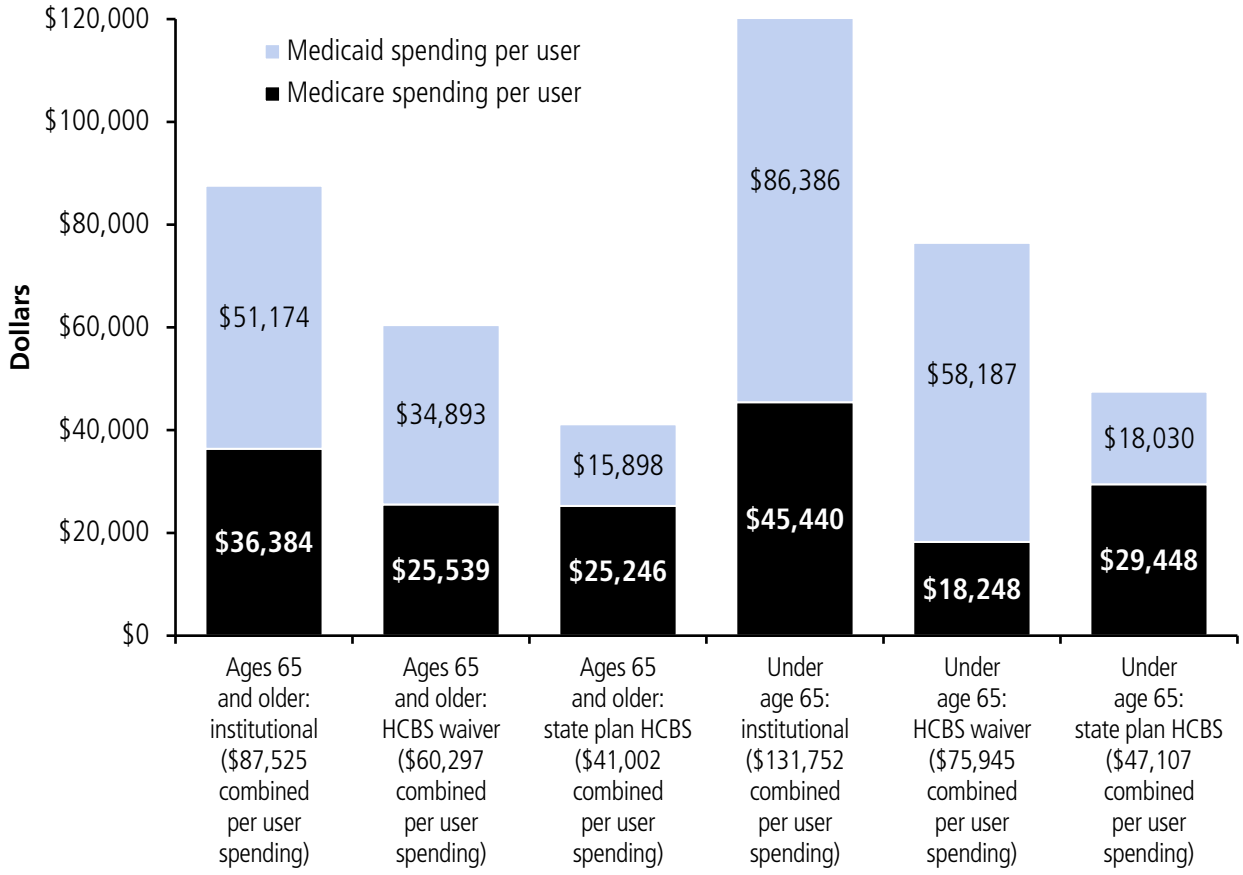


Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible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

- Users of Medicaid-covered institutional LTSS had the highest Medicare and Medicaid per user spending in CY 2019 ($38,048 and $57,646, respectively) compared with users of other types of Medicaid LTSS and non-LTSS users.
- Medicare and Medicaid per user spending for any type of Medicaid LTSS user (institutional, HCBS waiver, or state plan HCBS) was almost three times higher than per user spending on non-LTSS users ($74,952 vs. $25,188).
- Medicaid per user spending was generally higher than Medicare per user spending for Medicaid LTSS users, except for users of state plan HCBS. However, Medicare per user spending exceeded Medicaid per user spending for non-LTSS users.

Exhibit 19

Per user Medicare and Medicaid spending on FFS full-benefit dual-eligible Medicaid LTSS users by age, CY 2019



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

- Among Medicaid LTSS users who were ages 65 and older, combined Medicare and Medicaid per user spending was higher for those who received Medicaid LTSS in an institution ($87,525) than for those who received Medicaid LTSS through HCBS waivers ($60,297) or through state plan HCBS ($41,002).
- Among Medicaid LTSS users under age 65, Medicare per user spending was substantially higher for those who received Medicaid institutional LTSS compared with Medicare per user spending for those receiving Medicaid LTSS through HCBS waivers or through state plan HCBS ($45,440 vs. $18,248 and $29,448)
- Medicaid per user spending on Medicaid institutional LTSS users under age 65 ($86,386) was higher than per user spending on any other subgroup of Medicaid LTSS users. It was also substantially higher than per user spending on Medicaid institutional LTSS users who were ages 65 and older ($51,174).

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