Medicare-Medicaid Enrollee State Profile

The National Summary

Centers for Medicare & Medicaid Services

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Introduction

Medicare-Medicaid enrollees (often called dual eligibles) are low-income seniors and people with disabilities. They are among the most chronically ill and costly individuals enrolled in both the Medicare and Medicaid programs. Medicare-Medicaid enrollees often have multiple chronic conditions and need long-term services and supports. They have high rates of hospital and nursing home use, making them disproportionately costly to both Medicare and Medicaid. In 2007, combined Medicare and Medicaid expenditures for Medicare-Medicaid enrollees totaled $229 billion.

FIGURE 1. MEDICARE MEDICAID ENROLLEES AS SHARE OF PROGRAM PARTICIPANTS VS SHARE OF EXPENDITURES, 2007

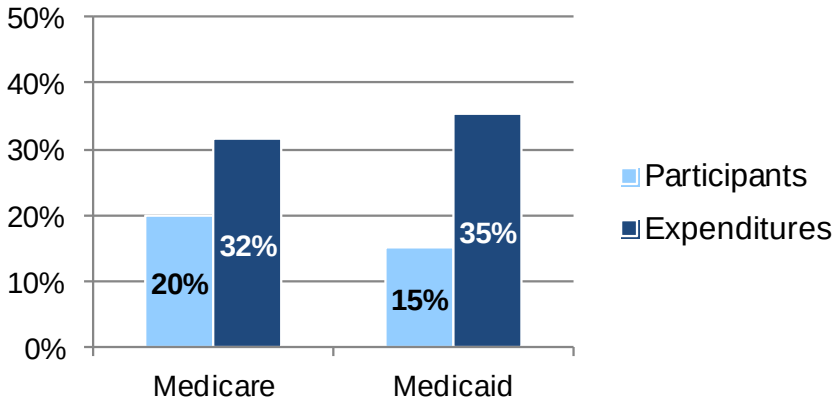


Figure 1 shows that nationally in 2007, Medicare-Medicaid enrollees comprised 20% of the Medicare population and 32% of Medicare expenditures. They comprised 15% of the Medicaid population and 35% of Medicaid expenditures.

The Affordable Care Act recognized the importance of Medicare-Medicaid enrollees to both programs by creating the Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare and Medicaid Services (CMS). MMCO is charged with ensuring that Medicare-Medicaid enrollees have full access to seamless, high quality health care, and with making the system as cost-effective as possible. This national summary, along with individual profiles for each of the 50 States and the District of Columbia, was produced to facilitate greater understanding of Medicare-Medicaid enrollee characteristics as States and CMS develop and test the effectiveness of integrated care models.

This national summary complements the individual profiles for each State and the District of Columbia available at http://www.integratedcareresourcecenter.com/icmstateprofiles.aspx. The individual profiles contain more State-level detail, while this national summary compares values across States and the District of Columbia. It provides a national composite sketch of Medicare-Medicaid enrollees including demographics, selected chronic conditions, service utilization, expenditures and availability of integrated delivery programs. It describes the considerable variation that exists across States, which may be influenced by State Medicaid policy, practice patterns among providers, availability of services, environmental health factors, and socio-economic conditions.

Data Source and General Notes

Unless otherwise noted, the data source for the Medicare-Medicaid Enrollee National Summary is an analytic file developed by the Centers for Medicare & Medicaid Services (CMS) that contains linked calendar year 2007 Medicare and Medicaid administrative and claims data for persons ages 18 and older from the CMS Chronic Condition Data Warehouse (CCW) and Medicaid Analytic eXtract (MAX) files. As the Medicare claims data do not include Medicare spending on managed care, payments to Medicare Advantage plans were added to the linked file. The MAX files include Medicaid managed care capitation payments. The spending information does not include Medicaid Buy-In payments for Medicare Part B premiums nor any Medicare or Medicaid payments made outside of the claims processing system (with the exception of the payments to Medicare Advantage plans). All Medicaid expenditure amounts presented in the National Summary include both the State and Federal share.

Another limitation relates to the types of chronic conditions available in the CCW at the time the National Summary was developed as they did not include a range of mental health or developmental conditions. Newly proposed mental health, substance abuse, HIV/AIDS, and developmental conditions are under development to be added to the CCW. The addition of these conditions, which disproportionately affect Medicare-Medicaid enrollees under age 65, will make age-adjusted analyses of the prevalence of chronic conditions more robust.

A significant limitation of the linked analytic file is that it does not contain Medicare or Medicaid managed care encounter records. These records document utilization of, and sometimes spending on, services provided through managed care programs. Accordingly, for states with significant Medicare and/or Medicaid managed care enrollment, findings that are based solely on fee-for-service claims experience must be interpreted with caution as they may not be representative of the entire beneficiary population. If Full Benefit Medicare-Medicaid enrollees' participation in Medicare or Medicaid managed care was 35% or higher, the State's data was excluded and the National Summary figures affected by managed care enrollment were noted accordingly.

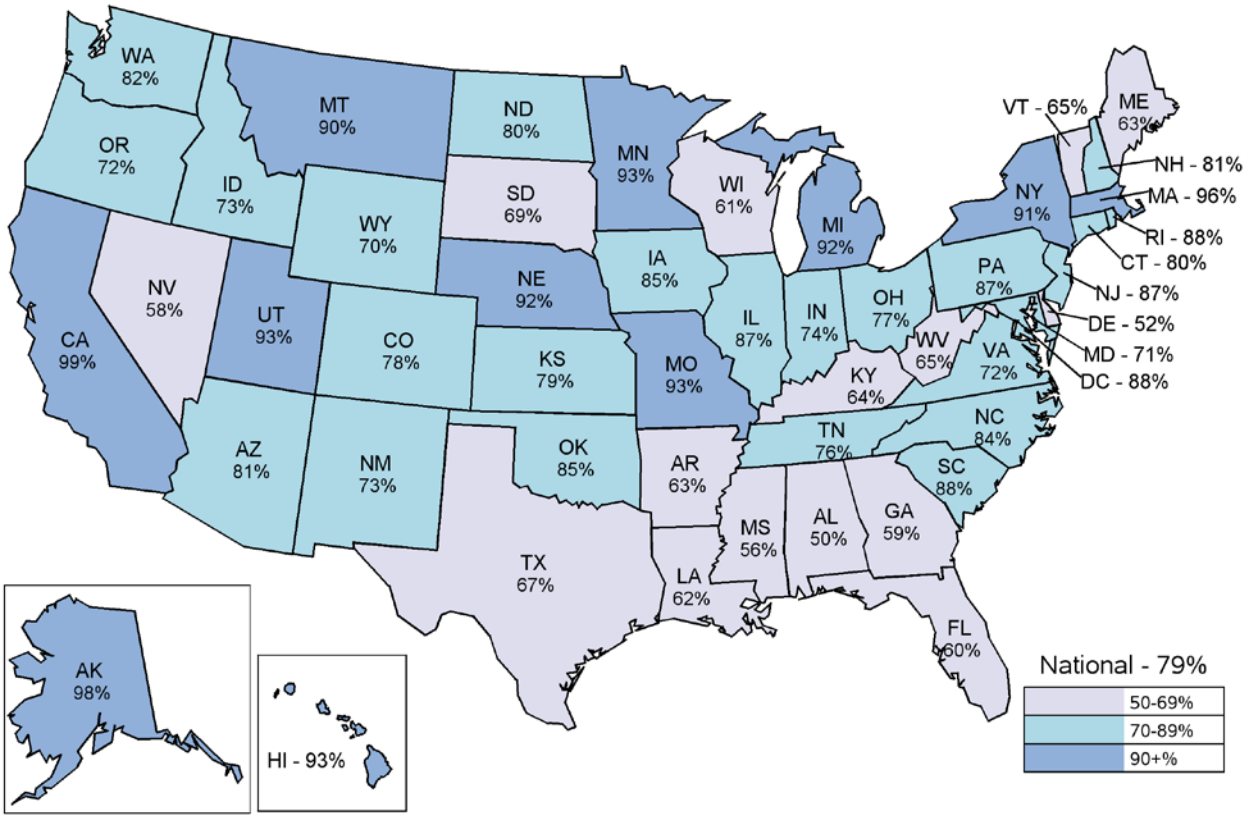
For more information, the *Medicare-Medicaid Linked Analytic File Methodological Summary* at http://www.integratedcareresourcecenter.com/icmstateprofiles.aspx provides a detailed description of the methodology used to produce the linked analytic file, the criteria used to define populations, data caveats, and limitations. This includes the understanding developed as a result of this analytic effort of some limitations of using MSIS data to identify dual eligible beneficiaries. In future analytical efforts this limitation can be addressed by shifting to State MMA file reported dual status.

Types and Ages of Medicare-Medicaid Enrollees

There were about 9 million Medicare-Medicaid enrollees in 2007. Based on the level of benefit they receive from Medicaid, Medicare-Medicaid enrollees may be grouped into 3 categories:

- **Full Benefit** enrollees receive the full array of Medicaid benefits available in the State;
- Qualified Medicare Beneficiaries (QMBs) are **Partial Benefit** enrollees who receive assistance from Medicaid to pay their Medicare premiums and cost sharing obligations;
- Specified Low Income Medicare Beneficiaries (SLMBs), Qualified Individuals (QIs) and Qualified Disabled and Working Individuals (QDWIs) are **Partial Benefit** enrollees who receive assistance from Medicaid to pay Medicare premiums only.

FIGURE 2.1. PERCENT OF MEDICARE-MEDICAID ENROLLEES WHO WERE FULL BENEFIT ENROLLEES, 2007



Nationally, 79% of Medicare-Medicaid enrollees were Full Benefit enrollees in 2007. As shown in Figure 2.1, the percentage varied significantly across the States, ranging from 50% in Alabama to 99% in California. This variation occurs because State eligibility rules affect whether or not a person qualifies for full Medicaid benefits. For example, in Alabama, an older person may qualify for full Medicaid benefits with income up to 75% of the Federal Poverty Level, whereas in California, an older person may qualify with income up to 100% of the Federal Poverty Level.

Nationally in 2007, 60% of Full Benefit enrollees were 65 years of age or older, and 40% were under 65. These two groups follow distinct pathways to becoming Medicare-Medicaid enrollees. Most Medicare-Medicaid enrollees under 65 became eligible for Medicaid due to a disability, and became eligible for Medicare 24 months after qualifying for Social Security Disability Insurance benefits. Most older persons qualify for Medicare upon turning 65. If they also are low-income, they may qualify for Medicaid at that time. If they do not meet Medicaid eligibility rules upon turning 65, they may become eligible for Medicaid after using resources for long-term services and supports or medical needs.

FIGURE 2.2. AGE DISTRIBUTION OF FULL BENEFIT MEDICARE-MEDICAID ENROLLEES, 2007

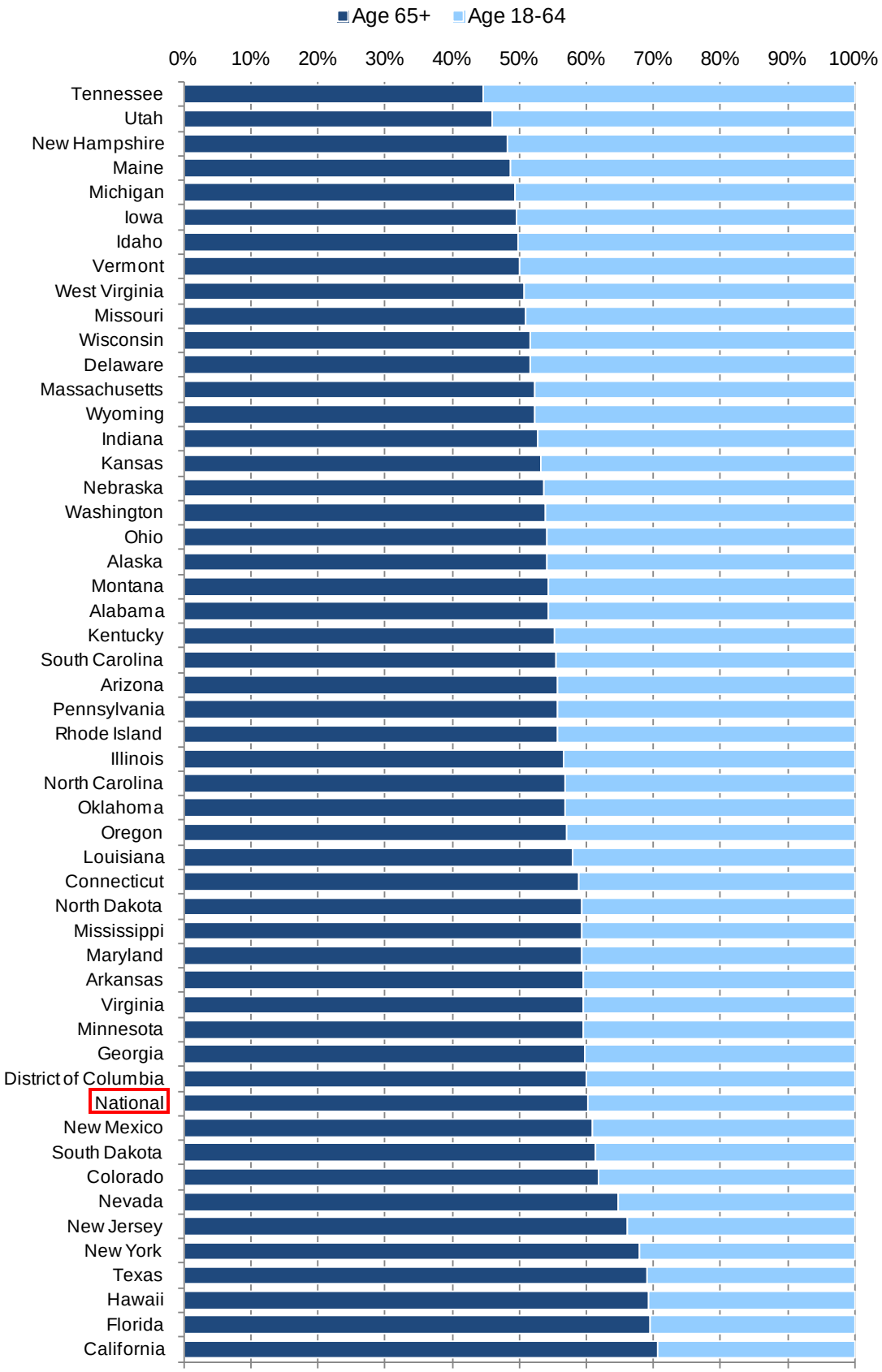
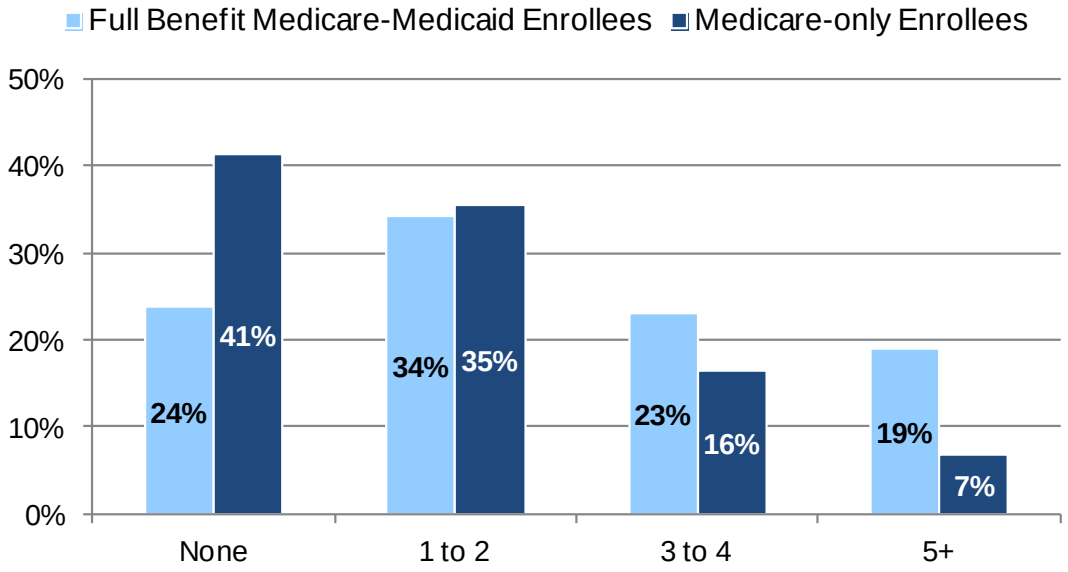


Figure 2.2 shows that the size of each age group varied across States in 2007. Tennessee had the lowest percentage of Medicare-Medicaid Enrollees who were 65 years and older, at 45%. California had the largest at 71%. The age composition of Medicare-Medicaid enrollees is affected by State eligibility rules, demographics, disability rates and other factors.

Chronic Conditions

Medicare-Medicaid enrollees were more likely to have chronic conditions than Medicare-only beneficiaries in 2007. Figures 3.1 through 3.5 are based upon analyses of claims data; some differences among States could be due to coding differences.

FIGURE 3.1. PERCENT OF FULL BENEFIT MEDICARE-MEDICAID ENROLLEES AND MEDICARE-ONLY ENROLLEES WITH CHRONIC CONDITIONS, 2007

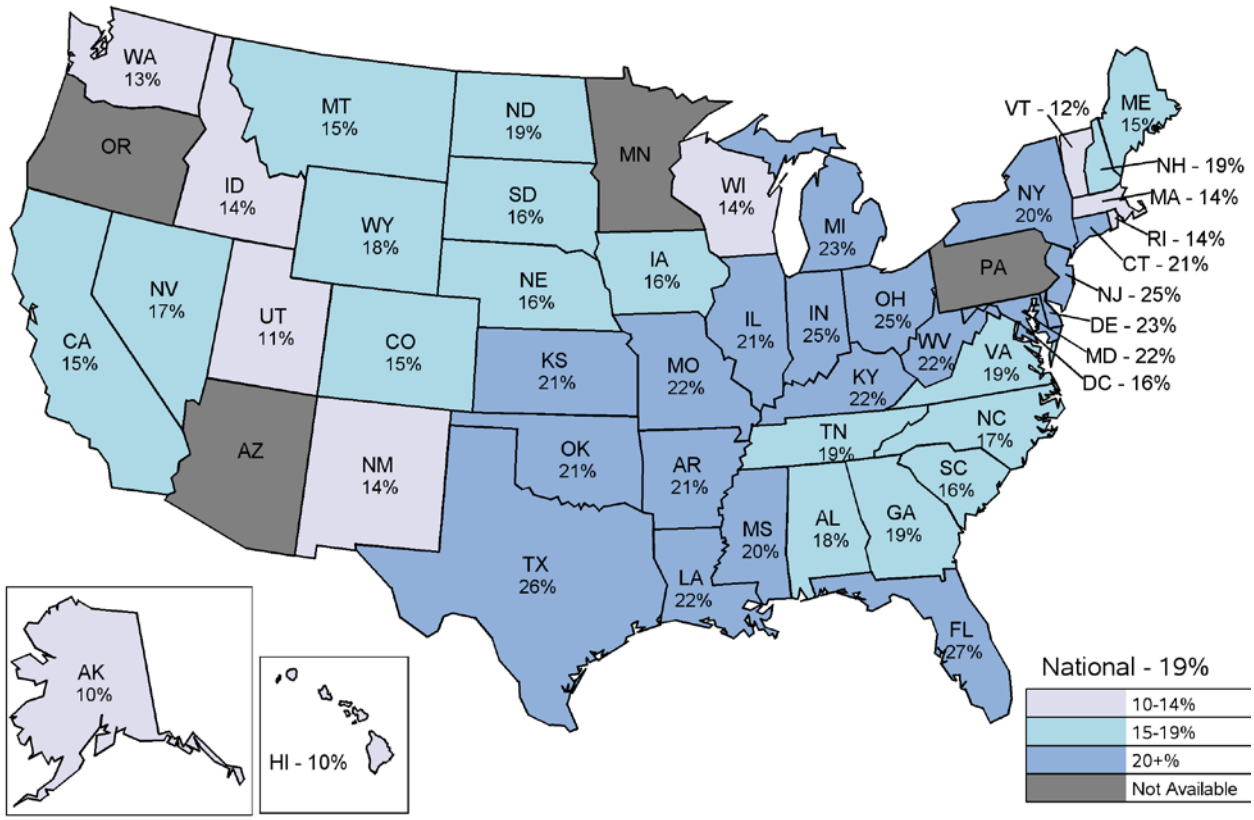


Findings related to chronic conditions were not age-adjusted. At the time the National Summary was developed, the data source did not capture the range of mental health or developmental conditions, which disproportionately affect the age 18 - 64 Medicare-Medicaid enrollee population.

Figure 3.1 shows that 24% of Full Benefit Medicare-Medicaid enrollees had no chronic conditions, compared to 41% of Medicare-only enrollees. In addition, 19% of Full Benefit Medicare-Medicaid enrollees had 5 or more chronic conditions, compared to 7% of Medicare-only enrollees.

The number of chronic conditions among Full Benefit Medicare-Medicaid enrollees varied by State in 2007.

FIGURE 3.2. PERCENT OF FULL BENEFIT MEDICARE-MEDICAID ENROLLEES WITH 5 OR MORE CHRONIC CONDITIONS, 2007

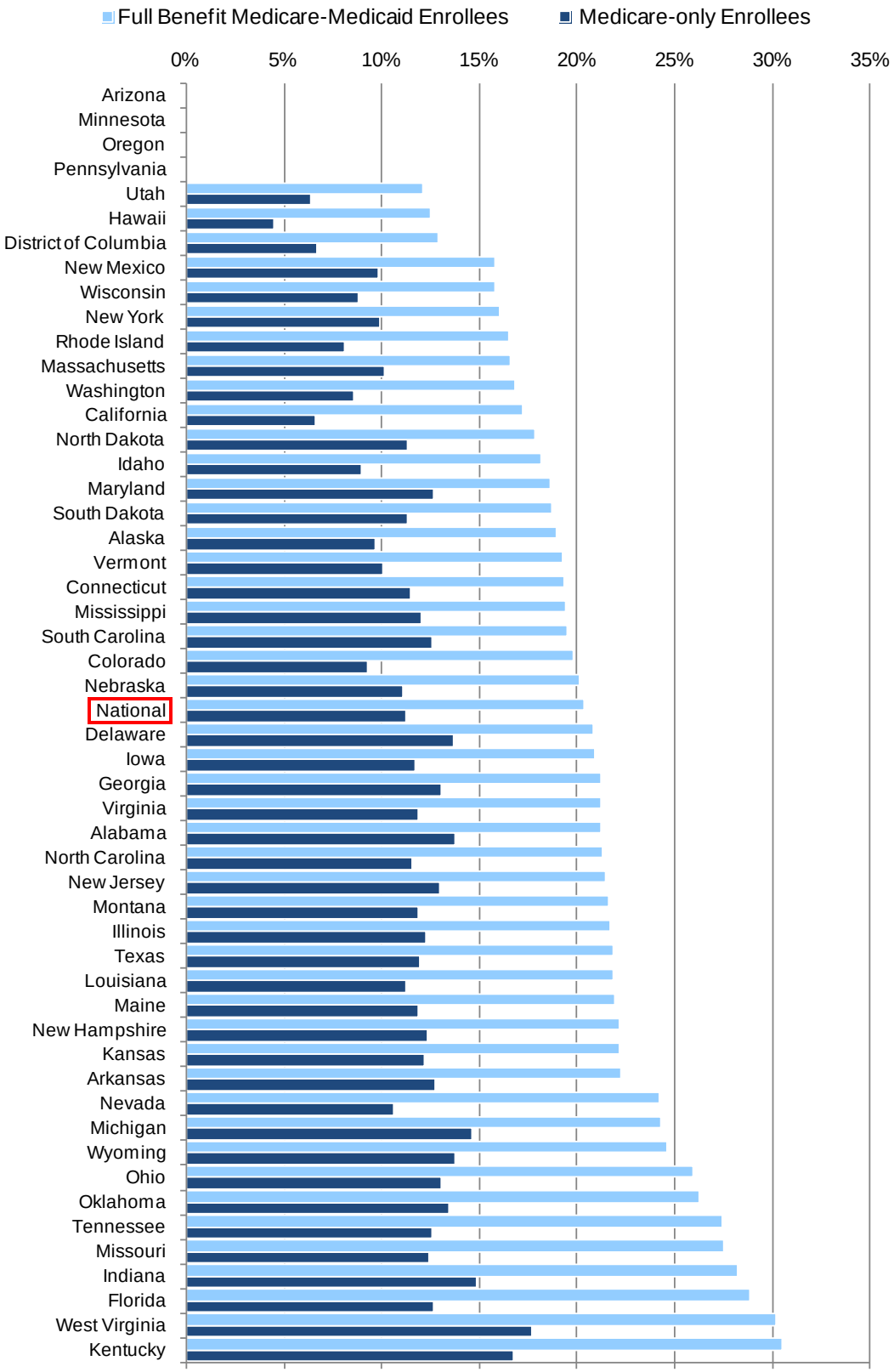


Arizona, Minnesota, Oregon and Pennsylvania were excluded because Full Benefit Medicare-Medicaid enrollees' participation in Medicare Advantage was 35% or higher.

Figure 3.2 shows that Alaska and Hawaii had the lowest percentage of full Benefit Medicare-Medicaid enrollees with 5 or more chronic conditions, at 10%, while Florida had the highest, at 27%. Differences in health status across States may be due to socio-economic factors, migration patterns and differences in how chronic conditions are reported.

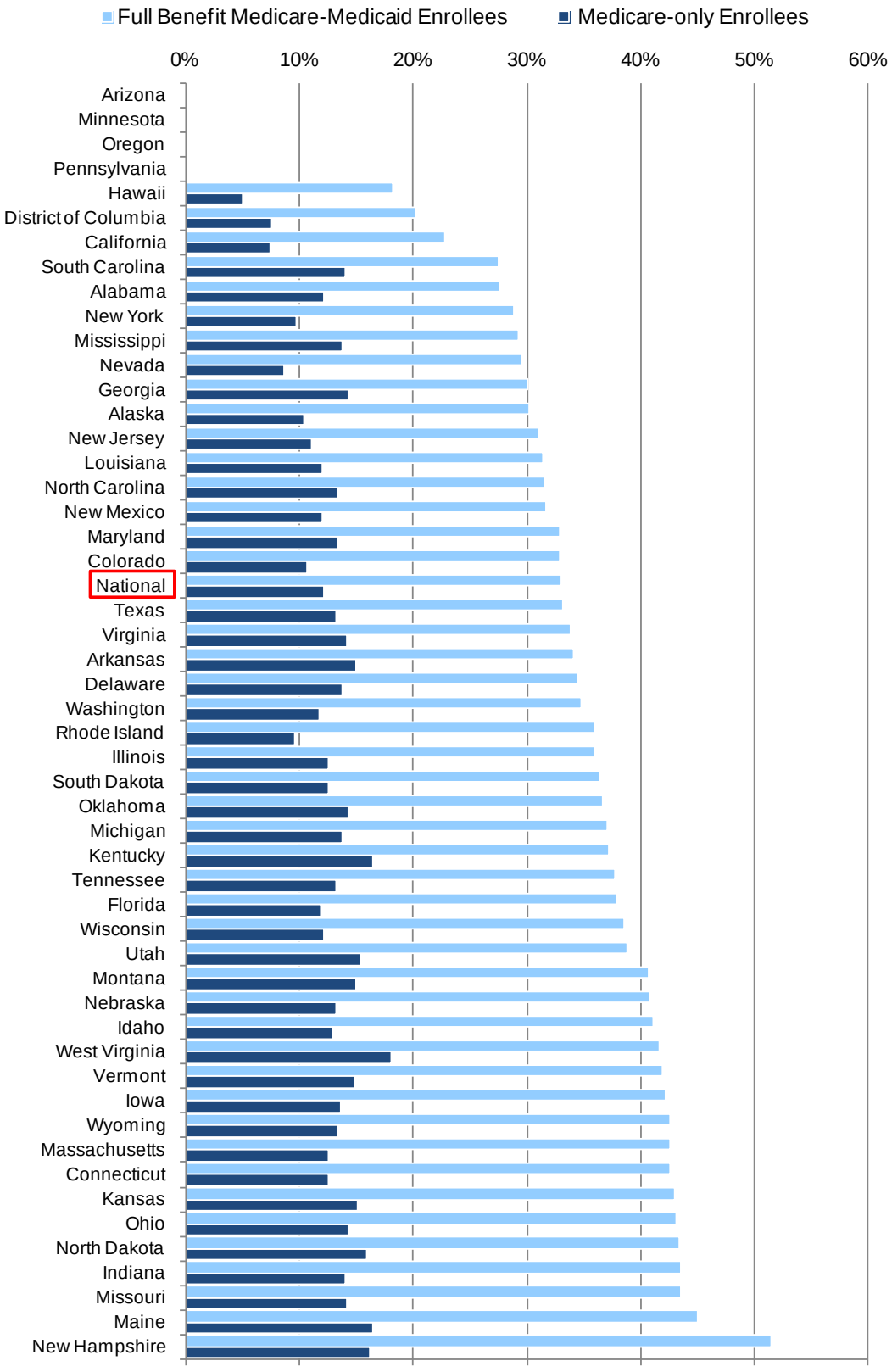
Full-Benefit Medicare-Medicaid enrollees also are more likely to have any single chronic condition than Medicare-only enrollees are.

FIGURE 3.3. PERCENT OF FULL BENEFIT MEDICARE-MEDICAID ENROLLEES AND MEDICARE-ONLY ENROLLEES WITH COPD, 2007



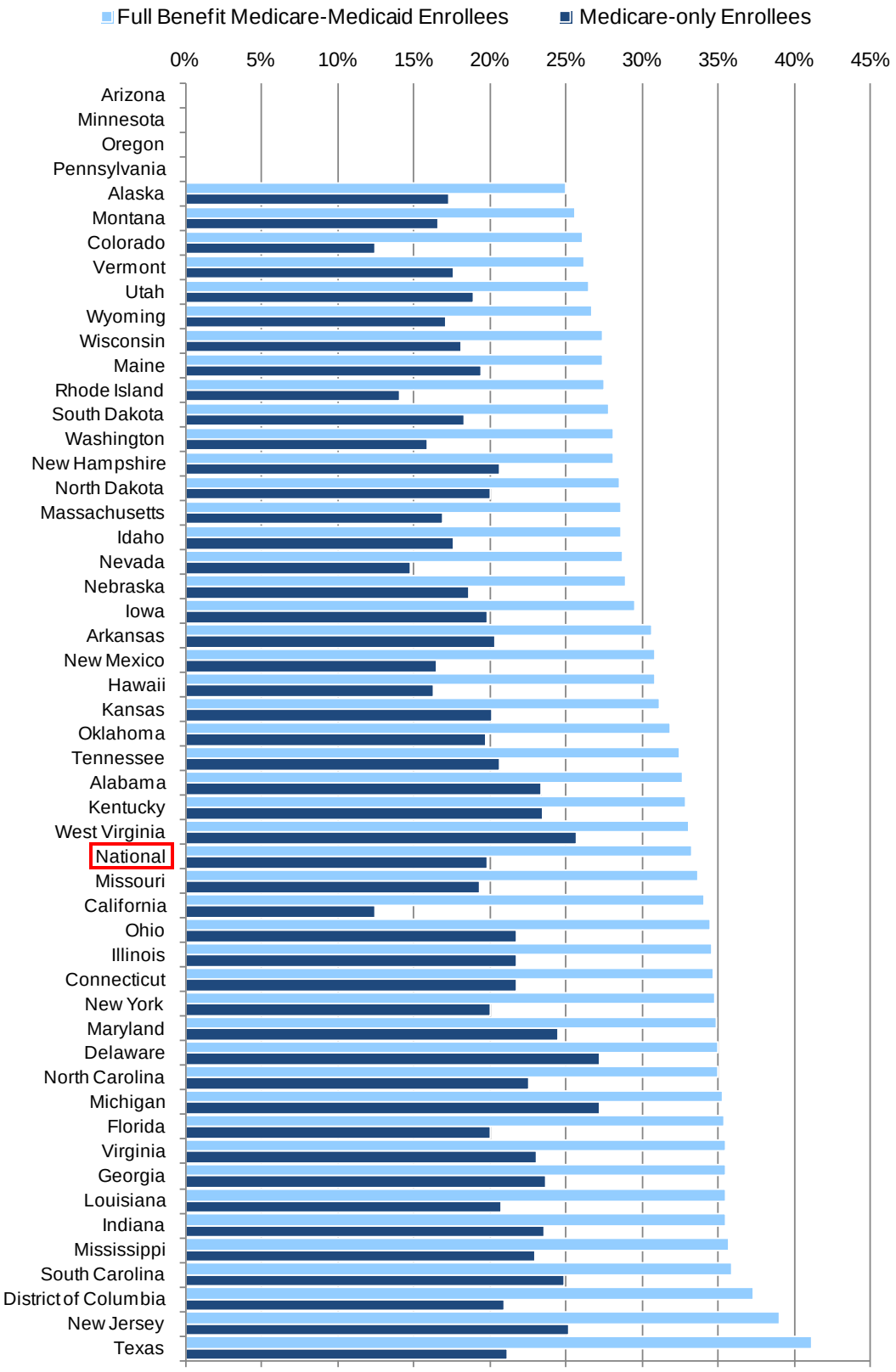
Arizona, Minnesota, Oregon and Pennsylvania were excluded because Full Benefit Medicare-Medicaid enrollees' participation in Medicare Advantage was 35% or higher.

FIGURE 3.4. PERCENT OF FULL BENEFIT MEDICARE-MEDICAID ENROLLEES AND MEDICARE-ONLY ENROLLEES WITH DEPRESSION, 2007



Arizona, Minnesota, Oregon and Pennsylvania were excluded because Full Benefit Medicare-Medicaid enrollees' participation in Medicare Advantage was 35% or higher.

FIGURE 3.5. PERCENT OF MEDICARE-MEDICAID ENROLLEES AND MEDICARE-ONLY ENROLLEES WITH DIABETES, 2007



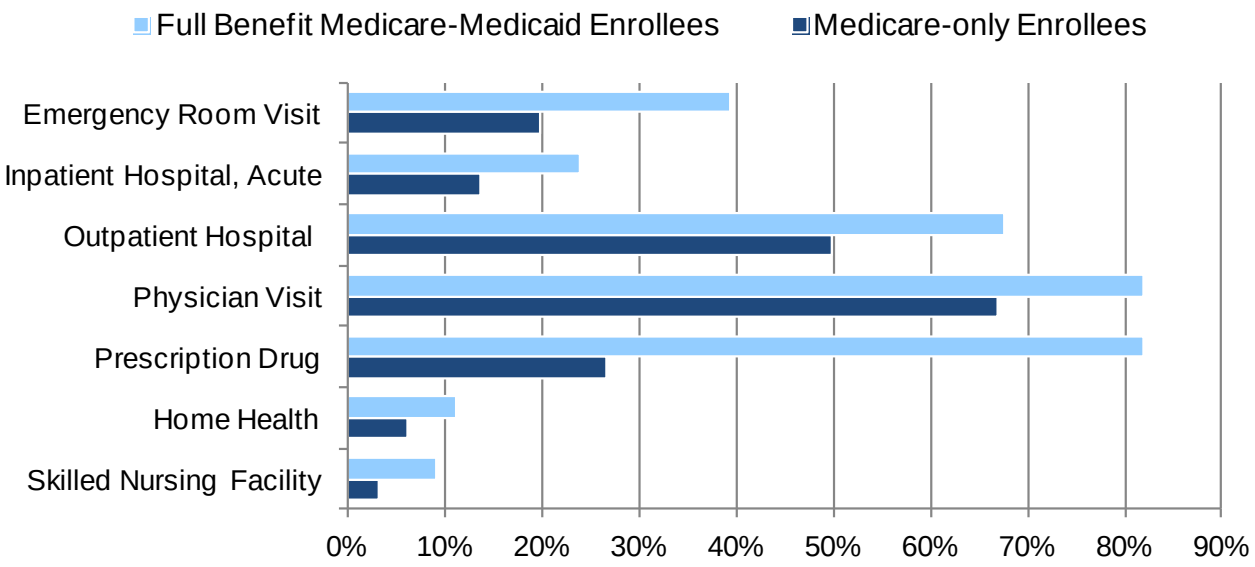
Arizona, Minnesota, Oregon and Pennsylvania were excluded because Full Benefit Medicare-Medicaid enrollees' participation in Medicare Advantage was 35% or higher.

Figures 3.3, 3.4 and 3.5 show that this was true for chronic obstructive pulmonary disease (COPD), depression and diabetes in 2007. Note that the specific differences across States varies by condition. This may be due to occupational and environmental factors and differences in how chronic conditions are reported.

Utilization

In 2007, Full Benefit Medicare-Medicaid enrollees were more likely than Medicare-only enrollees to use every type of Medicare health service.

FIGURE 4.1. PERCENTAGE OF FEE-FOR-SERVICE FULL BENEFIT MEDICARE-MEDICAID ENROLLEES AND MEDICARE-ONLY ENROLLEES USING SELECT MEDICARE HEALTH SERVICES, 2007

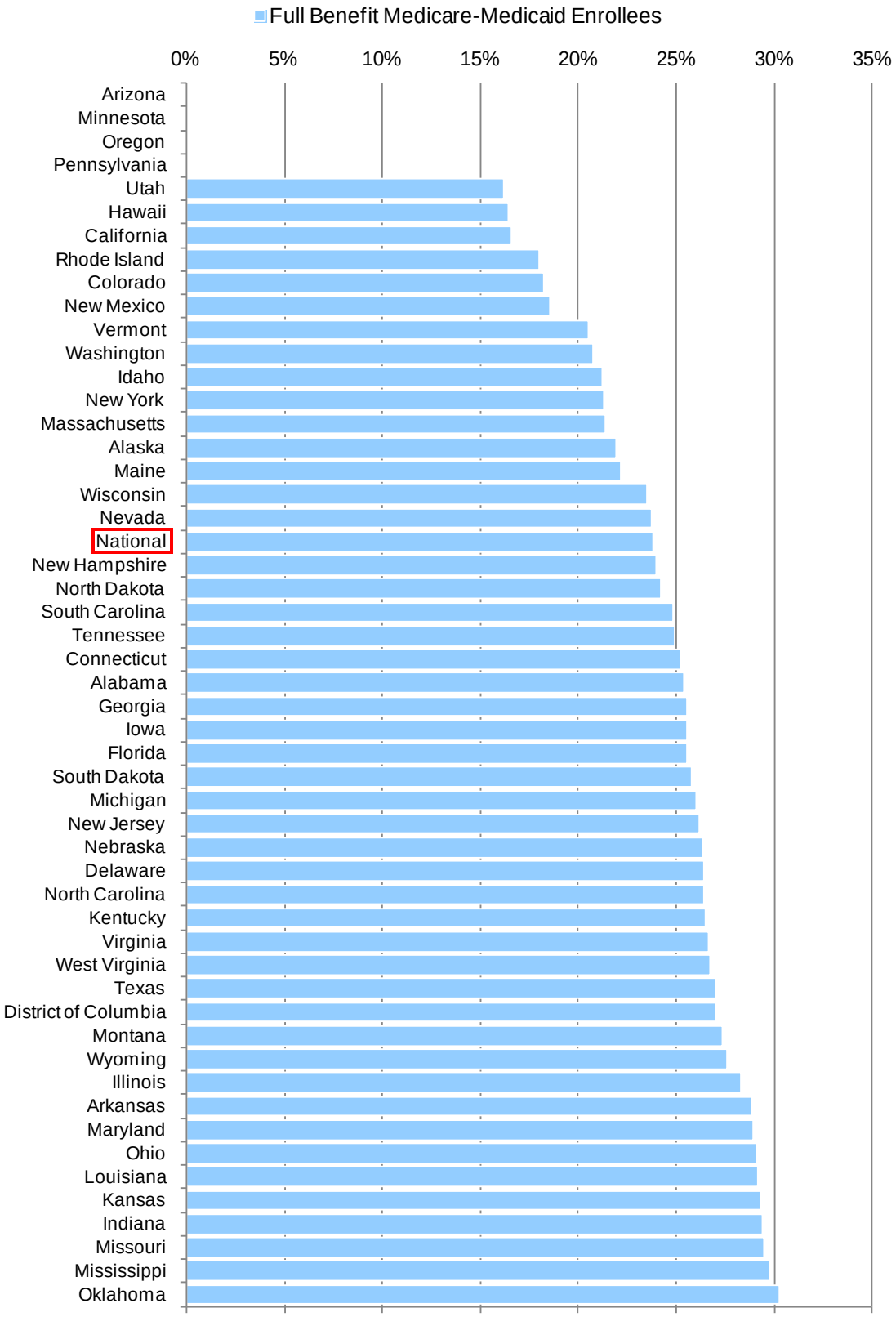


Arizona, Minnesota, Oregon and Pennsylvania were excluded from this national calculation because Full Benefit Medicare-Medicaid enrollees' participation in Medicare Advantage was 35% or higher.

Figure 4.1 shows that when compared with Medicare-only enrollees, a greater percentage of Full Benefit Medicare-Medicaid enrollees used skilled nursing facility, home health, prescription drugs, physician services, outpatient and acute inpatient hospital and emergency room services.

There was variation across States in the use of services in 2007.

FIGURE 4.2. PERCENTAGE OF FEE-FOR-SERVICE FULL BENEFIT MEDICARE-MEDICAID ENROLLEES USING INPATIENT HOSPITAL SERVICES, 2007

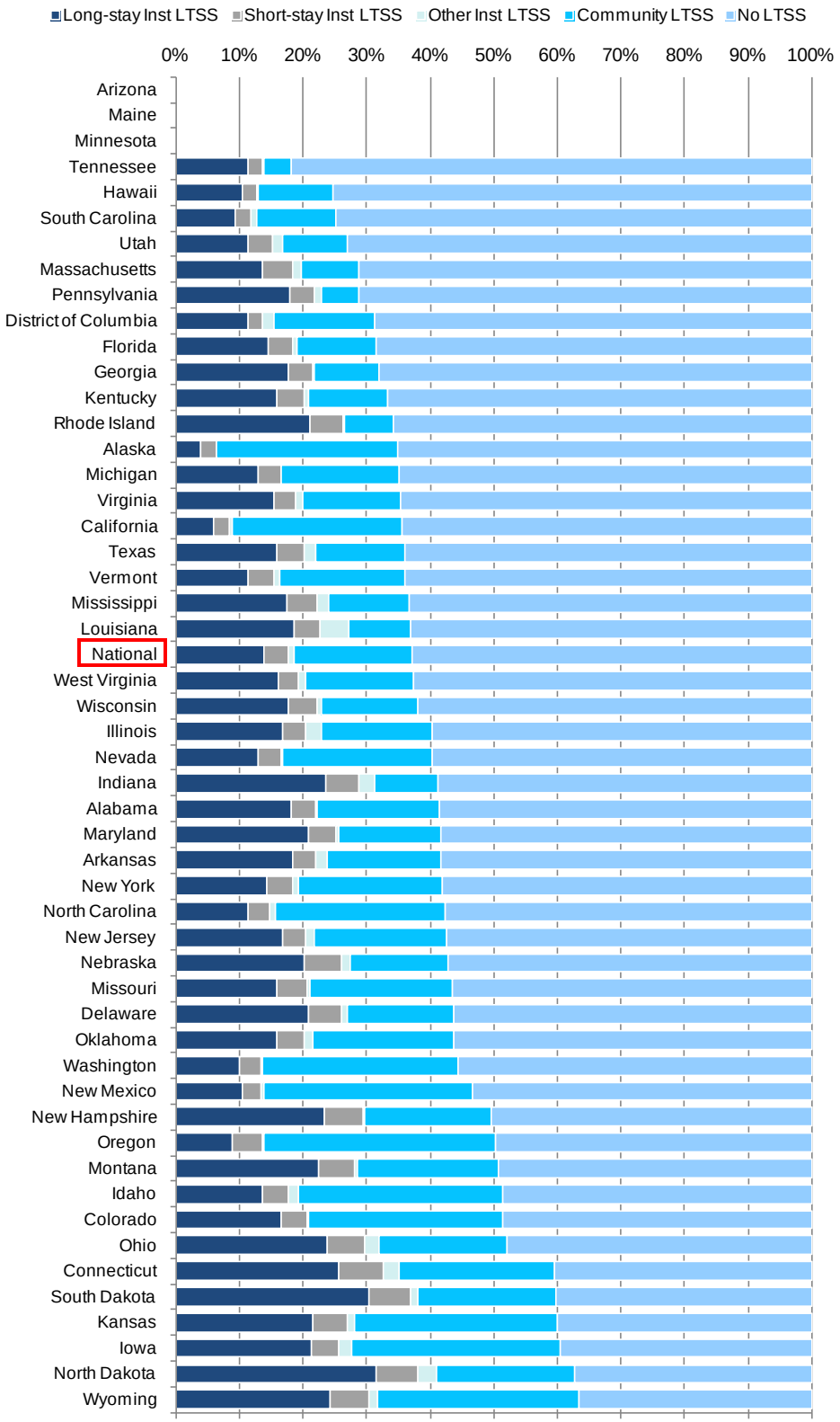


Arizona, Minnesota, Oregon and Pennsylvania were excluded because Full Benefit Medicare-Medicaid enrollees' participation in Medicare Advantage was 35% or higher.

Figure 4.2 shows that the percentage of Full Benefit Medicare-Medicaid enrollees using inpatient hospital services ranged from 16% in Hawaii and Utah to 30% in Mississippi and Oklahoma. Differences in hospital utilization could be affected by acuity of the population, availability of hospitals, availability of alternatives to hospitals, and local practice patterns.

States also were varied in the use of long term services and supports (LTSS) among Full Benefit Medicare-Medicaid enrollees in 2007.

FIGURE 4.3. PERCENTAGE OF FEE-FOR-SERVICE FULL BENEFIT MEDICARE-MEDICAID ENROLLEES USING MEDICAID-FUNDED LTSS, 2007



Arizona and Minnesota were excluded because Full Benefit Medicare-Medicaid enrollees' participation in Medicaid managed care program covering LTSS was 35% or higher. Maine was excluded due to issues with the State's Medicaid claims processing system in 2007.

Figure 4.3 shows that a low of 18% used any type of LTSS in Tennessee, to a high of 63% in Wyoming. A low of 4% used institutional services for 90 days or more in Alaska, to a high of 31% in North Dakota.

Spending

Corresponding to their high likelihood of service use, Full Benefit Medicare-Medicaid enrollees have high Medicare and Medicaid expenditures.

FIGURE 5.1. AVERAGE MONTHLY EXPENDITURES PER PERSON, TOTAL EXPENDITURES BY ENROLLMENT STATUS, 2007

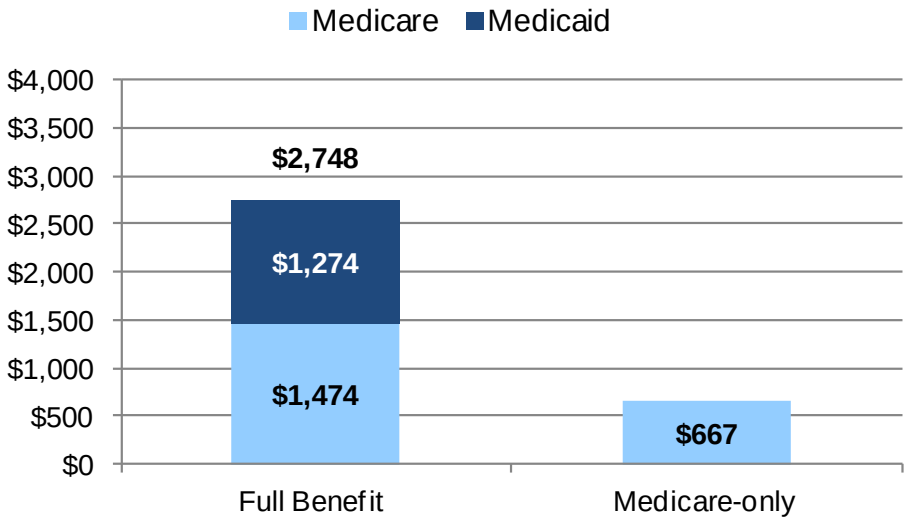
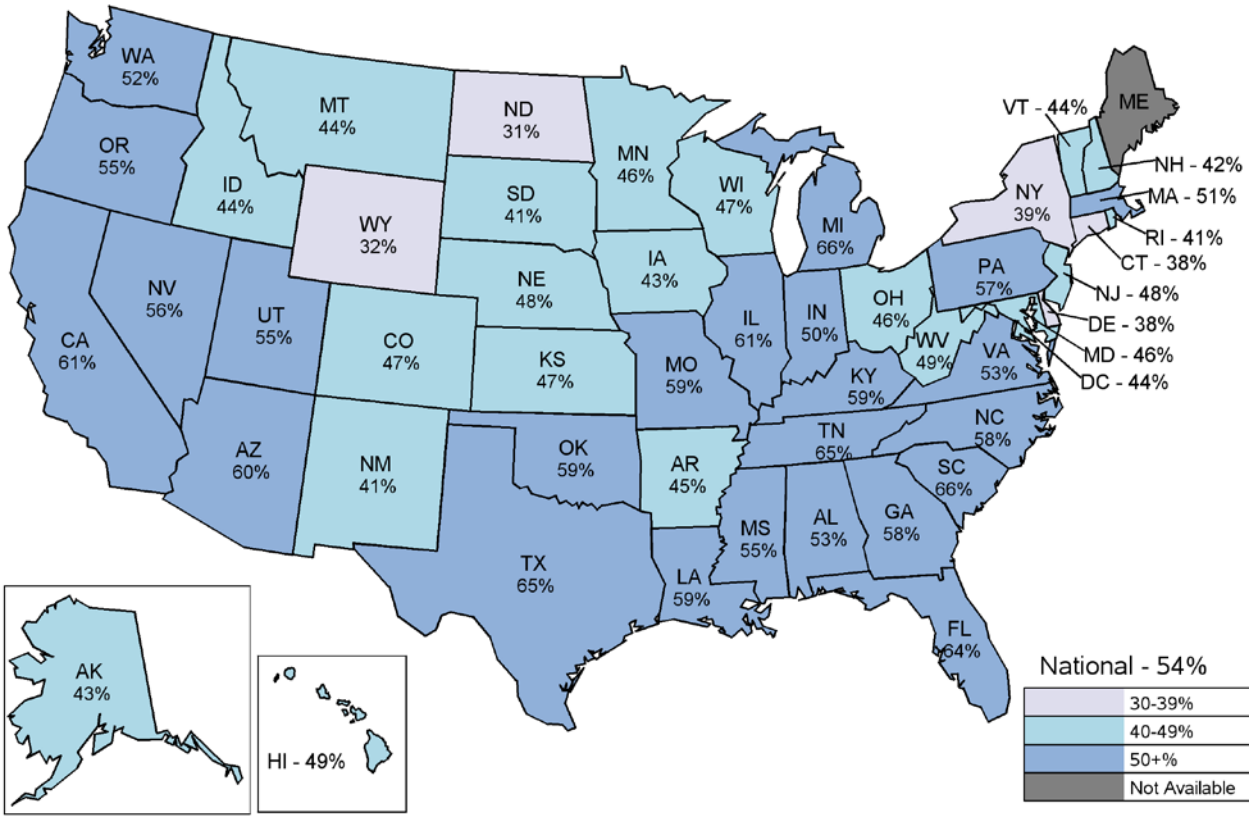


Figure 5.1 shows that in 2007, Medicare monthly expenditures per person averaged $1474 for Full Benefit Medicare-Medicaid enrollees versus $667 for Medicare-only enrollees. In addition, Full Benefit Medicare-Medicaid enrollees had average monthly Medicaid expenditures of $1274 per person, for total combined expenditures of $2748, more than four times as much as expenditures for Medicare-only enrollees.

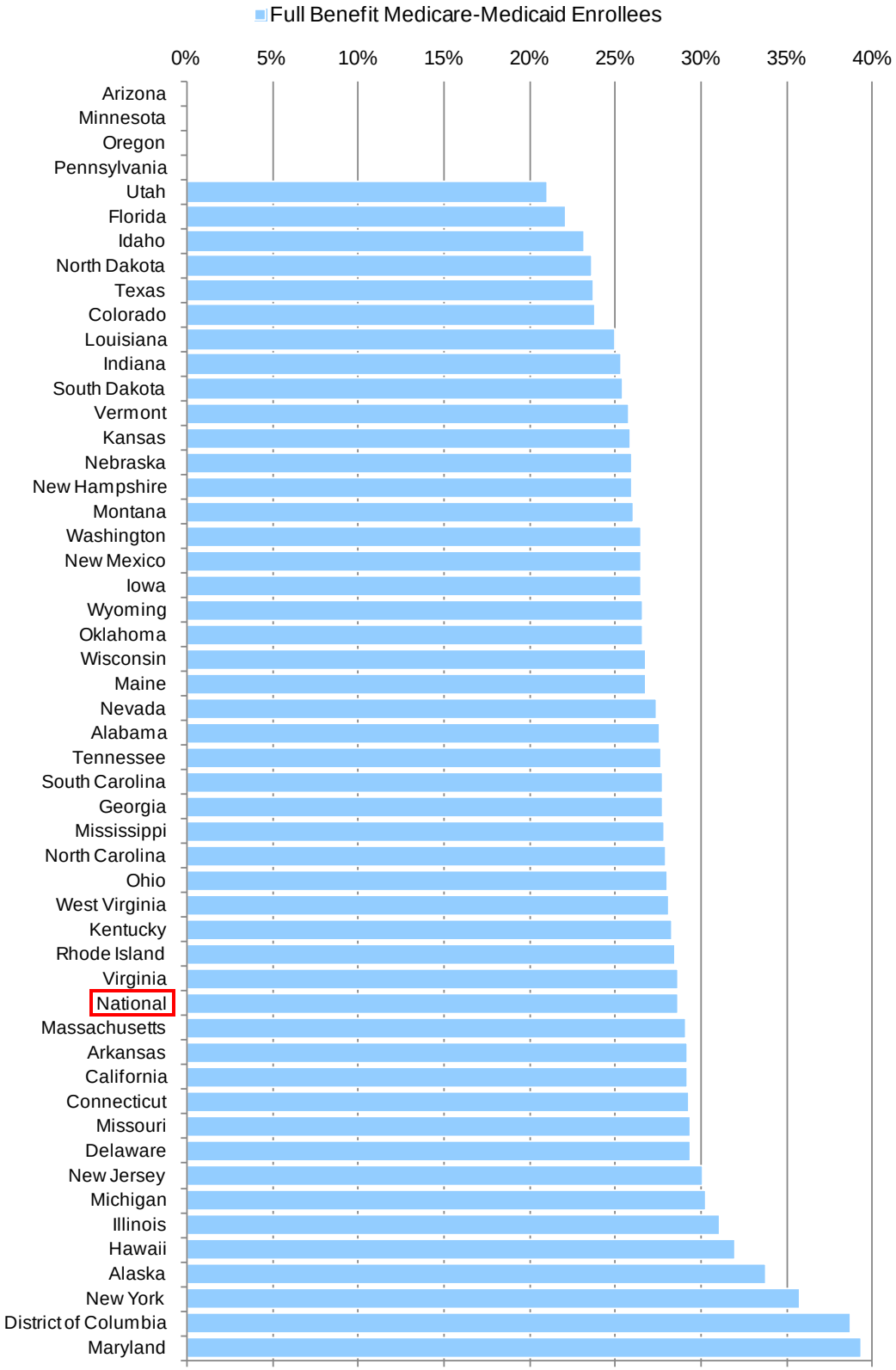
FIGURE 5.2. MEDICARE EXPENDITURES AS A PERCENT OF TOTAL EXPENDITURES FOR FULL BENEFIT MEDICARE-MEDICAID ENROLLEES, 2007



Maine was excluded from this analysis because of issues with the State's Medicaid claims processing system in 2007.

Nationally, 54% of total expenditures for Full Benefit Medicare-Medicaid enrollees were Medicare expenditures, and 46% were Medicaid expenditures. This varied significantly across the States, as shown in Figure 5.2. Medicare expenditures as a percent of total expenditures for Full Benefit Medicare-Medicaid enrollees were highest in Michigan and South Carolina, at 66%, and lowest in North Dakota, at 31%. This may be related to differences in Medicaid benefits, Medicaid and Medicare payment rates, and practice patterns across States.

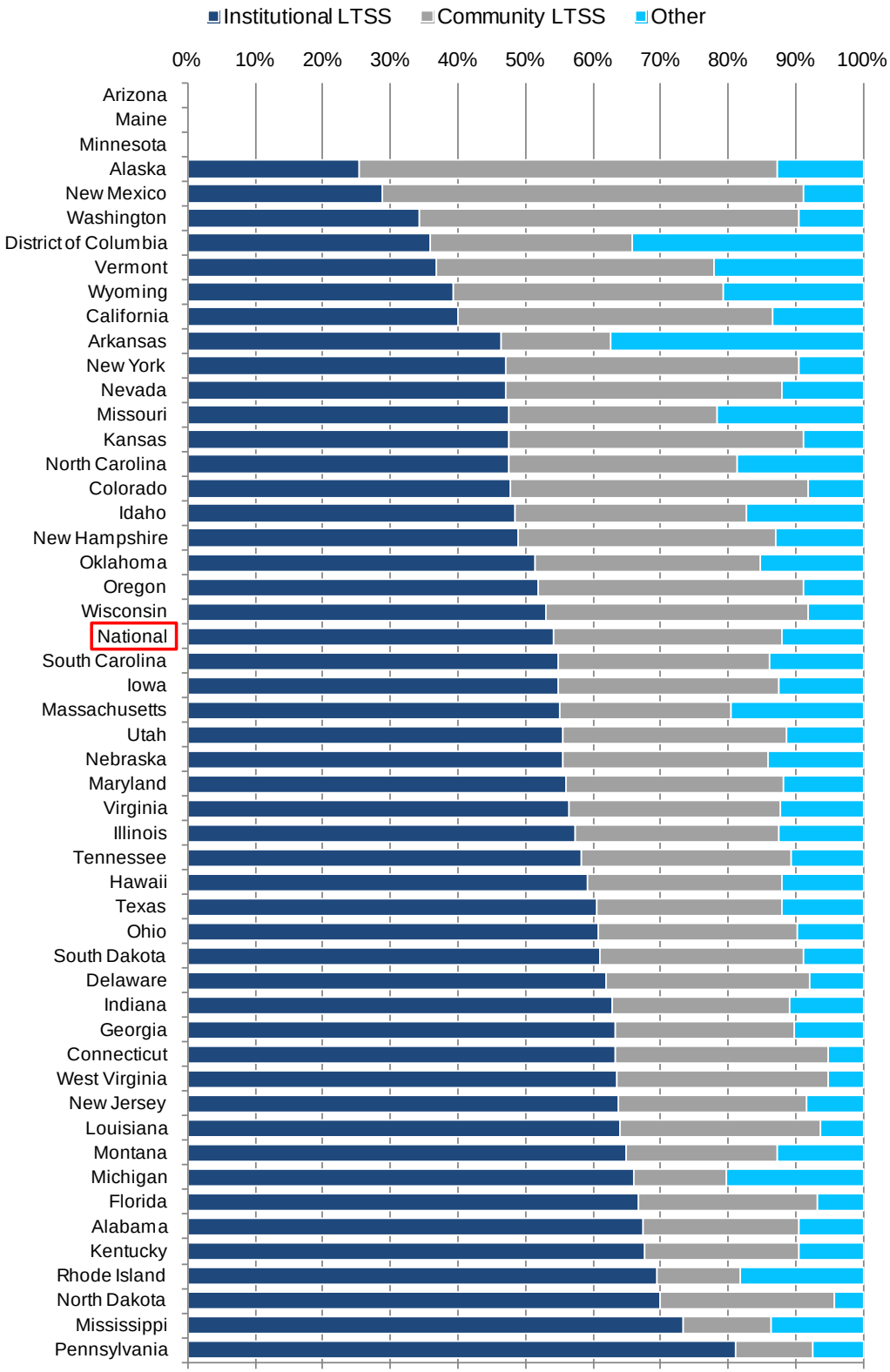
FIGURE 5.3. INPATIENT HOSPITAL SPENDING AS A PERCENT OF FEE-FOR-SERVICE MEDICARE SPENDING FOR FULL BENEFIT MEDICARE-MEDICAID ENROLLEES, 2007



Arizona, Minnesota, Oregon and Pennsylvania were excluded because Full Benefit Medicare-Medicaid enrollees' participation in Medicare Advantage was 35% or higher.

Nationally in 2007, the largest portion of fee-for-service Medicare expenditures for Full Benefit Medicare-Medicaid enrollees was for inpatient hospital services, at 29%. Figure 5.3 shows the variation in this percentage across States, from a low of 21% in Utah, to a high of 39% in the District of Columbia and Maryland.

FIGURE 5.4. PERCENT OF FEE-FOR-SERVICE MEDICAID SPENDING FOR FULL BENEFIT MEDICARE-MEDICAID ENROLLEES, BY CATEGORY OF SERVICE, 2007



Arizona and Minnesota were excluded because Full Benefit Medicare-Medicaid enrollees' participation in a Medicaid managed care program covering LTSS was 35% or higher. Maine was excluded due to issues with the State's Medicaid claims processing system in 2007.

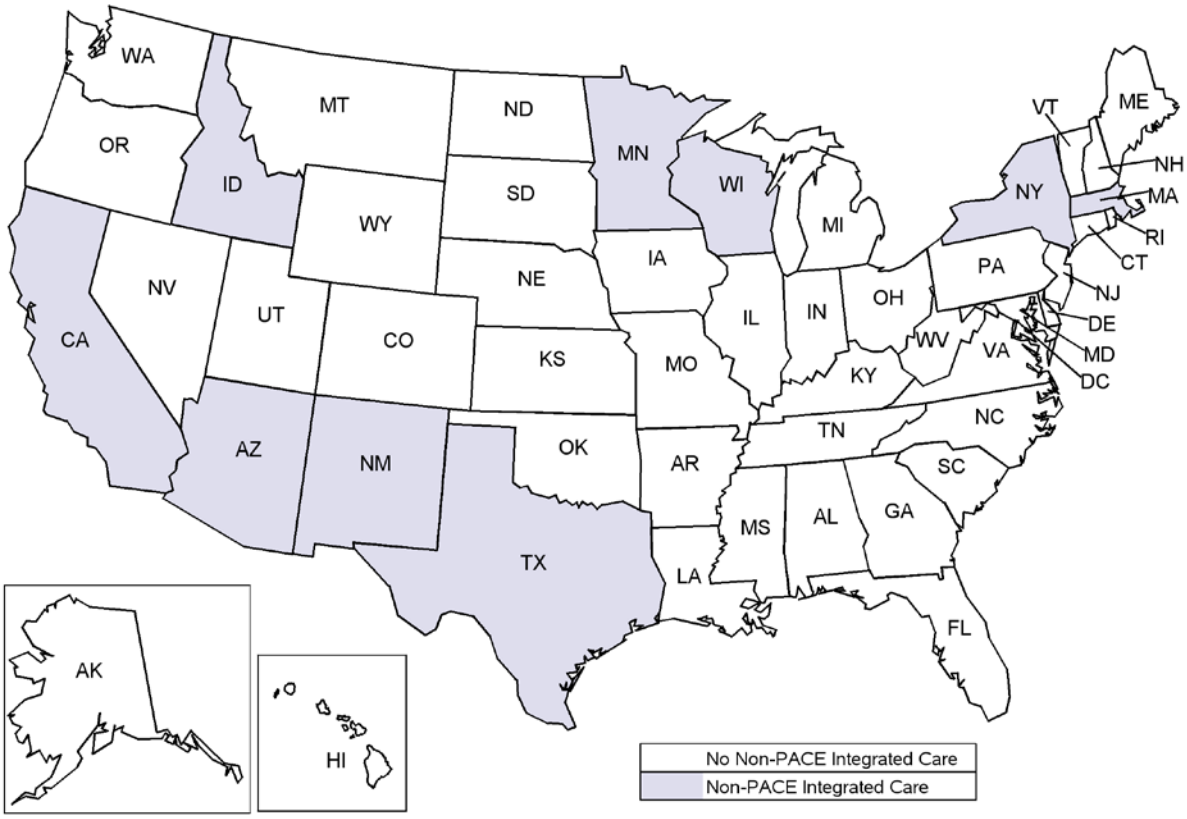
Nationally in 2007, the largest portion of fee-for-service Medicaid expenditures for Full Benefit Medicare-Medicaid enrollees was for institutional long term services, at 53%. Institutional services are primarily nursing facilities but may also include ICF-MR facilities and psychiatric facilities for older persons. Figure 5.4 shows the variation in this percentage across States, from a low of 25% in Alaska to a high of 81% in Pennsylvania.

Participation in Integrated Medicare-Medicaid Programs, 2011

For the purposes of this analysis, integrated Medicare-Medicaid programs are defined as those designed by states or counties, outside of PACE, to enable Medicare-Medicaid Enrollees to receive most or all of their Medicare and Medicaid services through a single entity that is accountable for the quality and cost of those services. Further, these programs promote integration by requiring participating plans to offer a companion Medicare Advantage product.

There are other programs and circumstances in which a health plan offers both Medicare and Medicaid products within the same market. Those are not identified as integrated Medicare and Medicaid programs because they are not required to be offered as part of an integrated program contract.

FIGURE 6.1. STATES WITH INTEGRATED MEDICARE-MEDICAID PROGRAMS OTHER THAN PACE, 2011



Source: Thomson Reuters, 2011.

Figure 6.1 shows the 9 States that offered integrated Medicare-Medicaid programs in 2011 as previously defined. The percentage of Medicare-Medicaid Enrollees in such programs was not available but varies significantly by State.

Conclusion

Medicare-Medicaid enrollees have high rates of chronic conditions and functional impairments, making them high users of both the medical and long-term services and supports systems. They use all categories of service, yet remain largely in fee-for-service programs, where they are less likely to receive comprehensive coordination of their care.

Medicare-Medicaid enrollees are an important group in every State, but spending, utilization, and service delivery vary significantly across States. Differences stem from State Medicaid policy, practice patterns among providers, availability of services, environmental health factors, and socio-economic conditions. As States and CMS work on new models for integrating care, each State presents its own unique opportunities to improve care for Medicare-Medicaid enrollees.