CHAPTER 3

The Roles of Medicare and Medicaid for a Diverse Dual-Eligible Population

Key Points

The Roles of Medicare and Medicaid for a Diverse Dual-Eligible Population

- Persons dually eligible for Medicare and Medicaid are a diverse population, with widely varying care needs and patterns of Medicare and Medicaid service use and spending.
- Among all-year, full-benefit dual eligibles in 2007, 59 percent used no Medicaid long-term services and supports (LTSS) and 41 percent used some LTSS, including 19 percent who used institutional services, 10 percent who used Medicaid home and community-based waiver services as an alternative to institutionalization, and 11 percent who used Medicaid state-plan LTSS only.
- Average annual Medicare and Medicaid spending varied widely across these four groups, from $70,000 for people who used institutional services in Medicaid to about $15,000 for people who did not use any LTSS.
- Full-benefit dual eligibles who did not use LTSS relied almost exclusively on Medicare. They accounted for 59 percent of all-year, full-benefit dual-eligible enrollees but just 11 percent of Medicaid spending on those dual eligibles. They accounted for 30 percent of Medicare spending on the all-year, full-benefit dual-eligible population, however.
- In contrast, people who needed an institutional level of care (who used Medicaid institutional LTSS or waiver services) relied much more heavily on Medicaid and accounted for the majority of Medicaid spending on all-year, full-benefit dual eligibles (78 percent).
- A variety of approaches will be needed to target solutions to the problems faced by these distinct subgroups with diverse needs, service use, and spending in Medicare and Medicaid.

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Individuals who are dually eligible are low-income seniors and persons with disabilities who are enrolled in both Medicare and Medicaid. In 2011, there were 10.2 million dual eligibles, including 7.5 million people with Medicare who qualified for full Medicaid benefits (full-benefit dual eligibles) and 2.7 million partial-benefit dual eligibles for whom Medicaid provided more limited financial assistance in paying for Medicare premiums or cost sharing (CMS 2013).

The two programs serve distinct roles and together address the needs of a diverse population. For all dual eligibles, Medicare is the primary source of health insurance, covering physician services, inpatient and outpatient hospital care, post-acute care, and prescription drugs. Medicaid fills in gaps in Medicare's coverage, providing financial assistance with Medicare costs for poor and near-poor Medicare beneficiaries, as well as access to services not covered by Medicare, including a wide range of long-term services and supports (LTSS), behavioral health services, vision and dental care, and other wraparound services.

Persons dually eligible for Medicare and Medicaid have been of particular interest to policymakers because they account for a relatively small share of enrollees in each program, but for a disproportionately large share of the expenditures in each. There is also concern that no single entity is responsible for dual eligibles because their care is financed by two separate programs. At times, the two programs appear to work at cross purposes to each other, as there may be incentives for cost shifting that compromise quality of care and raise overall costs. For example, Medicaid costs can be shifted to Medicare when nursing home residents whose care is covered by Medicaid are hospitalized for conditions that could have been managed in the nursing home. Similarly, if post-acute transitions are not properly managed, people who might otherwise have been successfully transitioned from the hospital to the community may instead end up as long-term nursing home residents, increasing costs for Medicaid.

Finally, researchers and health professionals who provide services to dual eligibles point to missed opportunities to provide appropriate, person-centered services that could help prevent predictable consequences of chronic illness and disability, improve health and well-being, and lower overall health care costs (Master 2012, Master and Eng 2001, Whitelaw and Warden 1999). The health care service delivery system does not always meet the needs of people with serious chronic conditions or disabilities who require ongoing care across multiple providers and settings. Too often, health care services for people with chronic illness and disability are fragmented and episodic. These gaps may be problematic for dual eligibles with extensive care needs—and especially for those with limited family and social supports.

Concerns about the quality of care provided to dual eligibles—and about the costs of their care—have prompted growing attention to policy reforms that may improve quality and potentially lower total Medicare and Medicaid costs. The Patient Protection and Affordable Care Act (ACA, P.L. 111–148, as amended) included a number of provisions designed to address policy issues relevant to dual eligibles, establishing a Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) and a Center for Medicare and Medicaid Innovation, both of which are involved in efforts to improve care for dual eligibles (CMS 2011).

Dual eligibles, however, are a diverse group, including people who are young and old, people who are relatively healthy as well as those who are gravely ill, and people who have no disabling or chronic conditions as well as those with significant disabilities who require nearly constant supervision. The diversity of the population is reflected in its widely varying use of services and spending in Medicare and Medicaid, with some people having very high spending, mostly for Medicaid LTSS, and others who are relatively healthy and who have low spending that is covered mostly by Medicare. Variation in needs and patterns of service use suggest that dual-eligible subpopulations likely face different challenges in accessing high-quality care. Consequently, different policy approaches will be needed to address the specific challenges faced by diverse subgroups.

To shed light on how the diversity of the dually eligible population may affect the design of policy solutions, we analyzed service use and spending for Medicare and Medicaid services for four distinct groups. Because LTSS use accounts for the majority of Medicaid spending for dual eligibles, our analysis focuses on four groups defined by their use of LTSS. We focus in this chapter on individuals who are fully eligible for both Medicare and Medicaid. Chapter 4 provides more information on the Medicare Savings Programs (MSPs), which assist low-income Medicare beneficiaries with their premiums and cost sharing but do not provide them with full Medicaid benefits.

This chapter begins with a brief overview of the roles of the Medicare and Medicaid programs for dual eligibles, including the benefits financed under each program and how these benefits address the needs of dually eligible individuals. Next, it provides a profile of dual eligibles' service use and spending across the two programs, focusing on the variation in their health care and supportive service needs—with a particular focus on LTSS in Medicaid. The Commission sees this analysis as an important first step in considering how current policy should be changed, both to address concerns about quality and costs and to ensure that the two programs are aligned to best meet the needs of the beneficiaries they serve.

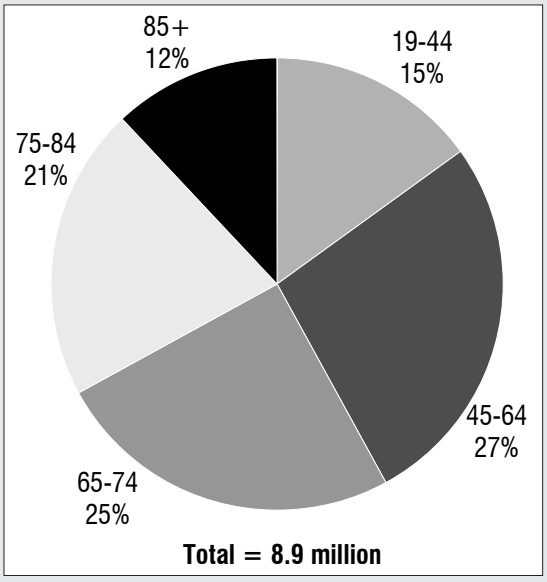
Characteristics of Dual Eligibles

The majority of dually eligible individuals are adults age 65 and older who qualify for Medicare on the basis of their entitlement to a Social Security retirement benefit; other dual eligibles are under age 65 and are enrolled in Medicare as a result of a serious disability.[1] In 2007, 58 percent of dual eligibles were age 65 and older, and 42 percent were under age 65 (Figure 3-1). A far lower percentage of non-dually eligible beneficiaries in Medicare, just 12 percent in 2007, were under age 65 (Coughlin et al. 2012).

Dual eligibles who are 65 and over are often enrolled in Medicare first and then become eligible for Medicaid, typically when they need LTSS, such as care in a nursing home. Other dual eligibles are first enrolled in Medicaid and then become eligible for Medicare when they reach the end of the two-year waiting period for Social Security Disability Insurance (SSDI) benefits, for example.

Because Medicaid's assistance is means-tested, nearly all dually eligible individuals are poor or have very low income and limited financial assets. More than half of all dual eligibles in 2007 (53.4 percent) had an annual income below $10,000 compared to just 8.3 percent of other Medicare beneficiaries (Coughlin et al. 2012).

FIGURE 3-1. Dual Eligibles, by Age, 2007



Note: Children under age 19 are 0.03% of the dually eligible population.

Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

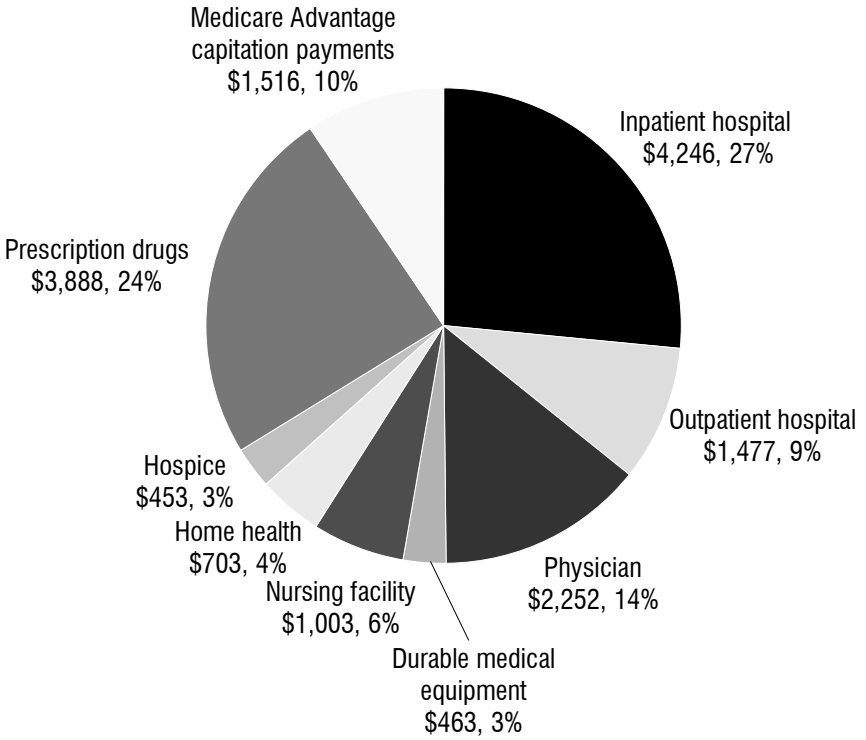
Medicare's Role for Dual Eligibles

For all dual eligibles, Medicare serves as the primary payer for health care services. Medicare provides coverage for medically necessary physician services and outpatient services (through Part B), inpatient hospital services, rehabilitative therapies, home health care, hospice care, and skilled nursing facility (SNF) care (through Part A), as well as coverage for prescription drugs (through Part D). In 2007, Medicare spending per all-year, full-benefit dual eligible averaged about $16,000. Just over half of their average spending was for inpatient hospital services and prescription drugs; roughly a quarter was for physician and outpatient services (Figure 3-2).

Why do people with Medicare need Medicaid?

Medicare has various exclusions and limitations that matter for persons who are frail or have disabilities. Medicare's traditional health insurance benefit package does not meet the needs of many frail adults age 65 and older or of non-aged persons with disabilities, including those with intellectual and developmental disabilities, physical disabilities like quadriplegia, or disabling conditions like cerebral palsy, multiple sclerosis, mental illnesses such as schizophrenia, and severe emotional conditions. For example, Medicare does

FIGURE 3-2. Average Medicare Spending per All-Year, Full-Benefit Dually Eligible Beneficiary, by Type of Service, 2007



Note: Physician spending also includes some other Part B spending, including lab and x-ray.
Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

not cover supportive services, extended home care for people who are frail, long-term custodial nursing home care, hearing aids, vision care, dental care, or non-emergency transportation services. Medicare covers nursing home services only in skilled facilities and only for beneficiaries who have had a minimum three-day prior hospital stay and who have skilled care needs. Medicare covers home health care only for individuals who need skilled care on a part-time or intermittent basis and who are homebound.

Medicare also requires significant contributions from beneficiaries in the form of premiums, coinsurance, and deductibles. For example, in 2013 Medicare beneficiaries pay a deductible of $1,184 for a hospital stay (of under 60 days) and additional cost sharing for longer inpatient stays. Chapter 4 discusses Medicare's cost-sharing requirements in more detail.

Given limits to Medicare's benefits package and substantial cost-sharing requirements, Medicaid plays an important role for dual eligibles in filling gaps and supplementing needed benefits.

How do people with Medicare qualify for Medicaid?

People with Medicare come into Medicaid through different eligibility pathways. Some people with Medicare come into Medicaid via the Medicare Savings Programs (MSPs). Through

the MSPs, Medicaid provides assistance with Medicare premiums and cost sharing to Medicare beneficiaries with very limited income and financial resources—covering out-of-pocket costs that can be unaffordable for the lowest-income people with Medicare. The 2.7 million individuals enrolled only in these programs—who are not otherwise eligible for Medicaid—are considered partial-benefit dual eligibles and are not included in the analysis in this chapter. Chapter 4 provides more information on the MSPs.

Other dually eligible individuals qualify for Medicaid through eligibility pathways that are available to people regardless of their eligibility for Medicare and that provide access to full Medicaid benefits. Some of these pathways are available only to people who are frail or who have serious disabling conditions that meet the standards for nursing home or other long-term institutional care (such as intermediate care facilities for persons with intellectual disabilities (ICFs/ID)).

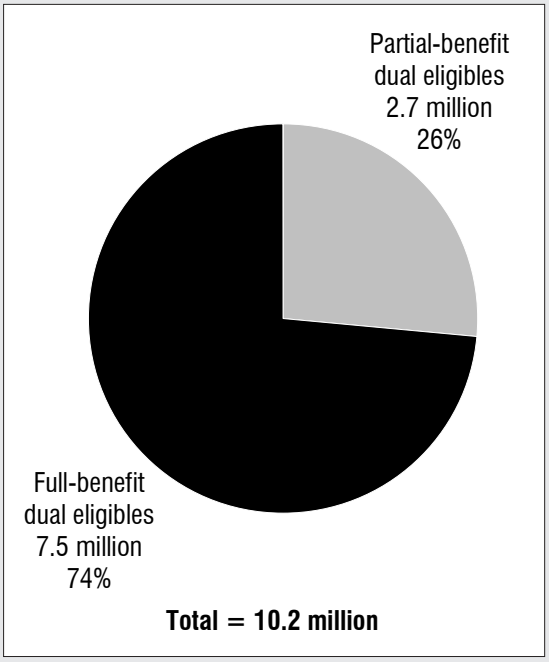
For these dually eligible individuals, Medicaid covers items and services that are not covered by Medicare, most importantly LTSS, but also mental health and behavioral health therapy and services (when they are not covered by Medicare), transportation services, and case management services, for example. Most, but not all, of these full-benefit dual eligibles also receive assistance from Medicaid with Medicare premiums and cost sharing.

The majority of dual eligibles (7.5 million of the 10.2 million dual eligibles in 2011) have full Medicaid coverage (Figure 3-3). There are four major categories of full-benefit dual eligibles:

People receiving Supplemental Security Income (SSI) cash payments. SSI is available to persons 65 and over, children, and adults with disabilities who are younger than 65 and who have income below poverty (below 75 percent of the federal poverty level) and very limited assets ($2,000 for an individual, $3,000 for a married couple). In most states (39 states and the District of Columbia), people who receive SSI are automatically enrolled in Medicaid. However, 11 states (so-called "209(b)" states) use financial eligibility criteria that are more restrictive than those that apply in the federal SSI program.[2] These states must offer a medically needy pathway to eligibility for very low-income people with medical or supportive service needs.

Poverty-related eligibility. States have the option of providing Medicaid coverage to people who receive a state supplementation payment in addition to SSI. States also have the option to extend Medicaid eligibility to people otherwise eligible for SSI—whose income exceeds the SSI limit, but who have annual income below the federal poverty level. In 2012, 22 states and the

FIGURE 3-3. Dual Eligibles by Medicaid Benefit Status, 2011



Source: CMS 2013

District of Columbia had this type of coverage (MACStats Table 11).

Medically needy eligibility. The medically needy option, offered by 32 states and the District of Columbia, enables states to cover persons with higher income who may have significant expenses for medical care or supportive services (MACStats Table 11). People with income above the medically needy threshold can deduct incurred expenses from their income—or spend down—below the financial eligibility threshold.[3] States may use different financial thresholds for medically needy eligibility and have the option to limit the Medicaid benefits package for these individuals.

Special income rule. States have the option to provide Medicaid benefits to people meeting special state income standards for nursing home residents, for participants in home and community-based waiver services (HCBS) programs—which serve people in the community who need the level of care provided by a nursing home—or for both. These special standards, used in 43 states and the District of Columbia in 2012, may be as high as 300 percent of the SSI benefit rate.

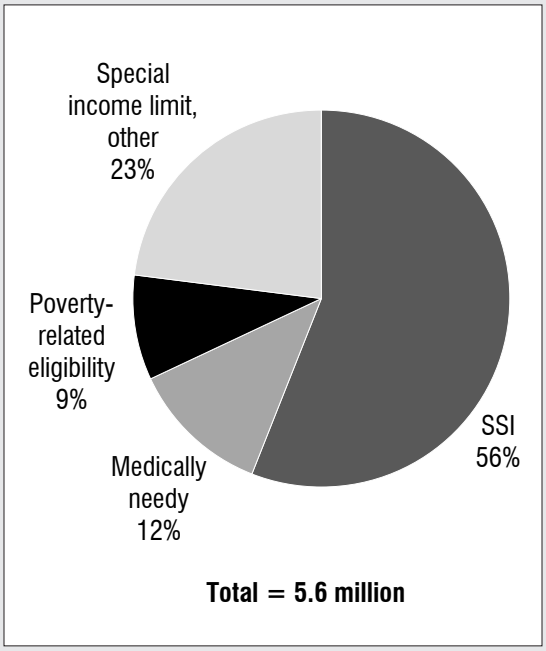
SSI is the primary Medicaid eligibility pathway for full-benefit dual eligibles. In 2007, more than half (56 percent) of individuals who were full-benefit dual eligibles for the entire year (all-year dual eligibles) came in to Medicaid through the SSI program. A relatively small percentage of dual eligibles (9 percent) were enrolled for full Medicaid through other poverty-related eligibility pathways, and about 12 percent came into Medicaid via a medically needy pathway. Nearly a quarter of full-benefit dual eligibles were enrolled in Medicaid through another pathway, including the special income limit for the institutionalized or individuals who are receiving HCBS waiver services (Figure 3-4).

Because the special income limit and medically needy pathways are used by people with high medical or LTSS needs, enrollees in these groups have much higher Medicaid spending, on average, than do dual eligibles who come in via the SSI or poverty-related pathways. All-year, full-benefit dually eligible individuals enrolled in Medicaid through a medically needy or special income pathway had average Medicaid costs of $36,085 and $28,680, respectively, in 2007, compared to average per capita spending of just about $8,000 for those enrolled through an SSI or poverty-related eligibility pathway (not shown).

Medicaid's Role for Dual Eligibles

Since Medicare is the primary payer for health care for dual eligibles, Medicaid acts as a secondary

FIGURE 3-4. Eligibility Pathways of All-Year, Full-Benefit Dual Eligibles, 2007



Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

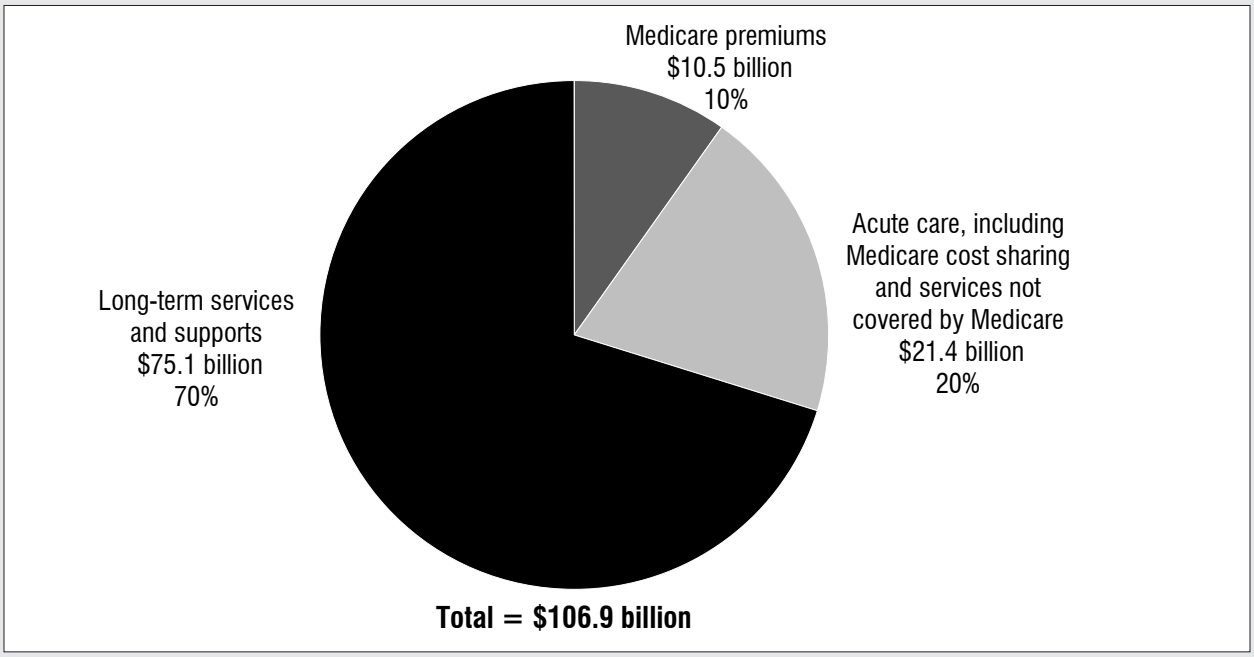
payer, filling in Medicare cost sharing and covering other acute care services not covered by Medicare. For example, Medicaid may cover acute care and post-acute services after the Medicare benefit is exhausted or if certain Medicare criteria are not met. Full-benefit dual eligibles are eligible for payment of any benefits covered under a state plan—if Medicare does not cover the service or if Medicare benefits have been exhausted—including certain mandatory federal benefits and any additional optional benefits that the state has decided to provide.[4]

Nationally, Medicaid spending on dual eligibles came to nearly $107 billion in 2007, including $75.1 billion on LTSS, $10.5 billion on Medicare premiums, and $21.4 billion on acute care services, including acute care services not covered by Medicare and Medicaid payments for Medicare cost sharing (which could not be disaggregated in the current analysis) (Figure 3-5).

Because Medicaid provides significant flexibility to states, Medicaid benefits for dual eligibles vary widely across the states. For example, some states impose much more restrictive clinical or functional eligibility requirements for nursing home services than others, limiting the number of people who are eligible to receive Medicaid-financed long-term nursing home care and the number eligible to receive services under HCBS waivers.

States have considerable flexibility under Medicaid to provide LTSS—both in institutional and in home and community-based settings—to adults age 65 and older who are frail or have disabilities and to non-elderly adults and children with disabilities who require supportive services. For people who have serious disabling conditions who meet state-based criteria for institutional care, Medicaid pays for supportive and skilled services in institutional settings, including nursing homes, ICFs/ID, and inpatient psychiatric facilities (for

FIGURE 3-5. Medicaid Expenditures for Dual Eligibles, 2007



Source: Mathematica Policy Research analysis of 2007 Medicare and Medicaid data for MACPAC (all but premiums) and MACPAC analysis of CMS-64 Financial Management Report net expenditure data (premiums)

people age 20 and younger and 65 and older). All states are required to provide home health benefits. Optional services include personal care attendant services, adult day health program services, and respite care. Care management is a covered service in Medicaid's home health benefit, in the personal care assistance benefits provided under a state plan, in HCBS waiver programs, and in the Program of All-inclusive Care for the Elderly (PACE). Many frail older adults and younger adults with disabilities receiving LTSS in Medicaid receive health and functional needs assessments, care plans, and care management services.

Medicaid benefits—those that are required to be provided (such as nursing facility services and home health) and those that are optional—must be provided on a statewide basis to everyone who is eligible for them. However, under waivers, states have substantial flexibility to target additional benefits and services to selected groups. The HCBS waiver program is the primary vehicle states use to finance non-institutional LTSS for people with disabilities. Under HCBS waivers, states can provide a wide range of services to enable persons with disabilities to achieve maximum independence in the community.

People receiving services under HCBS waivers often have unique constellations of needs that are very different from people with less severe disabilities living independently in the community. Individuals with a wide range of needs form this group, which includes people with intellectual disabilities, traumatic brain injury, physical disabilities, serious mental illness, and older adults who are frail or who have Alzheimer's disease or other cognitive limitations.

BOX 3-1. MedPAC's Recent Reports on People Who Are Dually Eligible for Medicare and Medicaid

The Medicare Payment Advisory Commission (MedPAC) has also reported on dually eligible beneficiaries in its recent reports. Their analysis has focused on:

- A profile of dual-eligible beneficiaries and their Medicare and Medicaid spending (MedPAC 2012a).
- Enrollment in integrated care programs and barriers to the development of integrated care (MedPAC 2010).
- Characteristics of managed care-based, provider-based, and fee-for-service care coordination programs (MedPAC 2011).
- Analysis of enrollment, Medicare payment, and quality measures in the Program of All-inclusive Care for the Elderly (PACE); analysis of dual-eligible special needs plans (D-SNPs); and CMS demonstration programs on integrated care and financial alignment. (MedPAC 2012b).

In its June 2012 Report to the Congress, MedPAC made recommendations related to the PACE program, including recommendations related to Medicare payments for PACE organizations. MedPAC also recommended changing the eligibility criteria for PACE to include individuals younger than 55.

In January 2013, MedPAC approved recommendations related to SNPs—Medicare Advantage plans that operate under a statutory authority that is set to expire. MedPAC has recommended that the Congress permanently extend D-SNPs, but only plans that are integrated with Medicaid. These recommendations will be included in the Commission's March 2013 Report to the Congress.

Depending on the needs and circumstances (e.g., availability of family members to provide assistance) of these individuals, the services provided under waivers vary widely and can include assistance with personal needs such as bathing, eating, and toileting, but may also include a broad range of supportive services that are related to maintaining function and maximum integration into the community. These may include supports for employment, adult day programs, transportation services, and habilitative services that allow a person with a disability to acquire or maintain life skills. States can also pay for housing to enable community living for people who would otherwise require an institutional level of care.

Waivers hold tremendous appeal for states because waivers enable them to annually budget for the number of persons who will be enrolled in the program and to establish participant waiting lists when that number is reached. As a result, some people who qualify for services may not receive them (Justice 2010). Services may be limited to specific groups (by type of disability, geographic region, or income, for example). Without federal minimum standards, some states have developed relatively comprehensive long-term care systems, while others offer relatively limited and fragmented care (Leutz 1999). As a result, low-income Medicare beneficiaries with disabilities may receive widely varying Medicaid assistance from state to state, and even within states if waiver services are not available statewide to all populations.

Dual Eligibles' Service Use and Spending across Both Programs

Dual eligibles vary widely in terms of their needs for medical care (whether they have serious acute or chronic conditions or multiple chronic conditions, for example) and their needs for LTSS. To illustrate the variation in care needs and the extent to which different dually eligible subpopulations rely on Medicare and Medicaid, this section examines the Medicare and Medicaid service use and spending of full-benefit dual eligibles, focusing on four subpopulations defined in terms of their use of Medicaid-financed LTSS. A recent analysis by Randall Brown and David Mann used similar categories (Brown and Mann 2012).

Dual-eligible subgroups

For this analysis, we took the full-benefit dual-eligible population that was enrolled in both Medicare and Medicaid for the entire year and divided the group into four mutually exclusive subgroups based on their use of Medicaid LTSS: an institutional users group, a group of people using HCBS waiver services, a group of people using state-plan LTSS only, and a group of people who do not use any Medicaid LTSS. Box 3-2 provides additional information on the data and methods.

Institutional group. The first subgroup includes dual eligibles who used any institutional services in Medicaid. This includes people who received Medicaid-financed nursing home services or LTSS in other institutional settings such as ICFs/ID. These individuals may also have used Medicaid HCBS under a waiver or regular Medicaid state plan rules.

HCBS waiver group. The second group includes people who received any services under Medicaid HCBS waivers. These individuals may have received state plan HCBS, such as home health care or personal care, but this category excludes anyone who received any Medicaid-financed institutional services during the year.

HCBS non-waiver group. The third group includes people who used regular state-plan

BOX 3-2. Methodology for the Analysis of the Dually Eligible Population

This analysis of dual eligibles' Medicare and Medicaid service use and spending is based on linked beneficiary-level data for 2007 from several sources, including the Medicaid Analytic eXtract (MAX) person summary file, Medicare Beneficiary Annual Summary File, and person summary files for Medicare Part D and Medicare Advantage. Individuals were identified as dually eligible if they were ever enrolled in both programs during the year, using indicators contained in the MAX data. Since enrollment status may vary during the year, individuals were classified as receiving full or partial Medicaid benefits based on their most recent month of dual eligibility.

To facilitate comparisons of annual spending across subgroups within the full-benefit dually eligible population, the information presented in this section and below is limited to people who were enrolled in both programs for the entire year (all-year enrollees), including people who were enrolled on January 1, 2007, but who died during the year.

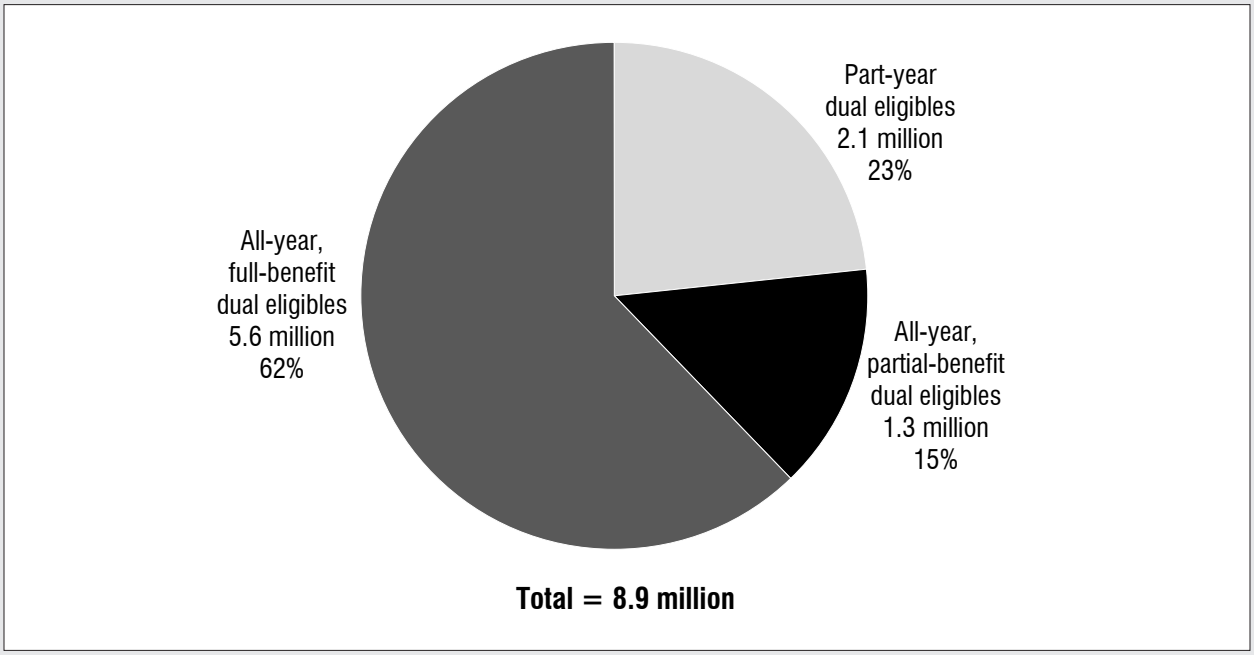
Most dual eligibles—6.9 million, or more than three-fourths—were enrolled in both Medicare and Medicaid throughout the year, reflecting the stability of Medicaid coverage for older adults and non-elderly persons with disabilities: once enrolled in Medicaid, they tend to stay enrolled. The all-year dual-eligible population includes 5.6 million full-benefit dual eligibles and 1.3 million partial-benefit dual eligibles. About 2.1 million (23 percent) were enrolled for only part of the year (Figure 3-6).

We disaggregated the all-year, full-benefit dual-eligible population by their use of Medicaid LTSS. We created four distinct (non-overlapping) groups defined as follows: (1) institutional group, (2) HCBS waiver group, (3) non-waiver HCBS group, and (4) non-LTSS user group: people who did not use any Medicaid LTSS.

We included in our enrollment and expenditure estimates dual eligibles enrolled in Medicare or Medicaid managed care plans. The annual amount of the Medicare and Medicaid payments to these plans (the per enrollee capitation) is included in the spending data reported below, but information on the service use and expenditures of these plan enrollees (encounter data) is not reported because it was not available (Medicare) or was of unknown quality and completeness (Medicaid). Readers should note that MAX data are known to undercount total U.S. Medicaid spending relative to CMS-64 data submitted by states to obtain federal matching funds, with variation by state and type of service. Medicaid spending amounts presented in this chapter have not been adjusted to address this issue, as may be done in other MACPAC analyses. In addition, most figures exclude Medicaid payments for Medicare premiums, which are effectively reflected in the Medicare spending shown in the chapter.

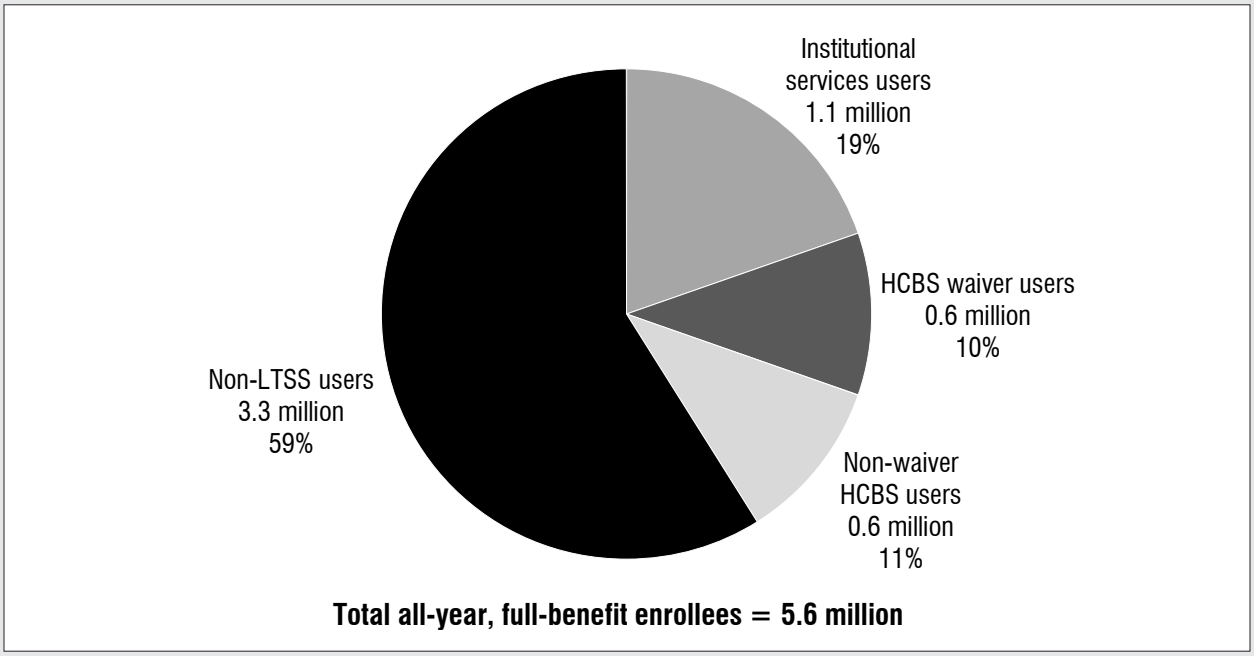
Although Medicaid benefits and eligibility for low-income people with Medicare and patterns of use and spending vary widely across states, this chapter provides a national picture. The Commission will examine state-level differences and their impacts in future reports.

FIGURE 3-6. Dual Eligibles, by Length of Enrollment and Type of Eligibility, 2007



Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

FIGURE 3-7. Distribution of All-Year, Full-Benefit Dual-Eligible Enrollment, by Type of LTSS Use, 2007



Note: LTSS is long-term services and supports. HCBS is home and community-based services.
Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

services in Medicaid, but who did not use any HCBS waiver or institutional LTSS. People in this group may have used state plan benefits such as home health care, personal care attendant services, and adult day health program services that are generally available to persons who are frail or have disabilities, but who do not necessarily meet the criteria for admission to a nursing home.

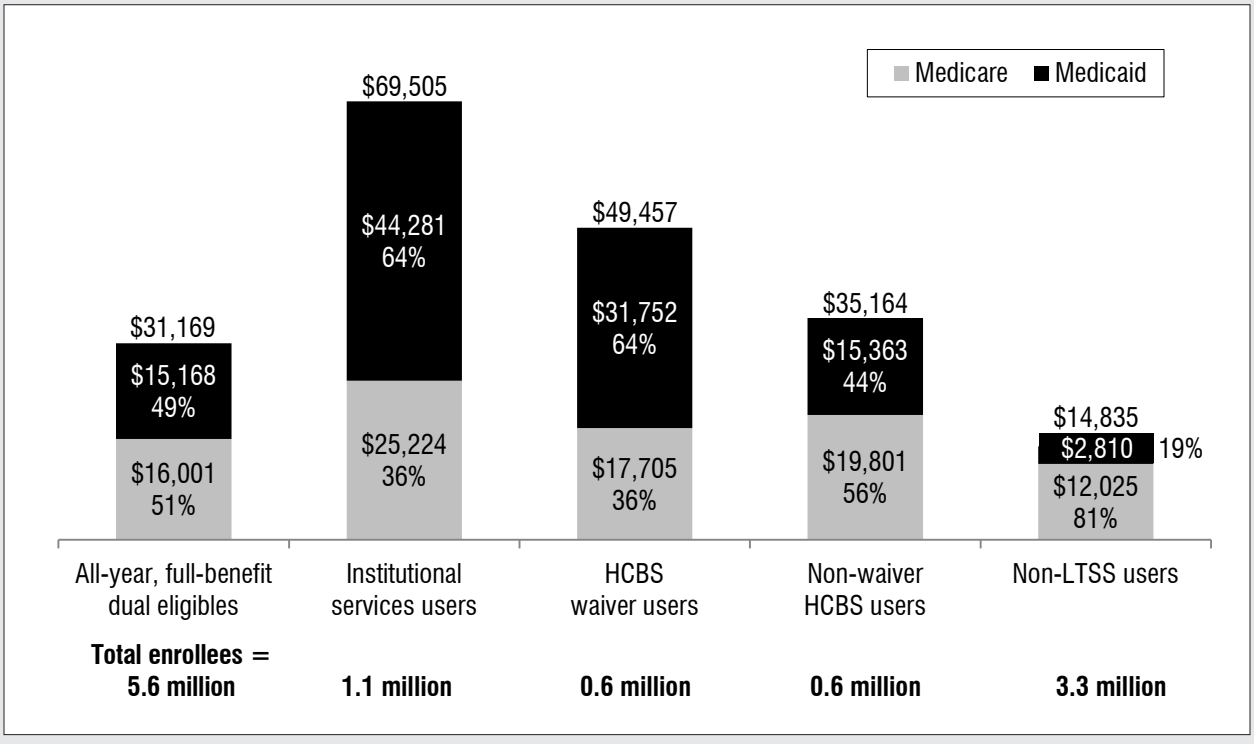
Non-LTSS user group. The fourth group includes dually eligible individuals who did not use any Medicaid LTSS.

The analysis shows that nearly 30 percent of all-year, full-benefit dual eligibles had serious disabilities and were eligible for nursing facility or other institutional care under Medicaid—including 19 percent who received institutional services and 10 percent who received services under Medicaid HCBS waivers. In addition, 11 percent used some Medicaid HCBS, but used only state-plan services that do not require an individual to meet a nursing home level of need. However, the majority of full-benefit dual eligibles (59 percent) did not use any Medicaid-financed LTSS (Figure 3-7). If partial-benefit dual eligibles who were enrolled in both programs for the entire year are included in the analysis, about two-thirds of dual eligibles (67 percent) did not use Medicaid-funded LTSS (not shown).

Variation in spending across dual-eligible subgroups

Average total program expenditures rise steadily with LTSS needs and types of service use

FIGURE 3-8. Average Medicare and Medicaid Spending per All-Year, Full-Benefit Dual Eligible, by Subgroup, 2007



Note: LTSS is long-term services and supports. HCBS is home and community-based services.
Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

TABLE 3-1. Medicare and Medicaid Spending per All-Year, Full-Benefit Dual Eligible, by Type of Service, 2007

Distribution of spending per enrollee by program and service category	All-Year, Full-Benefit Dual Eligibles							
	Institutional services users		HCBS waiver users		Non-waiver HCBS users		Non-LTSS users	
Medicare inpatient	$7,721	11.1%	$4,404	8.9%	$5,755	16.4%	$2,806	18.9%
Medicaid inpatient	588	0.8	278	0.6	500	1.4	203	1.4
Medicare outpatient, physician, & other acute	6,628	9.5	5,020	10.2	6,276	17.8	3,627	24.5
Medicaid outpatient, physician, & other acute	1,736	2.5	2,304	4.7	2,552	7.3	1,319	8.9
Medicare drugs	4,791	6.9	4,831	9.8	4,831	13.7	3,253	21.9
Medicaid drugs	122	0.2	152	0.3	188	0.5	107	0.7
Medicare skilled nursing facility	4,292	6.2	493	1.0	285	0.8	162	1.1
Medicaid nursing facility or other institution	40,284	58.0	0	0.0	0	0.0	0	0.0
Medicare home health	381	0.5	1,664	3.4	1,405	4.0	507	3.4
Medicaid home health	187	0.3	536	1.1	1,834	5.2	0	0.0
Medicaid HCBS, other than home health	1,117	1.6	27,978	56.6	9,653	27.5	0	0.0
Medicare capitated payments	1,411	2.0	1,293	2.6	1,249	3.6	1,670	11.3
Medicaid capitated payments	247	0.4	504	1.0	636	1.8	1,181	8.0
Combined program spending per enrollee	**$69,505**	**100%**	**$49,457**	**100%**	**$35,164**	**100%**	**$14,835**	**100%**
Medicaid spending per enrollee	**$44,281**	**64%**	**$31,752**	**64%**	**$15,363**	**44%**	**$2,810**	**19%**
Medicare spending per enrollee	**$25,224**	**36%**	**$17,705**	**36%**	**$19,801**	**56%**	**$12,025**	**81%**
Total program spending (billions)	**$74.4**		**$28.5**		**$22.0**		**$49.0**	
Number of enrollees (millions)	**1.2**		**0.5**		**0.5**		**3.3**	

Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

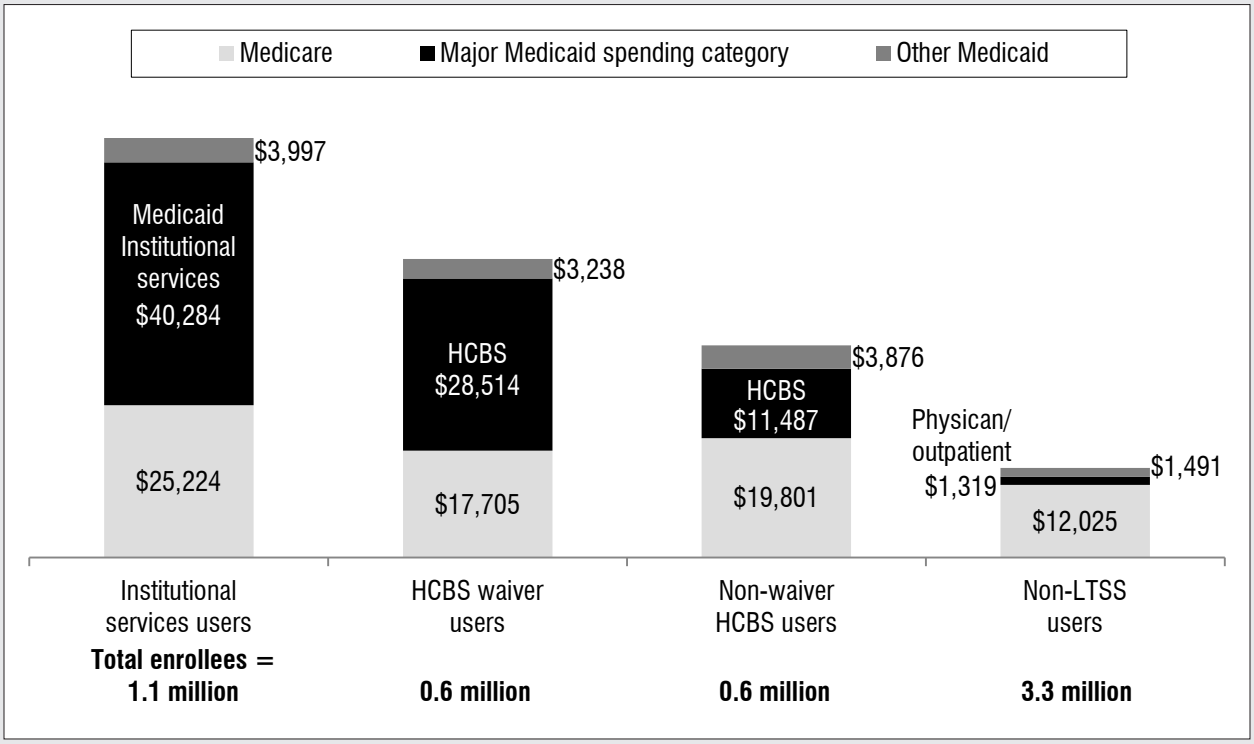
(Table 3-1, Figure 3-8). For each of the three LTSS user subgroups, the large majority of Medicaid spending was for long-term care services—with these expenditures far surpassing spending on any other Medicare- or Medicaid-financed service (Table 3-1, Figure 3-9).

Spending among non-LTSS users. The largest subgroup, comprised of dually eligible individuals who did not use LTSS, had the lowest total spending, with combined per capita Medicare and Medicaid spending of $14,835—the large majority of it (81 percent) in Medicare (Figure 3-8). This subgroup had the lowest use of Medicare-covered services and the lowest per capita spending in Medicare. For example, only 19 percent used any inpatient hospital services during the year (compared to 41 percent of the institutional subgroup), 77 percent used Medicare physician services, 63 percent used outpatient hospital services, and 91 percent used prescription drugs (Figure 3-10).

People in the non-LTSS user subgroup also had by far the lowest spending in Medicaid. Only a small percentage used any wraparound services in Medicaid (only 12 percent used any dental services under Medicaid, 10 percent used transportation services, and 11 percent used Medicaid psychiatric services). Most of the Medicaid spending for these non-LTSS users was for services covered by Medicare (e.g., inpatient hospital, outpatient hospital, and physician services) (Table 3-1).

Spending among non-waiver HCBS users. Dual eligibles who used state-plan LTSS only (the non-waiver HCBS subgroup) had average combined program spending ($35,164 per capita)

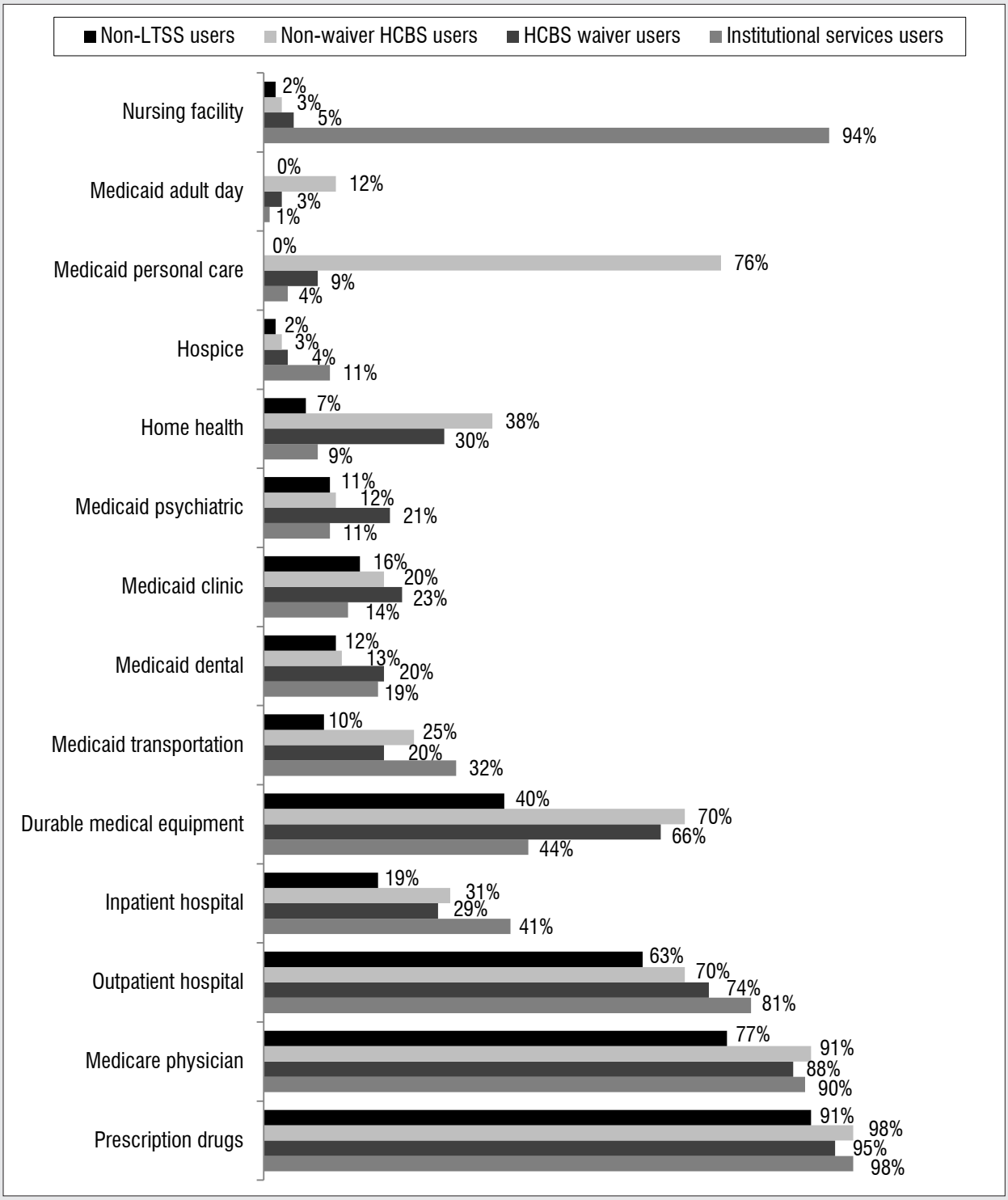
FIGURE 3-9. Distribution of Spending by Program and Type of Service, 2007



Notes: LTSS is long-term services and supports. HCBS is home and community-based services. The major Medicaid spending category is the largest category of spending by type of service. See Table 3-1 for additional detail on spending by type of service.

Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

FIGURE 3-10. Percentage of All-Year, Full-Benefit Dual Eligibles Using Selected Services, by Subgroup, 2007



Note: Unless otherwise indicated, Medicaid services are state plan services. Not all service use is reported. Total use of a service like home health or durable medical equipment can be higher because (1) services may be funded under waivers (not shown here) as well as under a state plan and (2) services provided under capitated managed care arrangements are excluded.

Source: Mathematica Policy Research Analysis of Medicare and Medicaid data for MACPAC

more than twice as high as the non-LTSS user group, with spending roughly evenly split between Medicare and Medicaid (Figure 3-8). Most of the difference in spending between these groups was accounted for by much higher Medicaid spending in the non-waiver HCBS group compared to the non-LTSS user group ($15,363 vs. $2,810), but their Medicare spending was also higher. Most of the Medicaid spending ($11,487 of the $15,363) for these dual eligibles was for LTSS (Figure 3-9), including spending on state-plan personal care (used by 76 percent of people in this group), Medicaid home health services (used by 23 percent, not shown), and state-plan adult day services (used by 12 percent). They also had somewhat higher use of some Medicaid wraparound services, including non-emergency transportation (used by a quarter of dual eligibles in this subgroup).

Dually eligible individuals in the non-waiver HCBS subgroup had higher average spending in Medicare ($19,801) than dual eligibles in the non-LTSS user group ($12,025). Correspondingly, they had higher use rates for Medicare services, including inpatient hospitalization (31 vs. 19 percent for the non-LTSS users), physician services (91 vs. 77 percent), and prescription drugs (98 vs. 91 percent), and higher spending on these services (Table 3-1).

Spending among users of HCBS waiver services. Dually eligible individuals with the most significant disabilities—who met the criteria for admission to a nursing home, ICF/ID, or psychiatric facility—had still higher average combined program spending (nearly $50,000 for dual eligibles receiving services under HCBS waivers, and nearly $70,000 for those residing in institutions), with Medicaid accounting for the majority of these costs (64 percent, on average) (Figure 3-8)

Dual eligibles using HCBS waiver services had Medicare spending that was slightly lower than Medicare spending for the non-waiver HCBS group. Nearly all of the Medicaid spending for people in the HCBS waiver subgroup, and 56 percent of their combined Medicare and Medicaid spending, was for the waiver services themselves, although there was some very modest spending for state-plan LTSS, mainly home health (Figure 3-9, Table 3-1). These dual eligibles also had higher rates of use of Medicaid-financed services, including psychiatric services (21 percent) and clinic services (23 percent), compared to the state-plan LTSS user group.

Spending among users of institutional services. The subgroup of dual eligibles using institutional LTSS had the highest average spending in Medicare and, correspondingly, the highest rates of medical care service use. Among dual eligibles who received LTSS in institutional settings, 41 percent used inpatient hospital services and 81 percent used hospital outpatient services. Ninety-four percent used nursing facility services (the remaining 6 percent used other institutional services, mostly facilities for persons with intellectual disabilities). Spending on Medicaid institutional services accounted for the large majority (90 percent) of all Medicaid spending and most (58 percent) of total program spending on this group (Figure 3-9). Since some in the institutional user group likely resided in the community during the year, there were also modest expenditures for HCBS, both waiver and state plan services (Table 3-1).

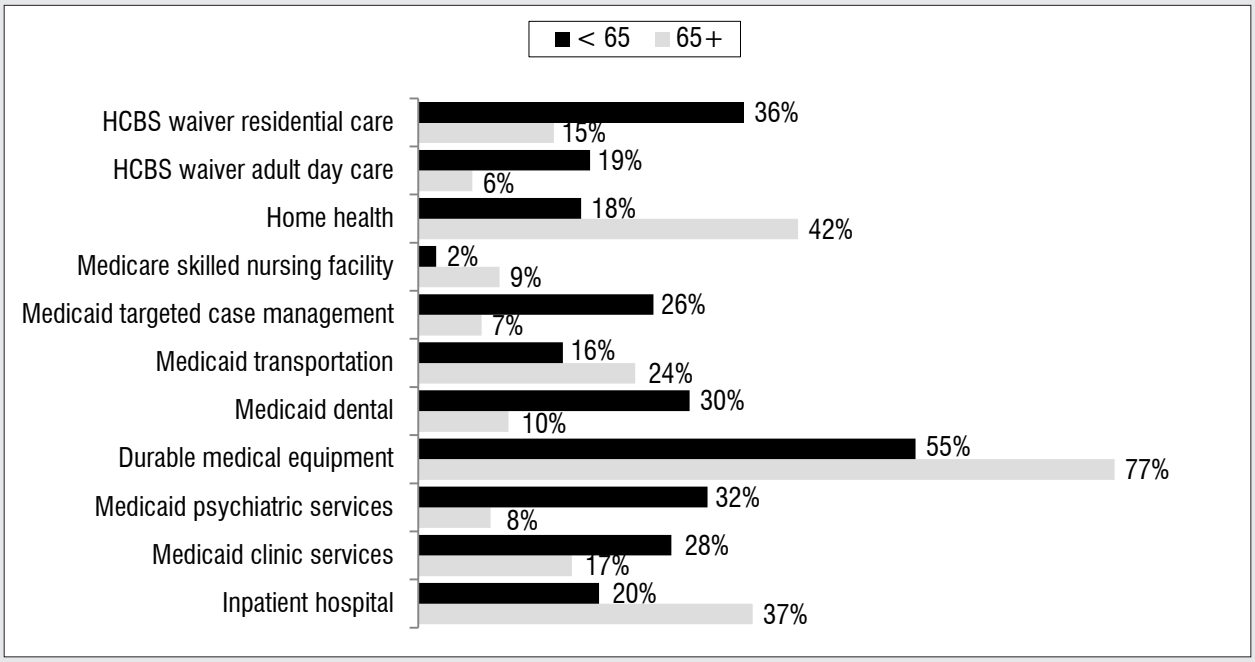
There are also significant differences in service use and spending within these groups. For example, looking just at the HCBS waiver services group—which is comprised of roughly equal numbers of adults younger than 65 and those age 65 and older—the mix of services used varies significantly across older and younger program participants. Utilization rates for HCBS waiver residential care, targeted case management, dental care, and

psychiatric services in Medicaid are significantly higher for non-elderly than for HCBS waiver participants who are age 65 and older, suggesting that non-elderly dual eligibles receiving services under HCBS waivers, on average, have far different needs than dual-eligible waiver participants age 65 and older (Figure 3-11).

Similarly, for people using institutional services in Medicaid, there are wide differences in spending by age, suggesting that those under age 65 have different kinds of care needs. Medicaid spending was substantially higher for non-elderly dual eligibles who use institutional LTSS than for their counterparts age 65 and older, for example (Figure 3-12). Most dual eligibles who receive institutional services received services in nursing homes (99 percent of persons age 65 and older and 67 percent of the non-elderly), but 30 percent of the non-elderly received services in ICFs/ID (not shown).

The fact that these groups have very different levels and kinds of needs, as reflected in patterns of service use and spending, suggests that different approaches may be needed to improve the way the programs work for distinct dual-eligible subpopulations. To be successful, providers and plans will need knowledge and understanding of particular populations, including unique expertise serving people with serious disabilities who receive LTSS under HCBS waiver programs designed to promote independence and community integration.

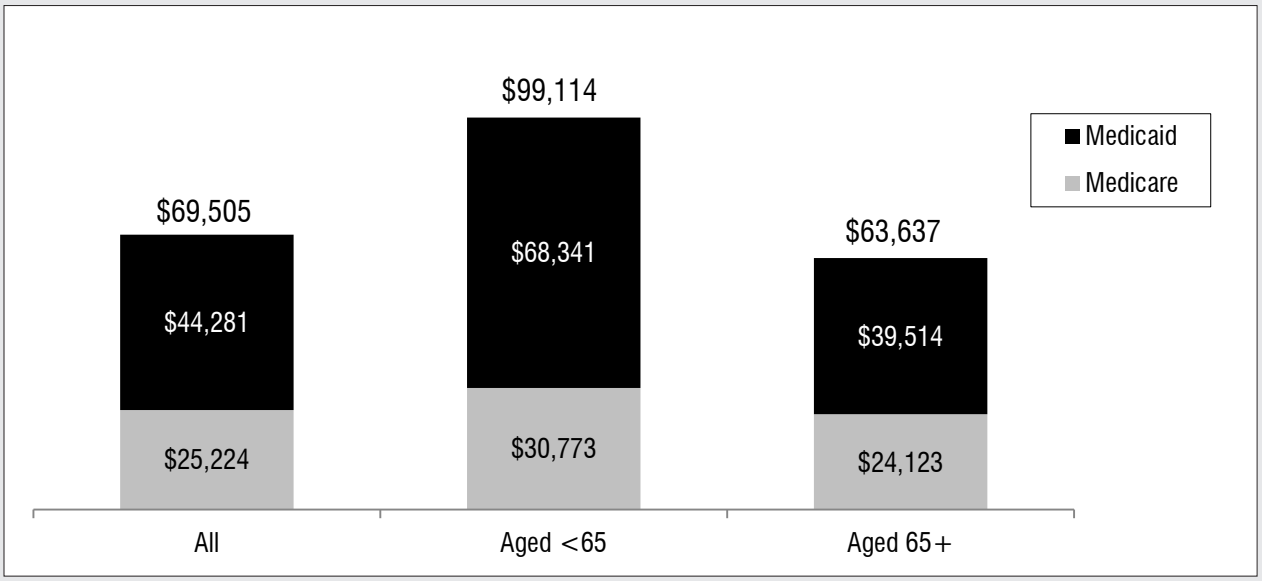
FIGURE 3-11. Percentage of All-Year, Full-Benefit Dual Eligible HCBS Waiver Participants Using Selected Medicare- and Medicaid-Financed Services, by Age, 2007



Note: Data are for all-year, full-benefit dually eligible individuals in HCBS waiver user subgroup. Unless otherwise indicated, Medicaid services are state plan services. Not all service use is reported. Total use of a service like home health or durable medical equipment can be higher because (1) services may be funded under waivers (not shown here) as well as under a state plan and (2) services provided under capitated managed care arrangements are excluded.

Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

FIGURE 3-12. Average Medicare and Medicaid Spending per All-Year, Full-Benefit Dual Eligible Using Institutional Services, by Age, 2007



Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

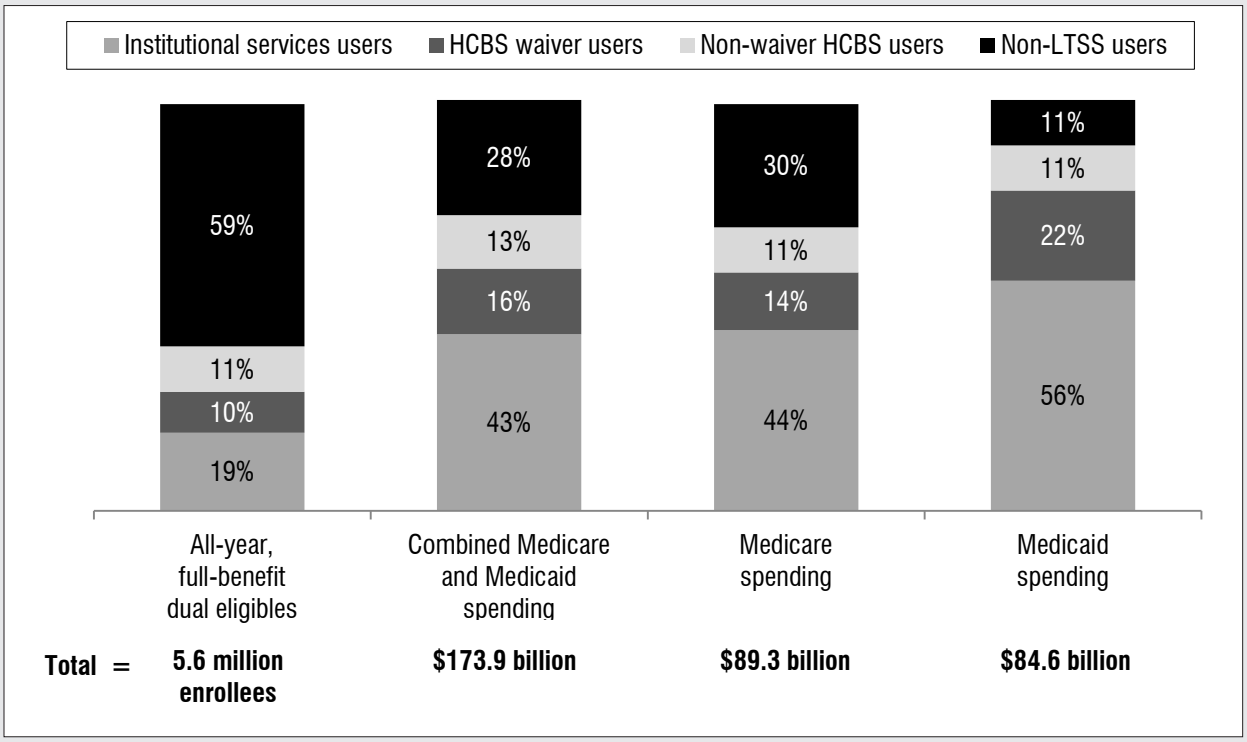
Aggregate program spending by subgroup

The distribution of aggregate program spending—for combined program spending on dual eligibles and for Medicare and Medicaid separately—illustrates the overall consequences of these different patterns of use for public spending on dual eligibles. For example, institutional users, who have the highest average spending in both Medicare and Medicaid, account for just 19 percent of enrollment but 43 percent of combined spending on the total population of all-year, full-benefit dual eligibles. At the same time, the large group of dual eligibles who have the lowest average spending in both Medicare and Medicaid account for 59 percent of all-year, full-benefit dual eligibles, but just 28 percent of combined Medicare and Medicaid spending on those dual eligibles (Figure 3-13).

Considering each program's expenditures on dually eligible individuals highlights the differences among subgroups. For example, non-LTSS users who account for 59 percent of enrollees have relatively low spending in Medicaid and account for just 11 percent of all Medicaid spending on all-year, full-benefit dual eligibles but a third of Medicare program spending on those dual eligibles. In contrast, institutional users account for 56 percent of all Medicaid spending on all-year, full-benefit dual eligibles and 44 percent of Medicare spending on those dual eligibles. And, when all dual eligibles who meet an institutional level of care are considered, they account for 78 percent of all Medicaid spending on all-year, full-benefit dual eligibles but are just 29 percent of those enrollees (Figure 3-13).

At the same time, the concentration of Medicaid spending is masked by these subgroup averages. The 10 percent of all-year, full-benefit dually eligible individuals with the highest spending in Medicaid accounts for 51 percent of all Medicaid spending on those dual eligibles but just 13 percent of all Medicare spending on those dual eligibles

FIGURE 3-13. Distribution of All-Year, Full-Benefit Dual Eligible Enrollment and Total Program Spending by Subpopulation, 2007



Note: LTSS is long-term services and supports. HCBS is home and community-based services.
Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

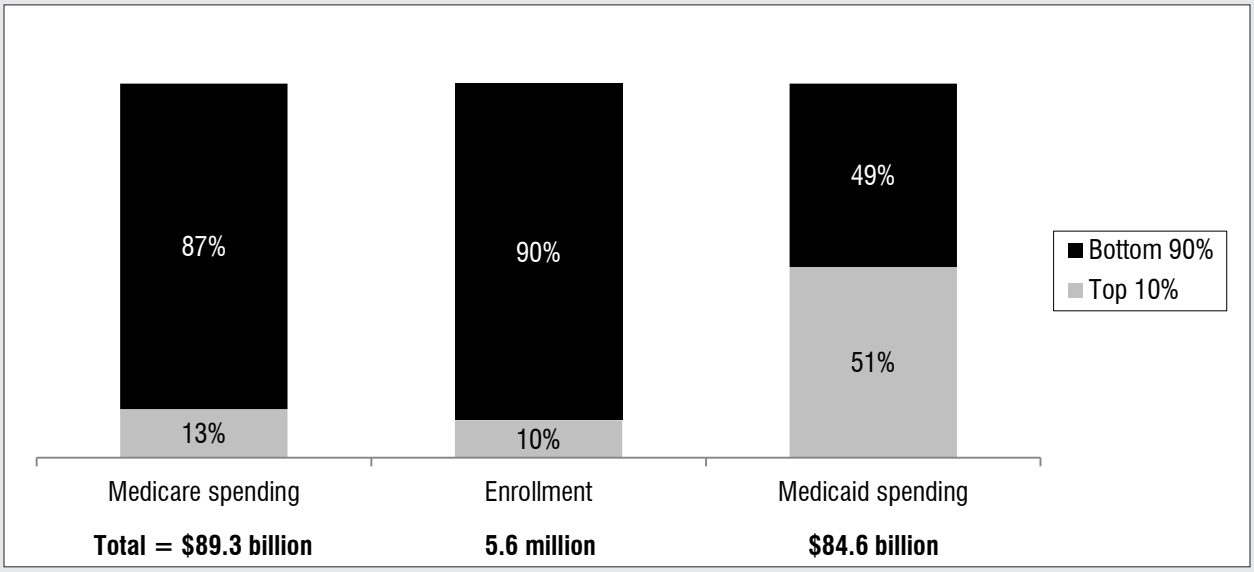
(Figure 3-14). The highest cost dual eligibles in Medicaid had average total spending of about $100,000 in 2007—the large majority of it in Medicaid. Additional analysis is needed to better understand the LTSS needs of these beneficiaries and whether more appropriate and cost-effective approaches to service delivery can be developed for them.

Looking Forward

This use and spending profile begins to provide a picture of the diversity of the dual-eligible population. The wide variation in service use and spending implies that different approaches will be needed to address the distinct challenges faced by unique subgroups. For some groups, spending is mostly for LTSS designed to achieve independence and community living. Efforts to improve their care will need to focus on the management and coordination of unique constellations of LTSS, many of which are nonmedical. For others, service delivery improvement should more likely focus on the management of medical and behavioral health services and linkages to social services. For the large group of dual eligibles who have modest spending in Medicaid, the focus may need to be on Medicare strategies, access to wraparound benefits in Medicaid, and the impact of Medicaid policies for paying Medicare cost sharing on access to care.

In future work, the Commission will examine options for improving care and services for dual eligibles and the implications for both Medicare and Medicaid. The Commission will assess the evidence on a variety of interventions designed to

FIGURE 3-14. Total Spending of the Highest-Cost Dual Eligibles to Medicaid, 2007



Note: High cost refers to people with expenditures in the top 10 percent of the distribution of Medicaid benefit spending for all-year, full-benefit duals. They account for 31 percent of combined spending on dual eligibles ($173.9 billion (not shown)).

Source: Mathematica Policy Research analysis of Medicare and Medicaid data for MACPAC

improve care and reduce costs for dual eligibles, including fee-for-service (FFS) approaches (e.g. care management programs) and managed care approaches (e.g., provider-based programs such as PACE— which enrolls older adults with significant disabilities—and insurance-based models such as fully integrated special needs plans for dual eligibles). The Commission will follow with interest the design, implementation, and operation of new integrated care models under the Centers for Medicare & Medicaid Services financial alignment demonstrations. Moving forward, the Commission plans to:

Continue to assess the diverse needs and circumstances of dual eligibles and opportunities to improve care and services. In future work, the Commission will explore opportunities for program improvement for different segments of the dually eligible population. Evaluating approaches to reform will depend on a richer description of dual-eligible subpopulations, including information on health and functional status, diagnoses and health conditions, and living situation and family supports. For example, additional information is needed to understand the characteristics of the non-LTSS users and whether they have multiple or severe chronic illnesses or other characteristics associated with their service needs, including needs for care management.

Since the fastest growing segment of the dually eligible population is the non-elderly population, more attention may be needed to understand Medicaid's role for these dual eligibles. This segment includes people with intellectual disabilities, serious mental illness, and a wide range of physical disabilities and chronic conditions requiring ongoing care and supportive services. The analysis of service use and spending provided here leaves out a number of factors that would help deepen the understanding of the need for and design of policy reforms, including information on the number and severity of chronic and acute conditions (mental health needs, for example).

The Commission also plans to explore the service utilization of the large group of dual eligibles who do not use LTSS (who are relatively low cost to Medicaid) to better understand what Medicaid services they are accessing and what their unmet needs may be. The Commission will also examine the service needs, use, and spending of non-elderly dual eligibles who are under age 65 and have intellectual disabilities, and dual eligibles with severe mental illness.

Examine the factors that contribute to high spending and assess opportunities for savings. The Commission is interested in understanding the factors that contribute to high spending and whether there are opportunities to reduce spending without harming the quality of care or quality of life for dually eligible enrollees. The Commission will examine approaches such as those designed to reduce potentially avoidable hospitalizations of nursing home residents, integrated financing and delivery approaches in managed care, and FFS care management approaches.

Examine state variation and the impact of state policy choices. The Commission will also assess the extent to which access to Medicare-covered services for dual eligibles is affected by Medicaid policy choices. The analysis presented in this chapter focuses on national estimates of dual eligibles' service use and spending, to highlight distinct subgroups. But Medicaid programs vary widely in terms of covered benefits (for example, the scope of state plan HCBS provided) and payment policies (such as the adequacy of nursing home payment rates). These state policy choices may affect access to care and quality of care for dual eligibles, and potentially also affect dual eligibles' use and spending in Medicare.

As a first step in understanding the extent of state variation and its impact, the Commission will undertake an assessment of Medicaid policies for paying Medicare cost sharing and their impact on access to care. Although a number of factors may limit access to Medicare-covered services for low-income Medicare beneficiaries (residence in medically underserved areas, for example), a 2003 report to the Congress from the U.S. Department of Health and Human Services documented that access to care for dually eligible individuals was lower where Medicaid payments for Medicare cost sharing were lower, with especially large gaps in access to mental health providers in states that did not pay Medicare cost sharing in full (Thompson 2003). The Commission is interested in an updated assessment of the impact of these Medicaid payment policies.

Conclusion

The 10.2 million people who are dually eligible for Medicare and Medicaid receive a good deal of policy attention because they account for a relatively small share of enrollees in each program but account for a disproportionately large share of the expenditures in each program. Because of substantial or complex needs, dual eligibles often require a broad range of services and therefore rely on both programs. But the mix and intensity of services used—and the role each program plays—varies across subpopulations, suggesting that an array of approaches will be needed to address the distinct challenges of unique subgroups within the diverse dual-eligible populations. Understanding the service use and spending of key subpopulations is essential to identifying policy priorities and evaluating policy proposals. The Commission will explore policy options to address the diverse needs of the nation's dual-eligible populations in future work.

Endnotes

1 Dual eligibles who are under age 65 and are enrolled in Medicare as a result of a serious disability are typically enrolled in the Social Security Disability Insurance program or are adult children with disabilities or widows who qualify through other disability-related pathways to Social Security and Medicare.

2 The 209(b) option allows states to use their 1972 state assistance eligibility rules in determining eligibility for persons age 65 and older instead of federal SSI rules. However, a state using its 1972 income or resource thresholds must also allow people to deduct health care expenses from income in determining eligibility.

3 Historically, an individual with income even $1 above the threshold in a state without a medically needy program would be ineligible for coverage. However, Qualified Income Trusts were established to permit people with income above the financial eligibility threshold to put those resources in a trust to be used to offset future Medicaid expenses, thus establishing financial eligibility for Medicaid.

4 Under Medicaid, all states cover a minimum set of benefits including physician services, inpatient and outpatient hospital care, laboratory and x-ray services, home health care, and nursing home care. States have the option of covering additional services—such as prescription drugs and HCBS (including case management) for adults age 65 and older who are frail and persons with disabilities—and have broad discretion to determine the scope of those benefits.

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