DECEMBER

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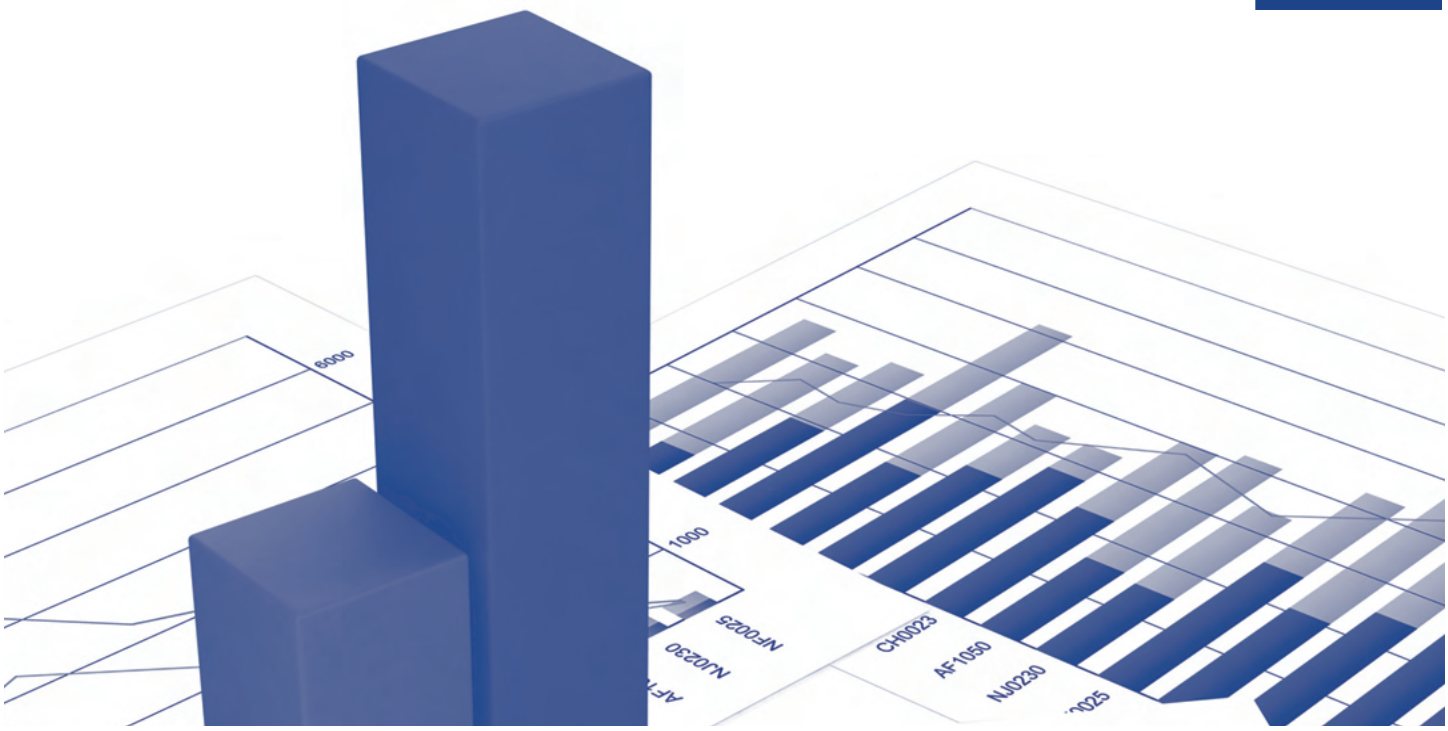

DATA BOOK

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 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, including payments to private health plans participating in Medicare and to providers in Medicare's traditional fee-for-service program, and beneficiaries' access to care and the quality of care provided to them. The U.S. Comptroller General appoints MedPAC's 17 commissioners, who bring diverse expertise in the financing and delivery of health care services.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress and the Secretary of the U.S. Department of Health and Human Services. In the course of these meetings, Commissioners consider the results of staff analyses and comments from interested parties. Commission members and staff also seek input on Medicare issues through frequent meetings with staff from congressional committees and the Centers for Medicare & Medicaid Services, health care researchers, health care providers, and beneficiary advocates.

MedPAC is required to submit reports to the Congress in March and June of each year. In addition to these reports and others on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on proposed regulations issued by 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 an independent congressional agency that provides policy and data analysis and makes recommendations to the 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 U.S. 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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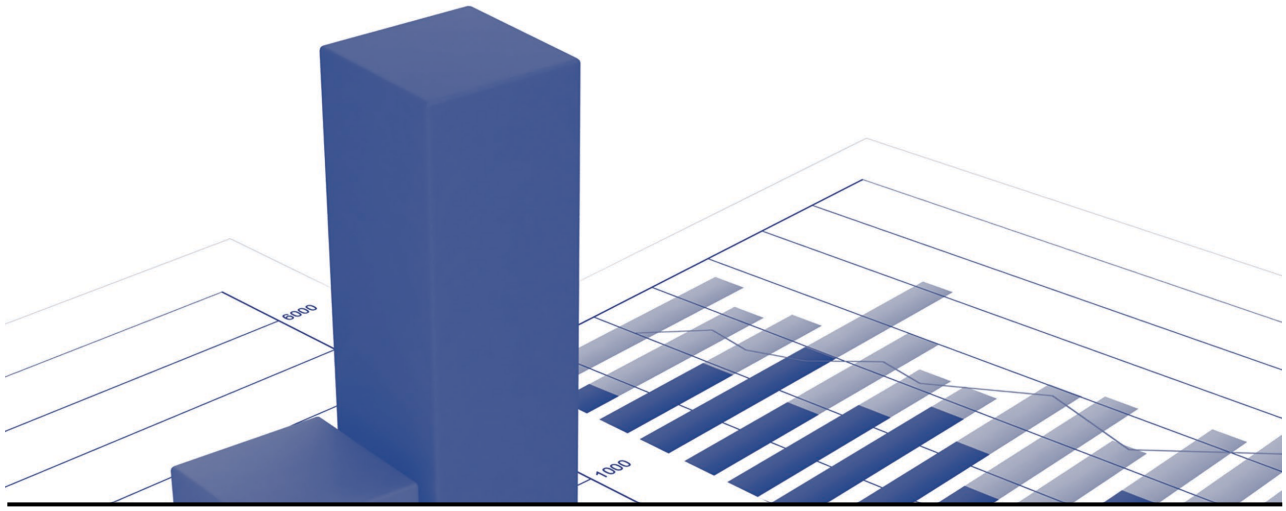
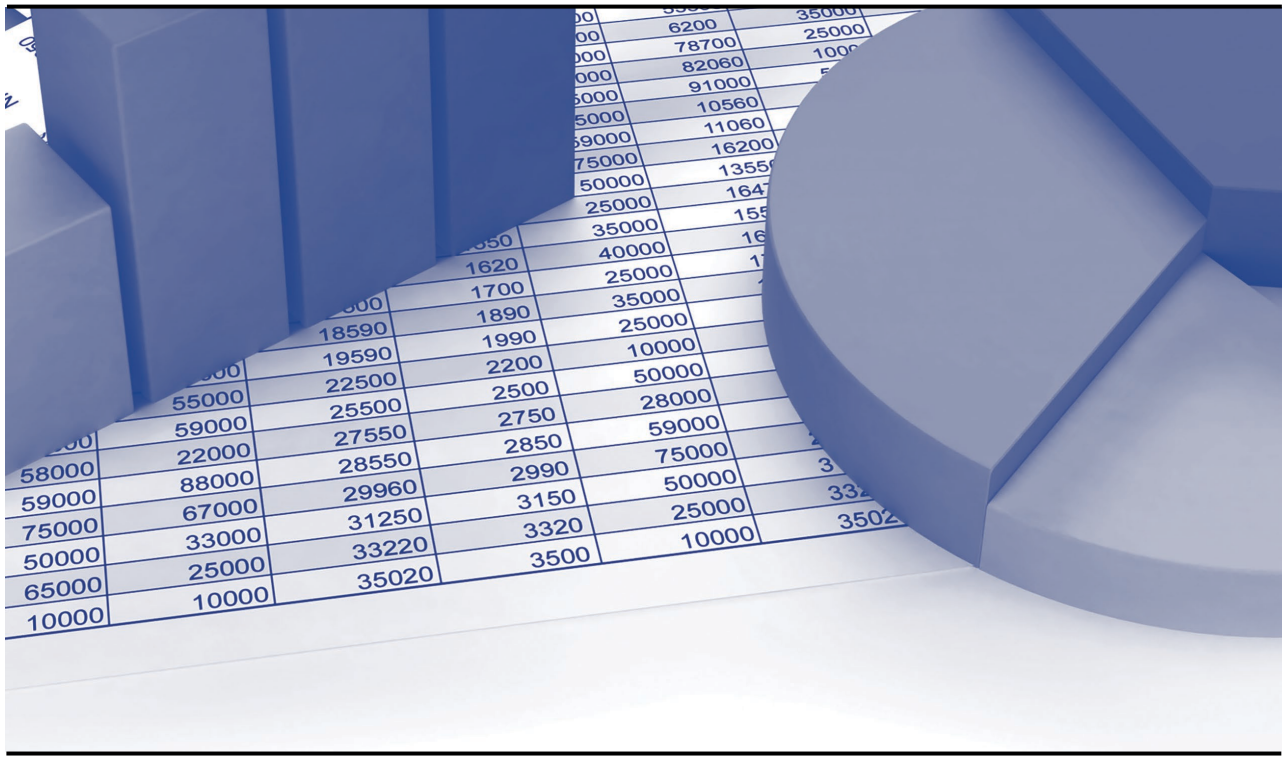


Introduction



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. Dually eligible beneficiaries receive both Medicare and Medicaid benefits by virtue of their age or disability and low income. 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 dually 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 dually eligible beneficiaries receive the full range of Medicaid benefits offered in a given state. Medicaid pays Medicare premiums and may also pay the cost sharing for Medicare services for partial-benefit dually eligible beneficiaries.

Policymakers have expressed particular interest in dually 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 of analyses intended to create a common understanding of the characteristics of dually eligible beneficiaries and their use of services.

This data book is organized into the following sections:

- overview of dually eligible beneficiaries;
- characteristics of dually eligible beneficiaries;
- eligibility pathways, managed care enrollment, and continuity of enrollment;
- utilization of and spending on Medicare and Medicaid services for dually eligible beneficiaries;
- Medicare and Medicaid spending for dually eligible beneficiaries by LTSS use;
- trends in dually eligible population composition, spending, and service use; and
- dually eligible beneficiaries in comprehensive Medicaid managed care.

In each section, we compare subgroups of dually eligible beneficiaries, including those with full versus partial benefits and those under age 65 versus those ages 65 and older. We also compare dually eligible beneficiaries with non–dually eligible Medicare and Medicaid beneficiaries. In the case of Medicaid, our non–dually 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–dually eligible comparison group includes all non–dually eligible Medicare beneficiaries, who may qualify for coverage on the basis of age, disability, or end-stage renal disease. In the last section, we examine dually eligible beneficiaries in comprehensive Medicaid managed care but do not compare them to other dually eligible beneficiaries or to non–dually eligible beneficiaries.

Section

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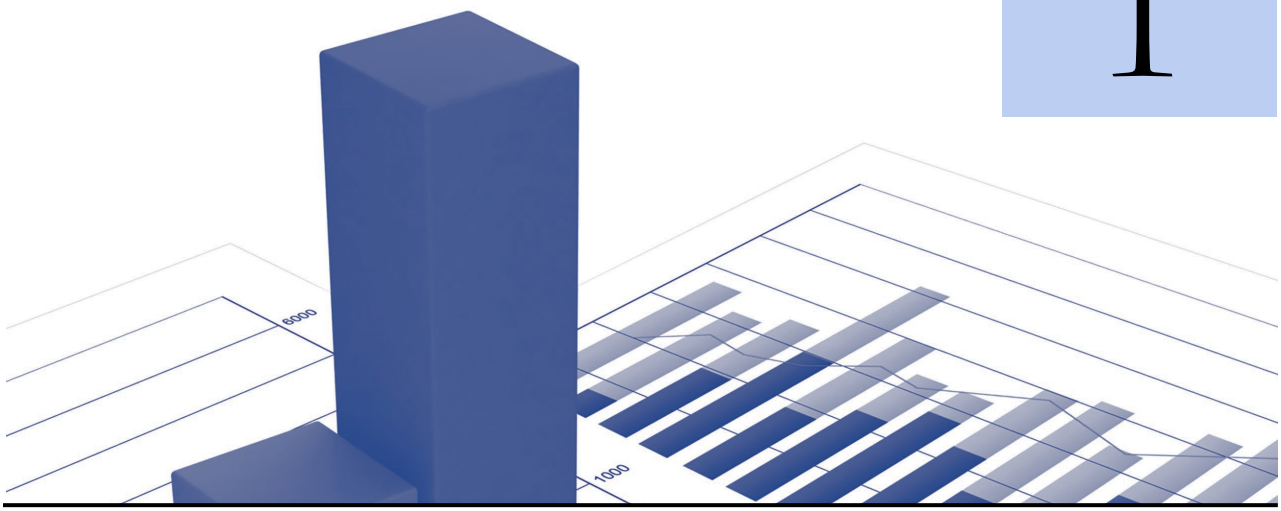


Overview of dually eligible beneficiaries

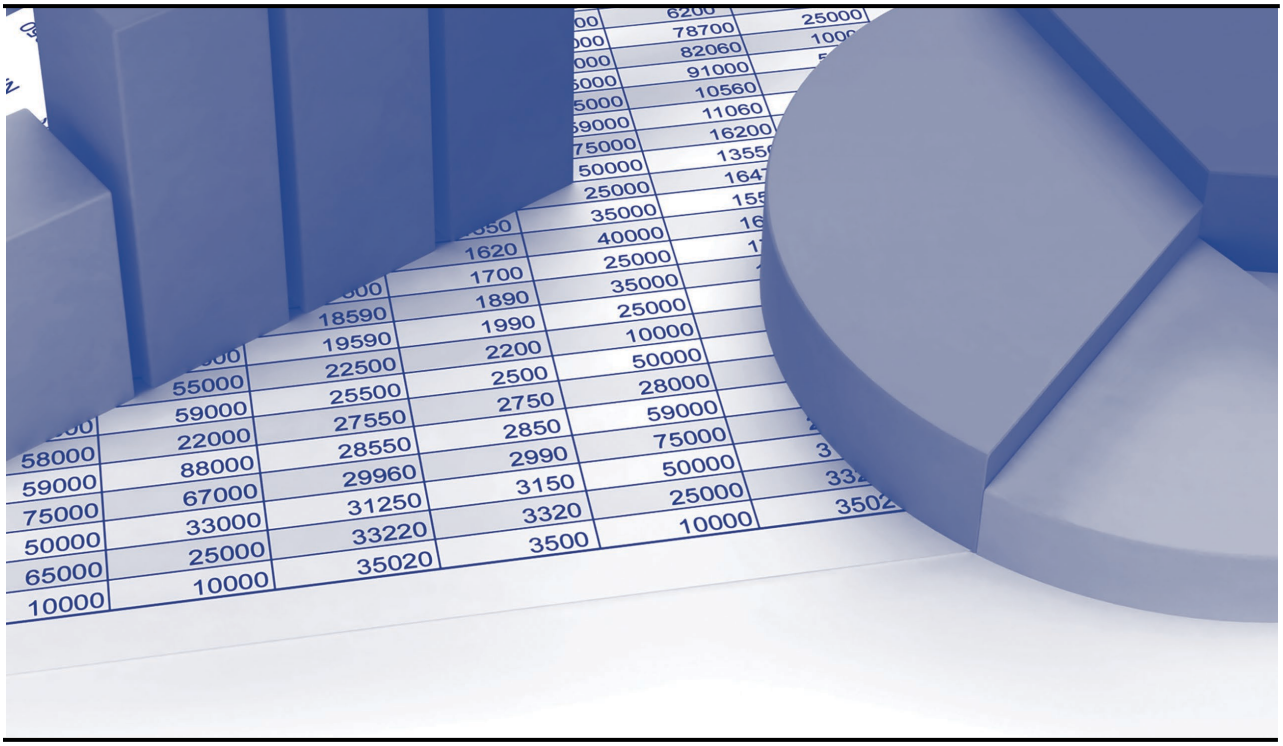
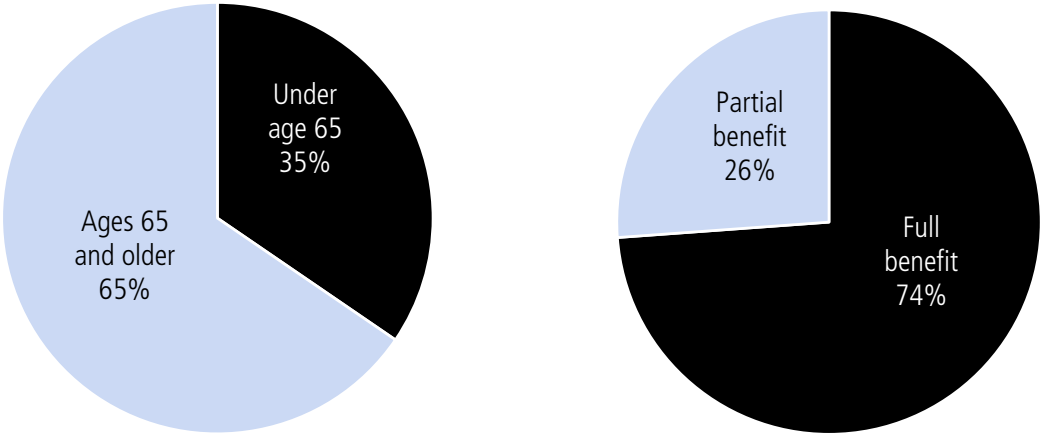


Exhibit 1

Snapshot of dually eligible beneficiaries by age and type of benefit, CY 2022

13.6 million dually eligible beneficiaries



Note: *CY (calendar year). Exhibit includes all dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease).*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- A total of 13.6 million individuals were dually eligible for Medicare and Medicaid benefits in at least one month of CY 2022. The majority (65 percent) of dually eligible beneficiaries were ages 65 and older.
- Most dually eligible beneficiaries (74 percent) were eligible for full Medicaid benefits.

Exhibit 2

Dually eligible beneficiary enrollment in full- and partial-benefit categories, CY 2022

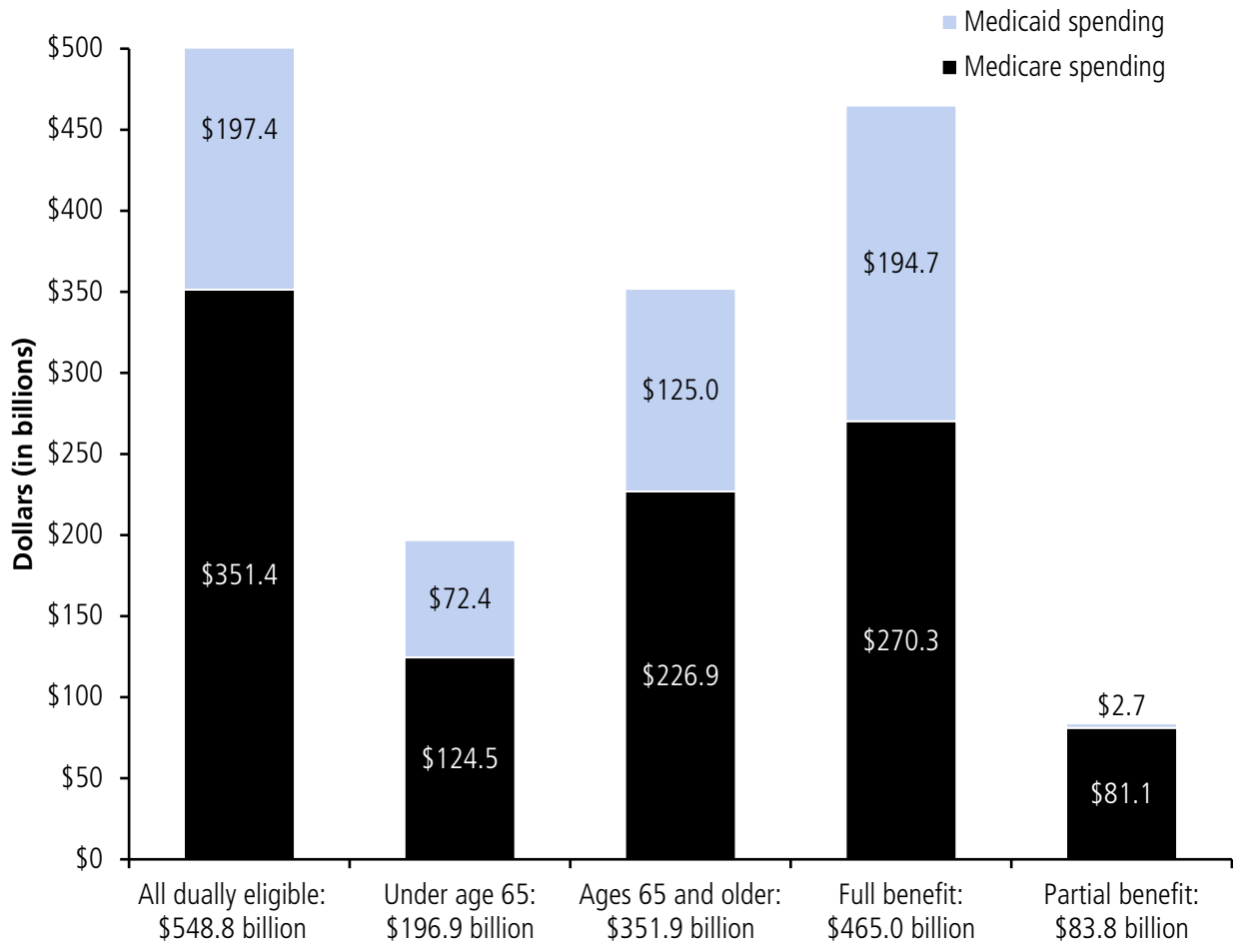
Benefit categories	Dually eligible beneficiaries		
	All	Under age 65	Ages 65 and older
Full-benefit dually eligible beneficiaries	**74%**	**76%**	**73%**
QMB plus	51	52	50
SLMB plus	3	4	3
Other full benefit	20	20	20
Partial-benefit dually eligible beneficiaries	**26**	**24**	**27**
QMB only	13	13	14
SLMB only	8	7	8
QI	5	4	5
QDWI	<1	<1	<1

Note: *CY (calendar year), QMB (qualified Medicare beneficiary), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual), QDWI (qualified disabled and working individuals). Exhibit includes all dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Percentages may not sum to 100 or to totals due to rounding. Beneficiaries in the QMB plus and SLMB plus categories qualify for QMB or SLMB benefits, respectively, and full Medicaid benefits. Beneficiaries in the QMB only and SLMB only categories are not eligible for full Medicaid benefits; their Medicaid coverage is limited to payment of Medicare premiums and sometimes cost sharing. More detail on each of the benefit categories reported in this table can be found in Appendix A.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- In CY 2022, almost three-quarters (74 percent) of individuals who were dually eligible for Medicare and Medicaid were eligible for full Medicaid benefits.
- Among the partial-benefit dually eligible beneficiary categories, the greatest enrollment (13 percent) was in the QMB-only category.

Exhibit 3

Medicare and Medicaid spending on dually eligible beneficiaries by age and type of benefit, CY 2022

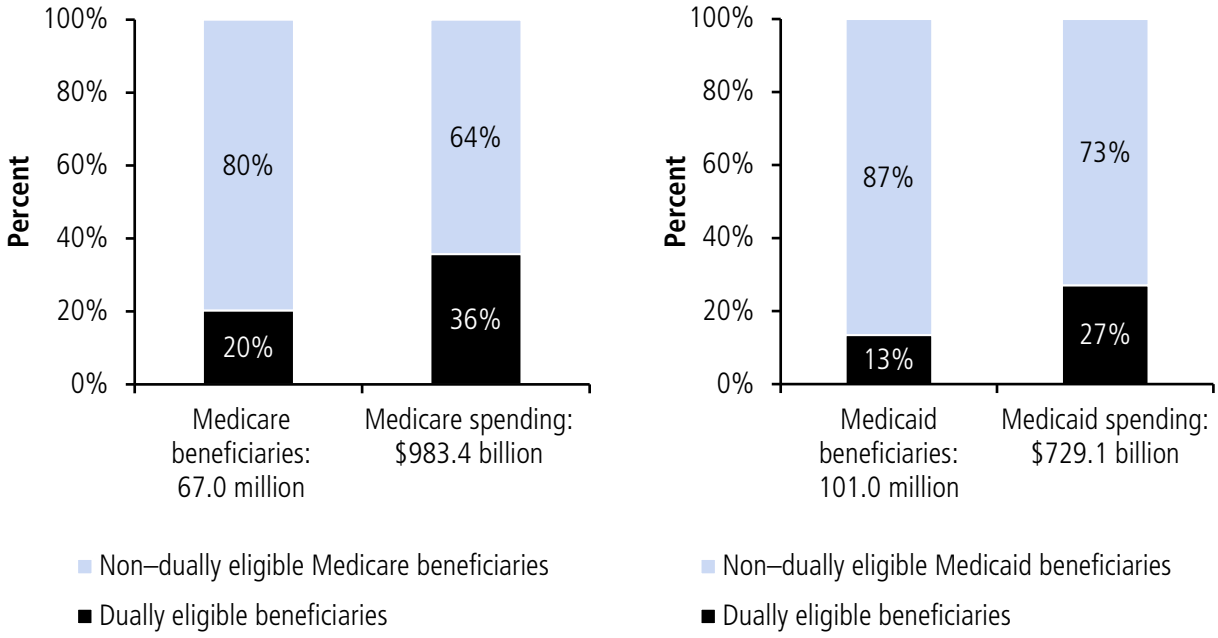


Note: *CY (calendar year). Exhibit includes all dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts for dually eligible beneficiaries include both federal and state spending and exclude Medicaid payments of Medicare premiums. Components may not sum to totals due to rounding. Exhibit excludes administrative spending.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and spending data.*

- Combined Medicare and Medicaid spending on individuals who were dually eligible for Medicare and Medicaid was $548.8 billion in CY 2022. (The Medicaid figure includes both federal and state spending.) Medicare accounted for about 64 percent of combined spending, or $351.4 billion.
- By age group, combined Medicare and Medicaid spending on dually eligible beneficiaries was higher for beneficiaries ages 65 and older ($351.9 billion in combined spending) than for beneficiaries under age 65 ($196.9 billion in combined spending).
- Combined Medicare and Medicaid spending was more than five times higher for full-benefit dually eligible beneficiaries than for partial-benefit dually eligible beneficiaries ($465.0 billion vs. $83.8 billion).

Exhibit 4

Dually eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2022



Note: *CY (calendar year). Exhibit includes all dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts for dually 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.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and spending data.*

- Individuals dually eligible for Medicare and Medicaid benefits accounted for disproportionate shares of Medicare and Medicaid spending in CY 2022.
- Dually eligible beneficiaries totaled 20 percent of the Medicare population in 2022 but accounted for 36 percent of Medicare spending.
- Similarly, dually eligible beneficiaries comprised 13 percent of all Medicaid beneficiaries but accounted for 27 percent of Medicaid spending.

Exhibit 5

Selected subgroups of dually eligible beneficiaries as a share of Medicare and Medicaid enrollment and spending, CY 2022

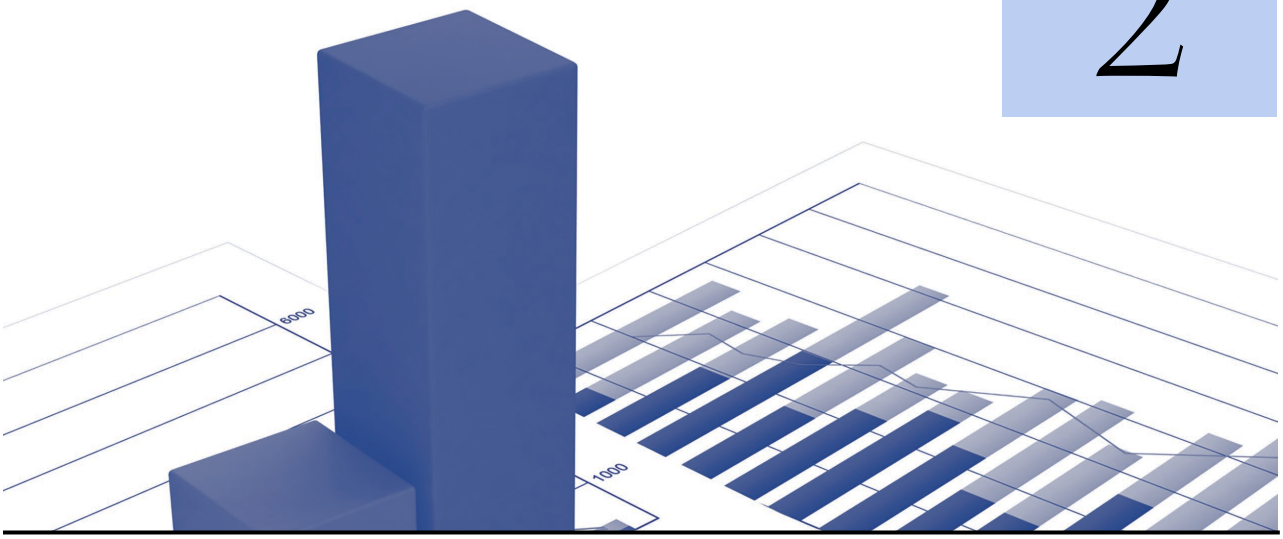
Dually eligible beneficiary subgroup	Percent of all Medicare beneficiaries	Percent of all Medicare spending	Percent of all Medicaid beneficiaries	Percent of all Medicaid spending
Age				
Under age 65	7%	13%	5%	10%
Ages 65 and older	13	23	9	17
Type of benefit				
Full benefit	15%	27%	10%	27%
Partial benefit	5	8	4	<1

Note: *CY (calendar year). Exhibit includes all dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). The sum of the subgroups as a percentage 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 dually eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and spending data.*

- Certain subgroups of individuals who were dually eligible for Medicare and Medicaid benefits accounted for disproportionate shares of Medicare and Medicaid spending.
- Dually eligible beneficiaries ages 65 and older made up 13 percent of the Medicare population in CY 2022 but accounted for 23 percent of Medicare spending. These beneficiaries also accounted for 9 percent of the Medicaid population but 17 percent of Medicaid spending.
- Full-benefit dually eligible beneficiaries also incurred disproportionate spending, particularly in Medicaid. In Medicare, they accounted for 15 percent of all enrollment but 27 percent of all Medicare spending; in Medicaid, they made up 10 percent of all enrollment but 27 percent of all Medicaid spending.

Section

2



Characteristics of dually eligible beneficiaries

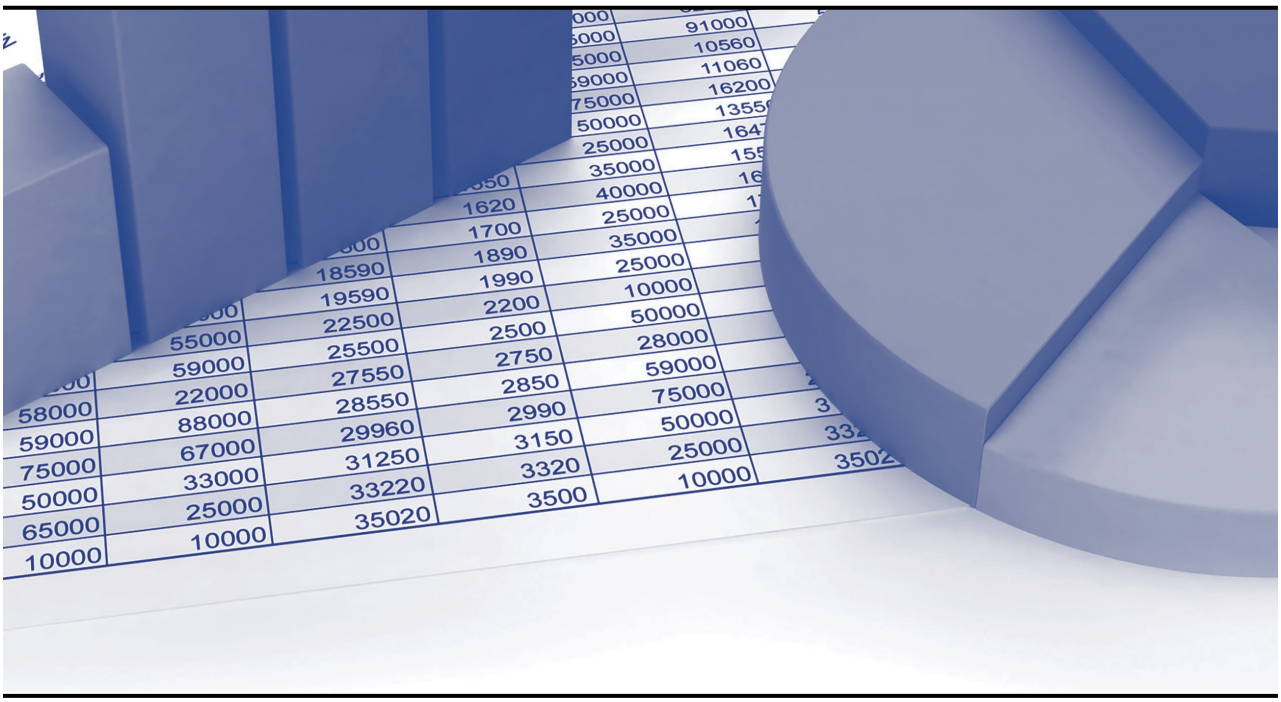


Exhibit 6

Demographic characteristics of dually eligible and non–dually eligible Medicare and Medicaid beneficiaries, CY 2022

Demographic characteristic	Dually eligible beneficiaries					Non–dually eligible Medicare beneficiaries	Non–dually eligible Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit		
Gender							
Male	41%	48%	38%	42%	41%	47%	56%
Female	59	52	62	58	59	53	44
Race/Ethnicity							
White/non-Hispanic	53%	60%	50%	52%	57%	82%	45%
Black/non-Hispanic	21	25	19	20	23	9	28
Hispanic	18	13	21	18	16	6	23
Other	8	3	11	10	4	3	4
Residence							
Urban	80%	76%	81%	81%	75%	80%	80%
Rural	20	24	19	19	25	20	20

Note: *CY (calendar year). Exhibit includes all dually eligible beneficiaries and non–dually eligible Medicare beneficiaries (fee-for-service, managed care, and end-stage renal disease). The non–dually eligible 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.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- Overall, most individuals who were dually eligible for Medicare and Medicaid benefits in CY 2022 were female (59 percent), White (53 percent), and lived in an urban area (80 percent).
- Dually eligible beneficiaries were more likely to be White (53 percent) than non–dually eligible Medicaid beneficiaries who were eligible on the basis of a disability (45 percent), but less likely than non–dually eligible Medicare beneficiaries (82 percent). The share of dually eligible beneficiaries who were Black (21 percent) and Hispanic (18 percent) was higher than the corresponding figures for non–dually eligible Medicare beneficiaries (9 percent and 6 percent, respectively) but lower than the corresponding figures for non–dually eligible Medicaid beneficiaries (28 percent and 23 percent, respectively).
- Dually eligible beneficiaries under age 65 were more likely than dually eligible beneficiaries ages 65 and older to be male (48 percent vs. 38 percent), White (60 percent vs. 50 percent), or Black (25 percent vs. 19 percent). Dually eligible beneficiaries ages 65 and older were more likely to be Hispanic than dually eligible beneficiaries under the age of 65 (21 percent vs. 13 percent, respectively).
- Comparing full-benefit and partial-benefit dually eligible beneficiaries, full-benefit beneficiaries were slightly more likely to be Hispanic (18 percent vs. 16 percent) or live in an urban area (81 percent vs. 75 percent).

Exhibit 7

Additional characteristics of dually eligible beneficiaries, CY 2022

Characteristic	Dually eligible beneficiaries					Non–dually eligible Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
Limitations in ADLs						
None	54%	44%	59%	47%	69%	83%
1–2 ADL limitations	23	32	18	24	20	12
3–6 ADL limitations	23	25	23	29	11	5
Self-reported health status						
Excellent or very good	22%	19%	23%	21%	24%	53%
Good or fair	59	58	60	59	61	38
Poor	12	17	9	13	9	3
Unknown	7	5	8	7	6	5
Living arrangement						
Institution	11%	6%	13%	15%	2%	2%
Alone	35	32	37	32	42	27
Spouse	15	12	17	14	18	55
Children, nonrelatives, others	39	50	33	39	39	16
Education						
No high school diploma	33%	26%	37%	33%	33%	7%
High school diploma only	32	40	27	31	32	23
Some college	31	33	30	29	35	69
Other	5	2	6	6	<1	1

Note: *CY (calendar year), ADL (activity of daily living). Exhibit includes all dually eligible and non–dually eligible Medicare beneficiaries (fee-for-service, managed care, and end-stage renal disease) who were linked to the Medicare Current Beneficiary Survey (MCBS). Non–dually eligible disabled Medicaid beneficiaries are not included because data are not available for these beneficiaries through the MCBS. The MCBS is collected from a sample of Medicare beneficiaries; year-to-year variation in some reported data is expected. Percentages may not sum to 100 due to rounding.*
Source: *2022 Medicare Current Beneficiary Survey.*

- Nearly half (46 percent) of individuals who were dually eligible for Medicare and Medicaid benefits in CY 2022 had at least one ADL limitation (for example, they require assistance with bathing).
- Dually eligible beneficiaries were more likely than non–dually eligible Medicare beneficiaries to report being in poor health (12 percent vs. 3 percent) or living in an institution (11 percent vs. 2 percent).
- Dually eligible beneficiaries ages 65 and older were more likely than younger dually eligible beneficiaries to live in an institution (13 percent vs. 6 percent). However, older dually eligible beneficiaries were more likely to report having no ADL limitations (59 percent vs. 44 percent) and less likely to report being in poor health (9 percent vs. 17 percent).
- Dually eligible beneficiaries with partial benefits were more likely than those with full benefits to report having no ADL limitations (69 percent vs. 47 percent). Partial-benefit dually eligible beneficiaries were also less likely than their full-benefit counterparts to live in an institution (2 percent vs. 15 percent).
- One-third of all dually eligible individuals (33 percent) did not graduate from high school, compared with 7 percent of non–dually eligible Medicare beneficiaries.

Exhibit 8

Selected chronic conditions for FFS Medicare dually eligible beneficiaries by age group, CY 2022

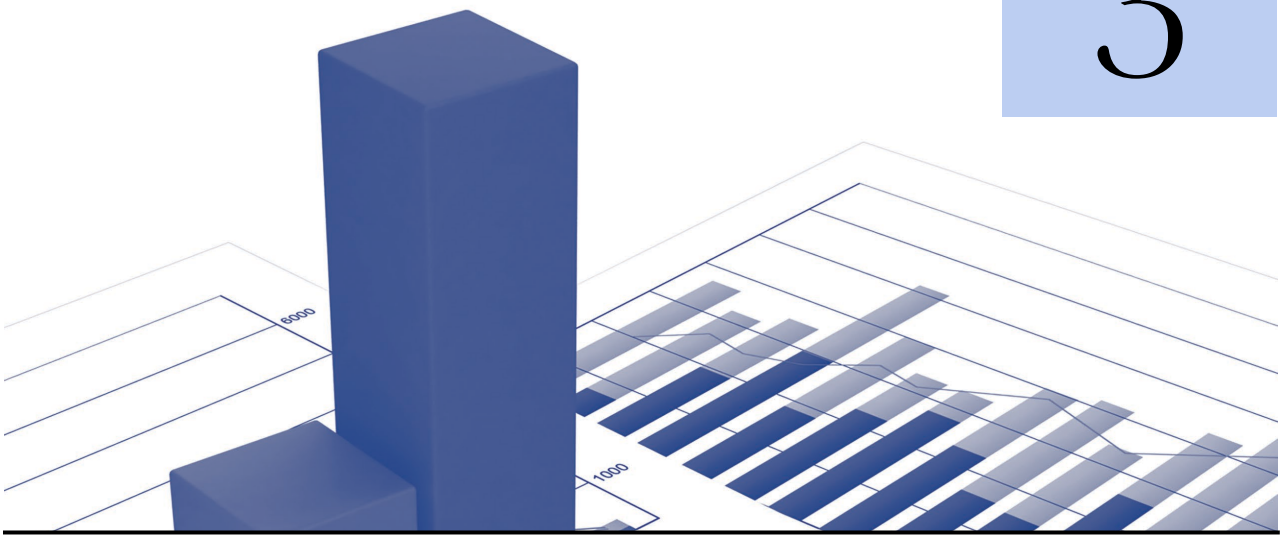
Condition	FFS Medicare dually eligible beneficiaries	
	Under age 65	Ages 65 and older
Cognitive impairment		
Alzheimer's disease or related dementia	2%	15%
Intellectual disabilities and related conditions	12	2
Physical health conditions		
Diabetes	22%	32%
Heart failure	6	16
Hypertension	41	64
Ischemic heart disease	8	21
Behavioral health conditions		
Anxiety disorders	34%	22%
Bipolar disorder	15	5
Depression	35	25
Schizophrenia and other psychotic disorders	14	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.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data and Medicare claims data.*

- The share of individuals who were dually eligible for Medicare and Medicaid benefits with selected chronic conditions differed between those under age 65 versus those ages 65 and older for beneficiaries enrolled in FFS Medicare.
- With respect to cognitive impairment, Alzheimer's disease or related dementia was much more common among the older dually eligible beneficiaries (15 percent vs. 2 percent). More dually eligible beneficiaries under age 65 had an intellectual disability (12 percent vs. 2 percent).
- Compared with the population under age 65, those ages 65 and older generally had higher rates of physical health conditions such as diabetes, heart failure, hypertension, and ischemic heart disease.
- Behavioral health conditions—anxiety disorders, bipolar disorder, depression, and schizophrenia and other psychotic disorders—were consistently more common among the dually eligible population under age 65 than those ages 65 and older.

Section

3



Eligibility pathways, managed care enrollment, and continuity of enrollment

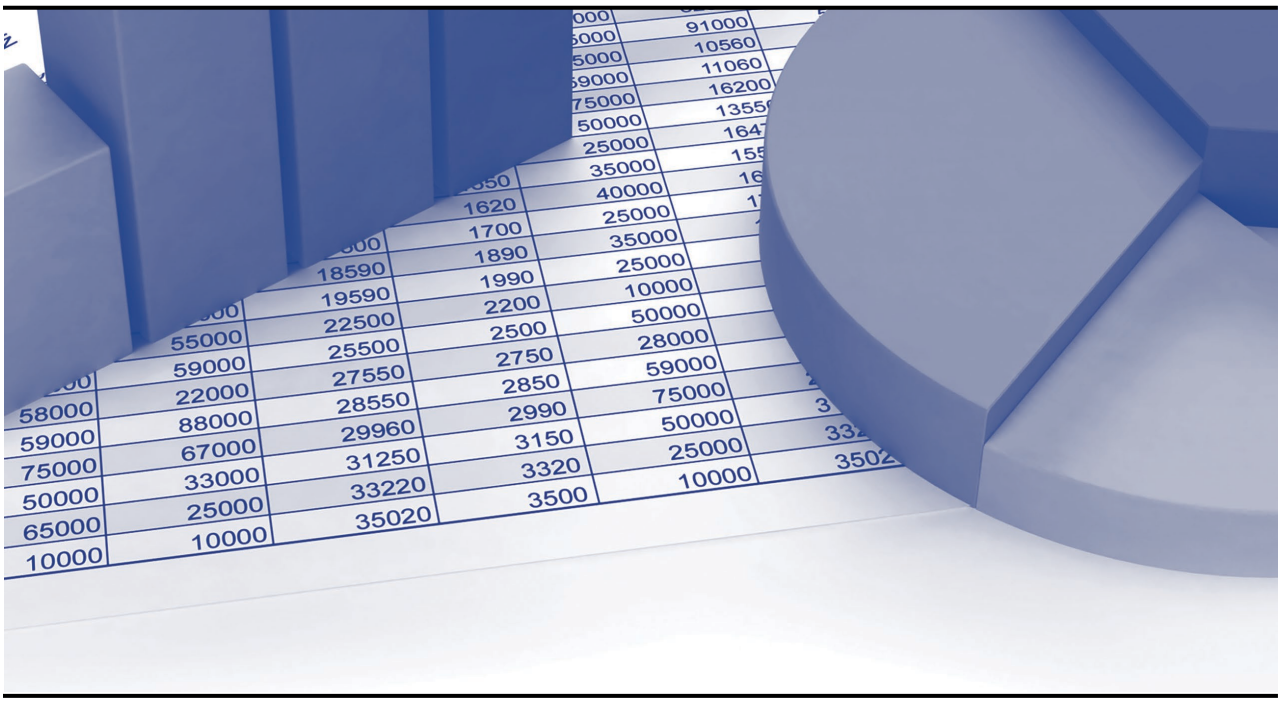


Exhibit 9

Medicare eligibility pathways, CY 2022

Original reason for entitlement to Medicare	Dually eligible beneficiaries			Non–dually eligible Medicare beneficiaries
	All	Full benefit	Partial benefit	
Age	49%	50%	48%	86%
ESRD	1	1	1	<1
Disability	49	49	51	14
Based on own record	82	78	93	96
Based on another's record	18	22	7	4

Note: *CY (calendar year), ESRD (end-stage renal disease). Exhibit includes all dually eligible beneficiaries and non–dually eligible Medicare beneficiaries (fee-for-service, managed care, and ESRD). Components may not sum to totals due to rounding.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- Overall, individuals who were dually eligible for Medicare and Medicaid benefits in CY 2022 were evenly split between those who originally qualified for Medicare benefits based on age (49 percent) and those who qualified for Medicare benefits based on disability (49 percent).
- In contrast to dually eligible beneficiaries, most non–dually eligible Medicare beneficiaries (86 percent) originally qualified for Medicare benefits based on their age.
- Most (78 percent) full-benefit dually eligible beneficiaries who originally qualified for Medicare because of disability were individuals with sufficient employment history to be eligible based on their own work record. A higher portion (93 percent) of partial-benefit dually eligible beneficiaries who originally qualified for Medicare benefits because of disability did so based on their own employment record.
- The remaining dually eligible beneficiaries (22 percent among those with full benefits and 7 percent among those with partial benefits) who originally qualified for Medicare because of disability were eligible based on another individual's work record. These beneficiaries include, among others, adult children ages 18 and older who have been disabled since childhood.

Exhibit 10

Medicaid eligibility pathways, CY 2022

Medicaid eligibility group	Dually eligible beneficiaries			Non–dually eligible Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	
SSI	34%	35%	34%	83%
Poverty related	43	40	44	5
Medically needy	7	5	7	3
Section 1115 waiver	<1	<1	<1	0
Special income limit and other	16	20	15	8

Note: *CY (calendar year), SSI (Supplemental Security Income). Exhibit includes all dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). The non–dually eligible 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.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- Overall, most individuals who were dually eligible for Medicare and Medicaid benefits in CY 2022 qualified for Medicaid benefits through poverty-related eligibility pathways (43 percent) or through receipt of SSI benefits (34 percent).
- In contrast to dually eligible beneficiaries, most non–dually eligible Medicaid beneficiaries eligible on the basis of a disability (83 percent) qualified for Medicaid benefits based on receipt of SSI benefits.
- Compared with those under age 65, dually eligible beneficiaries ages 65 and older were more likely to have been eligible for Medicaid due to 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 FFS and managed care enrollment, CY 2022

Type of Medicare enrollment	Dually eligible beneficiaries					Non–dually eligible Medicare beneficiaries
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
FFS only	38%	42%	36%	42%	27%	56%
Managed care only	51	45	54	45	66	40
Some FFS months and some managed care months	11	13	11	13	7	4
Among beneficiaries in managed care only						
Enrolled in a D–SNP	58	63	55	63	48	<1
Enrolled in other plan type	42	37	45	37	52	100

Note: *FFS (fee-for-service), CY (calendar year), 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 dually eligible beneficiaries and non–dually eligible Medicare beneficiaries (FFS, managed care, and end-stage renal disease). Percentages may not sum to 100 due to rounding.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- In CY 2022, a majority of individuals who were dually eligible for Medicare and Medicaid services (51 percent) were exclusively enrolled in managed care (either a Medicare Advantage (MA) plan or other type of Medicare health plan).
- Dually eligible beneficiaries were more likely to be exclusively enrolled in managed care than non–dually eligible Medicare beneficiaries (51 percent vs. 40 percent).
- Dually eligible beneficiaries ages 65 and older were more likely to be exclusively enrolled in managed care than those under age 65 (54 percent vs. 45 percent).
- Partial-benefit dually eligible beneficiaries were more likely to be exclusively enrolled in managed care than full-benefit beneficiaries (66 percent vs. 45 percent), while full-benefit beneficiaries were more likely to be in Medicare FFS only (42 percent vs. 27 percent).
- Among those exclusively enrolled in managed care, more than half of dually eligible beneficiaries (58 percent) were enrolled in D–SNPs, which are specialized MA plans that serve dually eligible beneficiaries exclusively. Full-benefit dually eligible beneficiaries were more likely to enroll in D–SNPs, while those with partial-benefit dual eligibility were more likely to enroll in other types of plans.

Exhibit 12

Medicaid FFS and managed care enrollment, CY 2022

Type of Medicaid enrollment	Dually eligible beneficiaries					Non–dually eligible Medicaid beneficiaries (disabled, under age 65)
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit	
FFS only	40%	39%	40%	23%	87%	11%
FFS and limited-benefit managed care only	17	20	15	22	1	15
At least one month of comprehensive managed care	43	41	45	54	13	74

Note: *FFS (fee-for-service), CY (calendar year). Exhibit includes all dually eligible beneficiaries (FFS, managed care, and end-stage renal disease). The non–dually eligible 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.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- Most individuals dually eligible for Medicare and Medicaid services in CY 2022 were either enrolled only in Medicaid FFS (40 percent) or in Medicaid FFS with a limited-benefit Medicaid managed care plan (17 percent).
- Non–dually eligible Medicaid beneficiaries eligible on the basis of a disability were more likely than dually eligible beneficiaries to have at least one month of enrollment in a comprehensive managed care plan (74 percent vs. 43 percent) and less likely to be enrolled in Medicaid FFS only (11 percent vs. 40 percent).
- Dually eligible beneficiaries ages 65 and older were more likely to be in comprehensive managed care than those under age 65 (45 percent vs. 41 percent).
- About three-quarters (76 percent) of full-benefit dually eligible beneficiaries were enrolled in some type of Medicaid managed care plan during the year.

Exhibit 13

Overlap between Medicare and Medicaid managed care enrollment for dually eligible beneficiaries, CY 2022

Enrollment status	Dually eligible beneficiaries				
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit
At least one month of simultaneous enrollment in Medicare managed care and comprehensive Medicaid managed care	27%	24%	28%	32%	11%
Some enrollment in Medicare managed care and/or comprehensive Medicaid managed care, but never in the same month	49	46	51	44	62
No months of enrollment in either Medicare managed care or comprehensive Medicaid managed care	24	29	22	24	27

Note: *CY (calendar year). Exhibit includes all dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Percentages may not sum to 100 due to rounding.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- Many proposals to improve Medicare–Medicaid integration for dually eligible beneficiaries rely on managed care, making the overlap between Medicare managed care and Medicaid managed care enrollment an important measure of the potential for greater integration.
- In CY 2022, more than one-quarter (27 percent) of all dually eligible beneficiaries had at least one month in which they were simultaneously enrolled in a Medicare managed care plan (either a Medicare Advantage plan or other type of Medicare health plan) and a comprehensive Medicaid managed care plan.
- Another 49 percent of all dually eligible beneficiaries had some enrollment in a Medicare managed care and/or comprehensive Medicaid managed care plan but did not have any months of simultaneous enrollment.
- Partial-benefit dually eligible beneficiaries were more likely than full-benefit dually eligible beneficiaries to have had some enrollment in Medicare managed care and/or comprehensive Medicaid managed care without any months of simultaneous enrollment (62 percent vs. 44 percent).
- Beneficiaries under age 65 were more likely than beneficiaries ages 65 and older to have no enrollment in either Medicare managed care or comprehensive Medicaid managed care (29 percent vs. 22 percent).

Exhibit 14

Continuity of enrollment status for dually eligible beneficiaries, CY 2022

Enrollment status	Dually eligible beneficiaries				
	All	Under age 65	Ages 65 and older	Full benefit	Partial benefit
Full-year enrollment status					
Enrolled 12 months, all with dually eligible status	84%	88%	82%	83%	87%
Enrolled 12 months, some with Medicare or Medicaid only	10	9	11	11	9
Enrolled fewer than 12 months	5	3	7	6	4
Consistency of full and partial dually eligible status during the year					
Exclusively full or exclusively partial	98	97	98	98	97
Switched between full and partial	2	3	2	2	3
Attainment of dually eligible status during the year					
Was previously dually eligible	89	91	88	88	91
Became dually eligible	11	9	12	12	9
Of those who became dually eligible during the year, the share who were:					
Medicare beneficiaries who gained Medicaid coverage	49	30	57	39	88
Medicaid beneficiaries who gained Medicare coverage	51	70	43	61	11
Individuals who gained Medicare and Medicaid coverage simultaneously	<1	<1	<1	<1	1

Note: *CY (calendar year). Exhibit includes all dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Percentages may not sum to 100 due to rounding.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- Overall, most individuals dually eligible for Medicare and Medicaid benefits (84 percent) were dually eligible beneficiaries during every month of CY 2022.
- Only 2 percent of all dually eligible beneficiaries in 2022 switched between full-benefit and partial-benefit dually eligible status.
- Eleven percent of dually eligible beneficiaries first became dually eligible during 2022. Among those individuals, about half were non–dually eligible Medicare beneficiaries who gained Medicaid coverage (49 percent) and the other half were non–dually eligible Medicaid beneficiaries who gained Medicare coverage (51 percent).
- Among beneficiaries who became dually eligible during 2022, those under age 65 were more likely to have been non–dually eligible Medicaid beneficiaries before they became dually eligible beneficiaries (70 percent). Those ages 65 and older were more likely to have been non–dually eligible Medicare beneficiaries before becoming dually eligible beneficiaries (57 percent).
- Full-benefit dually eligible beneficiaries who became dually eligible during the year were more likely to be non–dually eligible Medicaid beneficiaries first (61 percent) than non–dually eligible Medicare beneficiaries (39 percent).

Section

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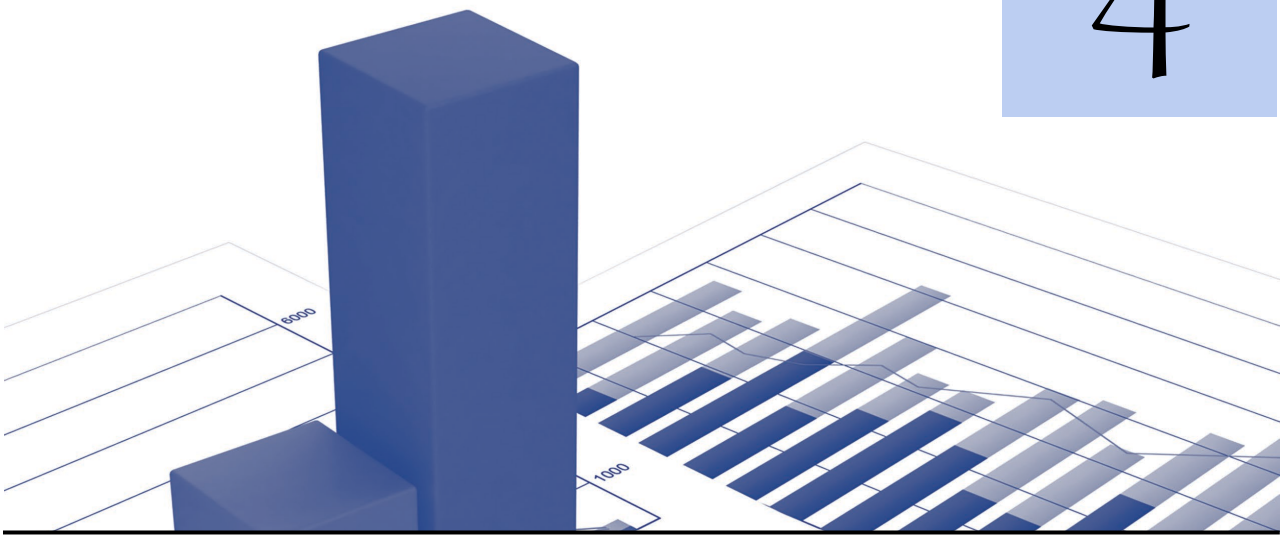

Utilization of and spending on Medicare and Medicaid services for dually eligible beneficiaries

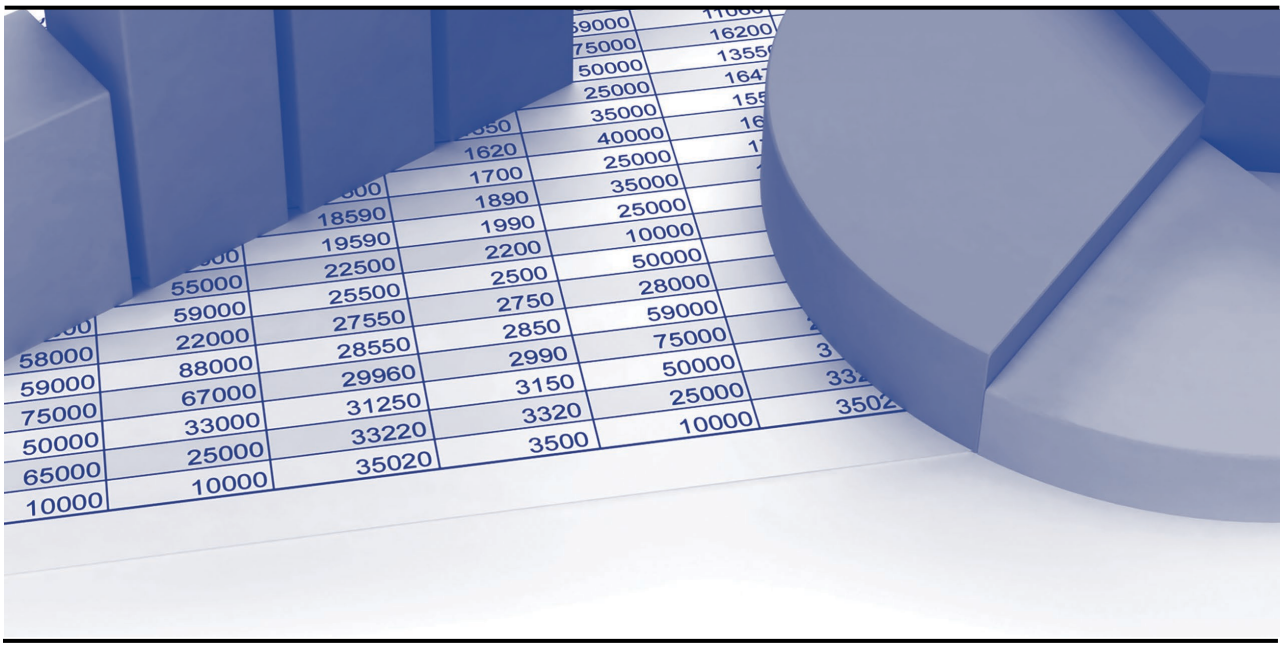

Exhibit 15

Use of Medicare services and per user Medicare spending for FFS dually eligible beneficiaries and non–dually eligible beneficiaries, CY 2022

Selected Medicare services	Full-benefit FFS dually eligible beneficiaries			FFS non–dually eligible Medicare beneficiaries		
	Percent using service	Spending per user	Percent of total spending	Percent using service	Spending per user	Percent of total spending
Part A and Part B						
Inpatient hospital	22%	$28,317	35%	13%	$22,717	28%
Skilled nursing facility	11	24,631	16	3	17,369	5
Home health	11	6,390	4	9	5,030	4
Other outpatient	93	8,114	42	93	6,774	60
Part D						
Prescription drugs	90	9,578		95	2,542	

Note: *FFS (fee-for-service), CY (calendar year). "Dually eligible beneficiaries" in this table refers only to full-benefit dually eligible beneficiaries in Medicare FFS and Medicaid FFS. Beneficiaries with end-stage renal disease are excluded. "Inpatient hospital" includes psychiatric hospital services. "Other outpatient" includes physician services, hospice, durable medical equipment, hospital outpatient, emergency department not preceding an inpatient stay, and services in 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.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and claims data.*

- Individuals enrolled in FFS Medicare who were dually eligible for Medicaid in CY 2022 had higher use of certain Medicare-covered services (inpatient hospital, skilled nursing facility, and home health) than did their non–dually eligible FFS counterparts.
- Per user Medicare FFS spending for each type of service was higher for dually eligible beneficiaries than for non–dually eligible Medicare beneficiaries.
- Inpatient hospital and skilled nursing facility services accounted for a higher portion of Medicare FFS spending on dually eligible beneficiaries than of Medicare FFS spending on non–dually eligible Medicare beneficiaries (35 percent vs. 28 percent and 16 percent vs. 5 percent, respectively).

Exhibit 16

Use of Medicaid services and per user Medicaid spending for FFS dually eligible beneficiaries and non–dually eligible beneficiaries, CY 2022

Selected Medicaid services	Full-benefit FFS dually eligible beneficiaries			Full-benefit FFS non–dually eligible Medicaid beneficiaries (disabled, under age 65)		
	Percent using service	Spending per user	Percent of total spending	Percent using service	Spending per user	Percent of total spending
Inpatient hospital	10%	$2,838	1%	13%	$29,068	12%
Outpatient	84	2,561	8	80	7,410	20
Institutional LTSS	16	59,661	33	4	88,512	11
HCBS state plan	16	15,930	9	17	16,134	9
HCBS waiver	20	52,295	37	18	39,524	24
Prescription drugs	27	350	<1	67	7,118	16
Managed care capitation	45	7,477	12	68	3,626	8

Note: *FFS (fee-for-service), CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). "Dually eligible beneficiaries" in this table refers only to full-benefit dually eligible beneficiaries in Medicare FFS and Medicaid FFS. Beneficiaries with end-stage renal disease are excluded. "Outpatient" includes all Medicaid services that are not inpatient, LTSS (institutional or HCBS), drugs, or managed care capitation (for FFS beneficiaries in limited-benefit plans). The non–dually eligible Medicaid beneficiary category excludes nondisabled Medicaid beneficiaries under age 65 and Medicaid beneficiaries ages 65 and older who did not have Medicare coverage. Medicaid spending amounts for dually eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and claims data.*

- Compared with non–dually eligible Medicaid beneficiaries who are eligible on the basis of a disability, individuals dually eligible for Medicare and Medicaid were more likely to use Medicaid-covered institutional LTSS under FFS (16 percent utilization among dually eligible beneficiaries vs. 4 percent utilization among non–dually eligible disabled Medicaid beneficiaries). Institutional LTSS also accounted for a higher portion of Medicaid spending on FFS dually eligible beneficiaries than of Medicaid spending on non–dually eligible disabled FFS Medicaid beneficiaries (33 percent vs. 11 percent).
- However, per user FFS spending on institutional LTSS was higher for non–dually eligible disabled Medicaid beneficiaries ($88,512) than for dually eligible beneficiaries ($59,661).
- More FFS dually eligible beneficiaries used Medicaid HCBS through an HCBS waiver than through a state plan (20 percent vs. 16 percent), and Medicaid FFS spending per user was also more than three times higher for HCBS provided through a waiver than for state-plan HCBS ($52,295 vs. $15,930). As a result, HCBS provided through a waiver accounted for a much higher portion of Medicaid FFS spending on dually eligible beneficiaries than state-plan HCBS (37 percent vs. 9 percent).

Exhibit 17

Use of Medicare and Medicaid services and per user Medicare and Medicaid spending for FFS dually eligible beneficiaries by age, CY 2022

Selected services	Full-benefit FFS dually eligible beneficiaries under age 65			Full-benefit FFS dually eligible beneficiaries ages 65 and older		
	Percent using service	Spending per user	Percent of total spending	Percent using service	Spending per user	Percent of total spending
Medicare services						
Inpatient hospital	16%	$29,249	21%	27%	$27,849	26%
Skilled nursing facility	4	23,699	4	18	24,784	15
Home health	7	6,558	2	15	6,329	3
Other outpatient	92	6,918	28	94	9,056	29
Prescription drugs	88	11,608	44	89	7,962	25
Medicaid services						
Inpatient hospital	8%	$3,523	1%	12%	$2,445	1%
Outpatient	88	2,781	8	82	2,370	7
Institutional LTSS	6	84,705	18	24	54,125	48
HCBS state plan	17	16,208	9	16	15,699	9
HCBS waiver	27	63,153	55	14	35,879	19
Prescription drugs	26	425	<1	27	293	<1
Managed care capitation	46	5,823	9	44	8,888	15

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 dually eligible beneficiaries in Medicare FFS and Medicaid FFS. Beneficiaries with end-stage renal disease are 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 services in other outpatient facilities. Medicare "prescription drugs" reflects beneficiaries who filled Part D prescriptions. Medicaid "outpatient" includes all Medicaid services that are not inpatient, LTSS (institutional or HCBS), prescription drugs, or managed care capitation (for FFS beneficiaries in limited-benefit plans). Medicaid spending amounts for dually eligible beneficiaries exclude Medicaid payments of Medicare premiums. Administrative spending is excluded. In the "percent of total spending" columns, the Medicare figures do not sum to 100 percent because spending is shown only for selected services, and the Medicaid figures may not sum to 100 percent due to rounding.*

Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and claims data.*

- Among individuals dually eligible for Medicare and Medicaid services in CY 2022, those who were ages 65 and older had higher use of FFS Medicare–covered inpatient hospital, skilled nursing facility, and home health services. However, their average spending per user for these services was similar to the amount spent for individuals under 65. Similar shares of FFS dually eligible beneficiaries over and under age 65 used prescription drugs, but spending per user was higher for those under age 65.
- Among FFS dually eligible beneficiaries, those under age 65 had lower use of Medicaid-covered institutional LTSS (6 percent vs. 24 percent for those ages 65 and older). Institutional LTSS also accounted for a lower portion of Medicaid spending on FFS dually eligible beneficiaries under age 65 (18 percent vs. 48 percent), but per user spending was higher among FFS dually eligible beneficiaries under age 65 ($84,705 vs. $54,125).

Section

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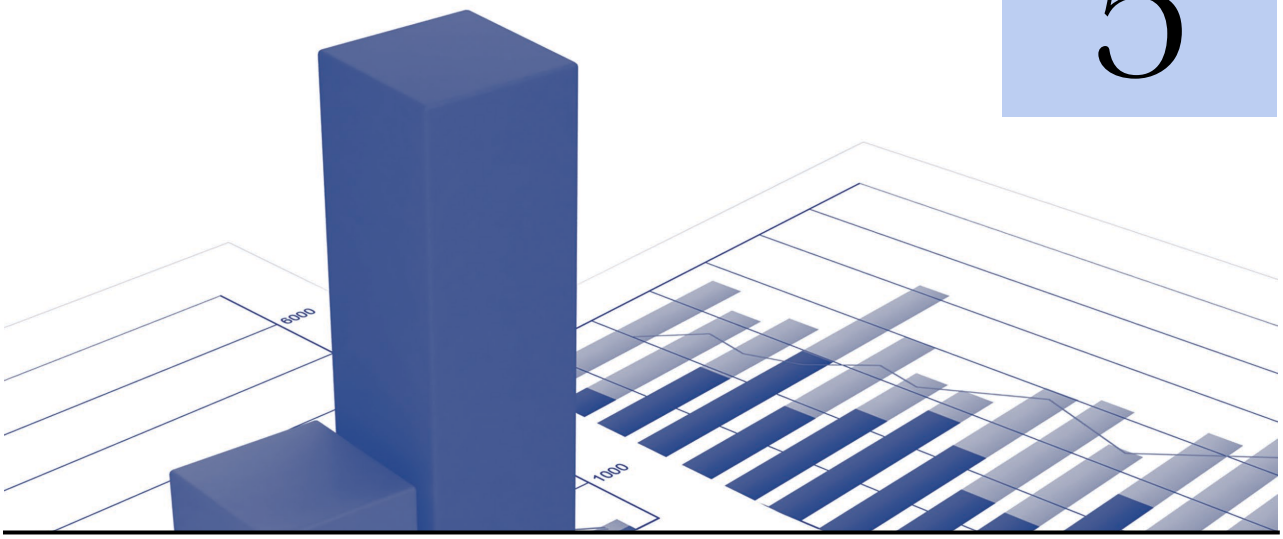


Medicare and Medicaid spending for dually eligible beneficiaries by LTSS use

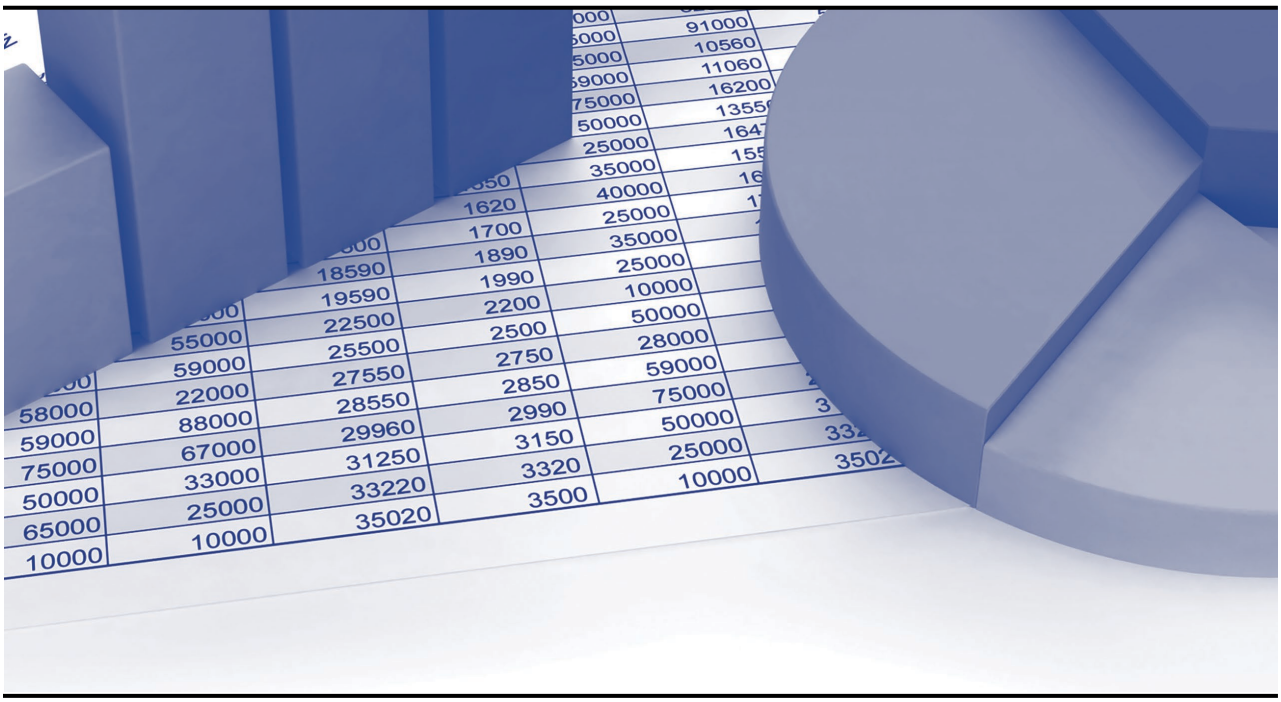
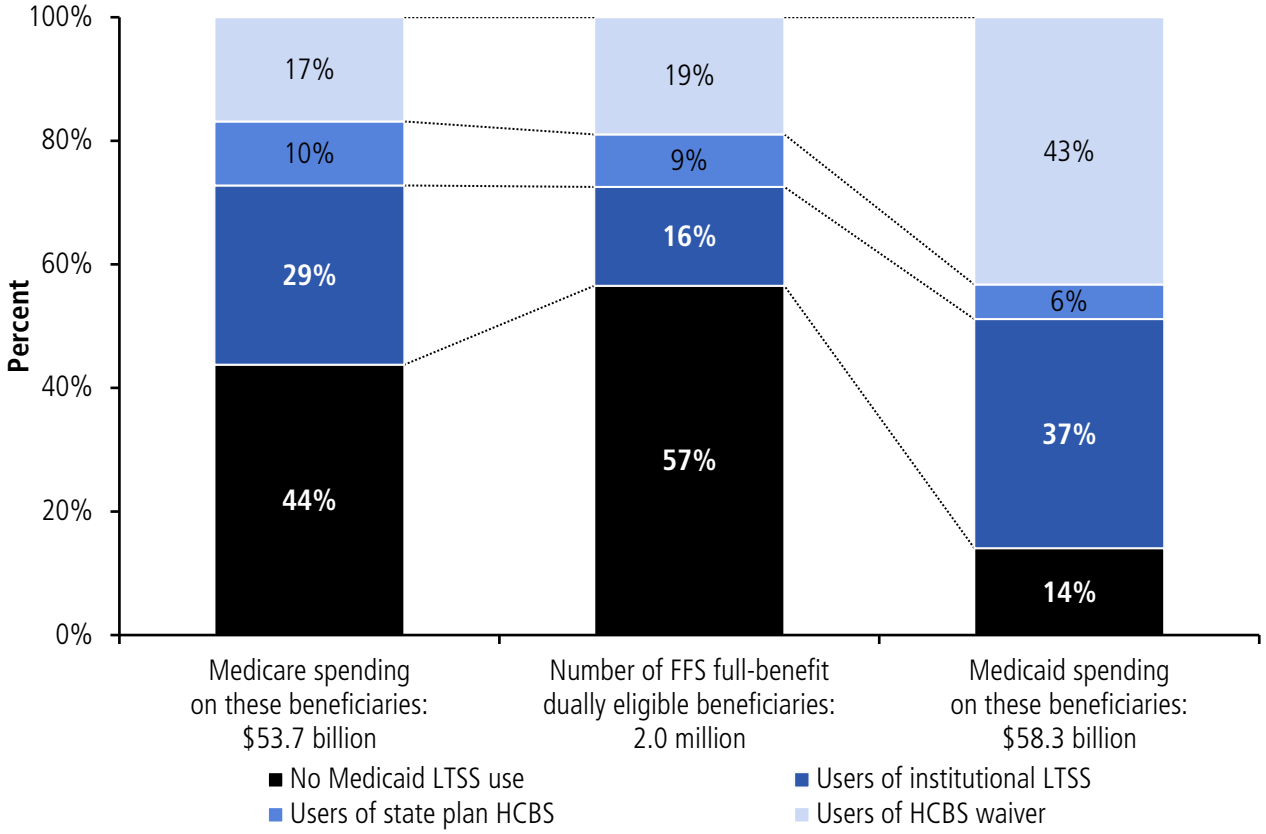


Exhibit 18

Medicare and Medicaid spending on FFS full-benefit dually eligible beneficiaries by type of Medicaid LTSS, CY 2022



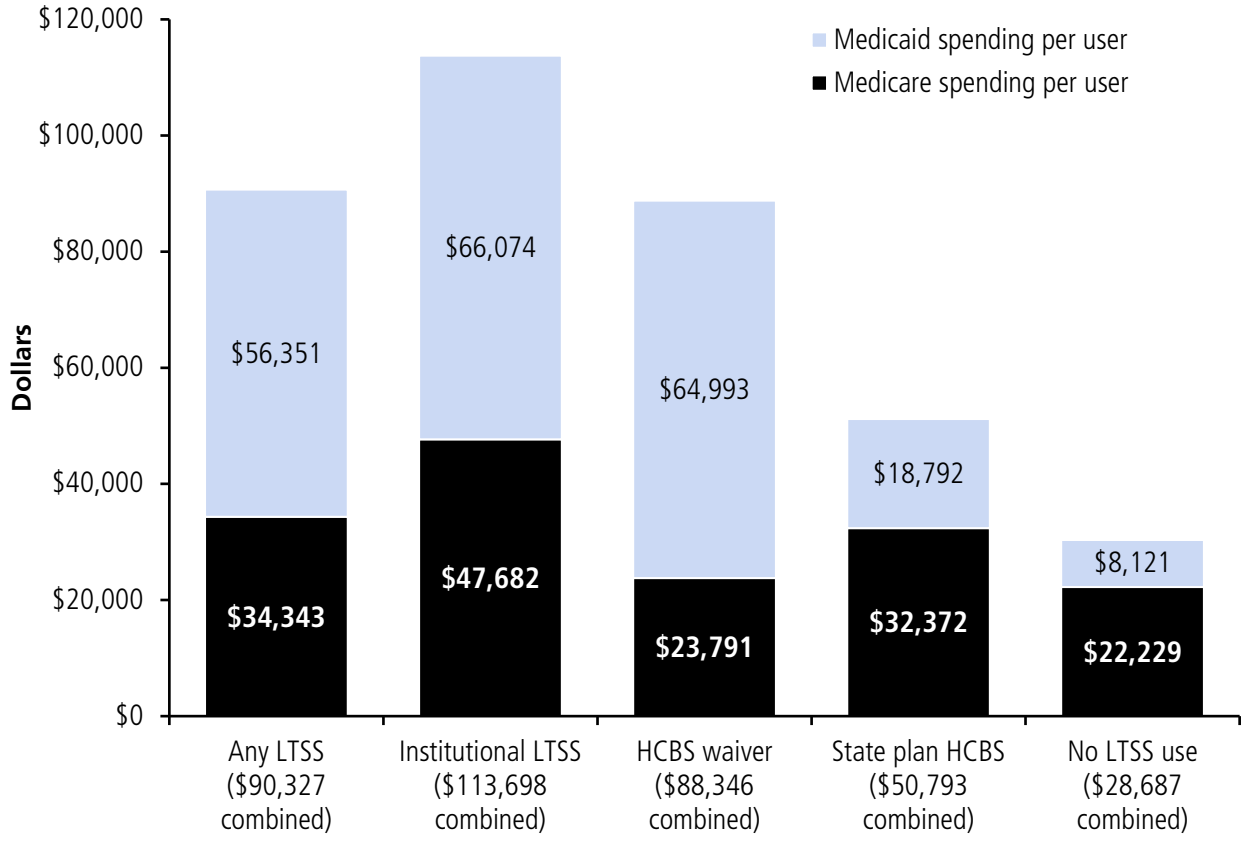
Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dually eligible beneficiaries in Medicare FFS and Medicaid FFS. Beneficiaries with end-stage renal disease are excluded. Medicaid spending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

Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and claims data.*

- In CY 2022, the majority (57 percent) of FFS full-benefit dually eligible beneficiaries used no Medicaid LTSS.
- Use of Medicaid-covered institutional LTSS among individuals dually eligible for Medicare and Medicaid services resulted in disproportionately high Medicare and Medicaid spending. Users of institutional LTSS made up 16 percent of FFS full-benefit dually eligible beneficiaries, but they accounted for 29 percent of Medicare spending and 37 percent of Medicaid spending on this population.
- Over the last two decades, federal and state policymakers have focused on shifting LTSS use from institutional settings toward HCBS. In CY 2022, the share of FFS full-benefit dually eligible beneficiaries who used HCBS was larger than the share who used institutional LTSS (28 percent vs. 16 percent), and HCBS accounted for a larger share of Medicaid spending than institutional LTSS (49 percent vs. 37 percent).

Exhibit 19

Medicare and Medicaid spending per user on FFS full-benefit dually eligible Medicaid LTSS users and non-users, CY 2022



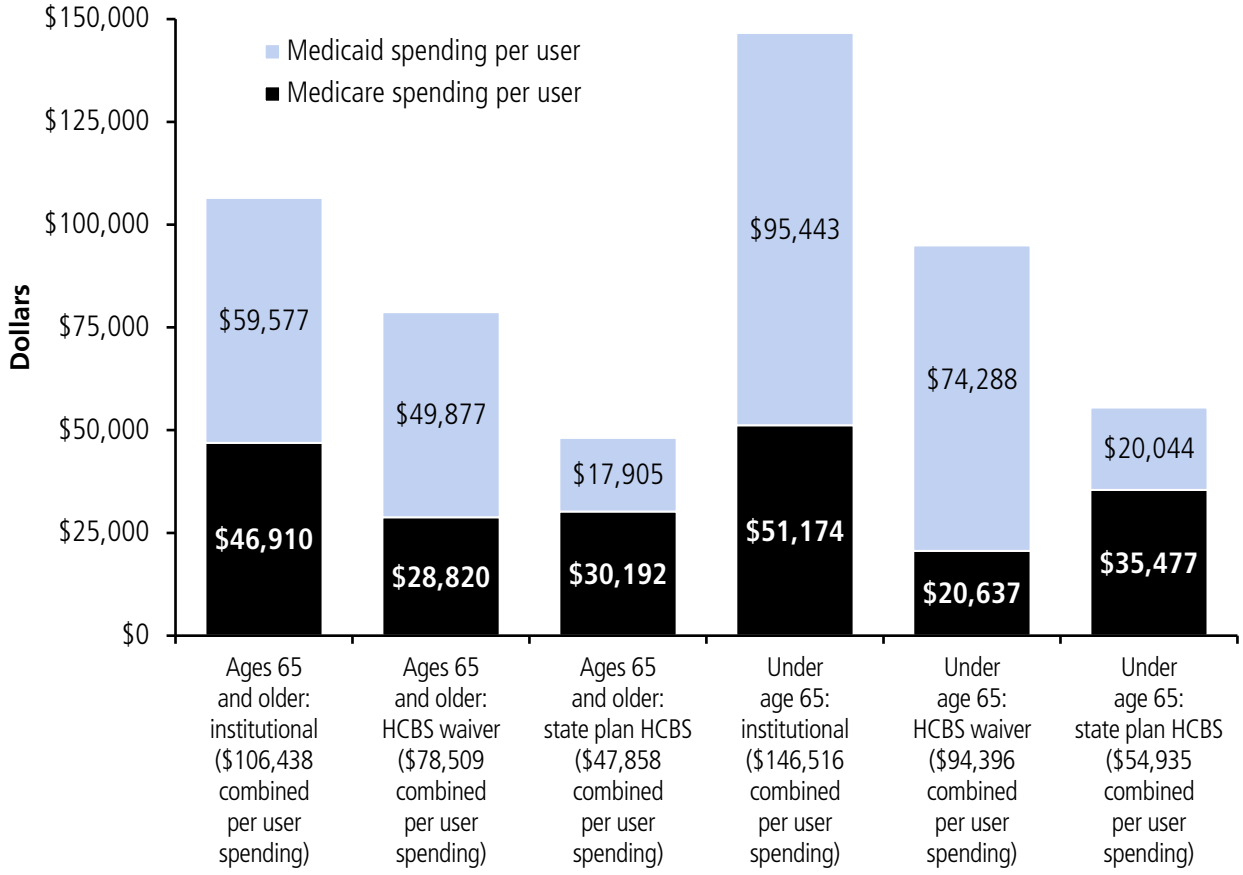
Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dually eligible beneficiaries in Medicare FFS and Medicaid FFS. Beneficiaries with end-stage renal disease are excluded. Medicaid spending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

Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and claims data.*

- Users of Medicaid-covered institutional LTSS had the highest Medicare and Medicaid spending per user in CY 2022 ($47,682 and $66,074, respectively) compared with users of other types of Medicaid LTSS and with non-LTSS users.
- Medicare and Medicaid spending per user for any type of Medicaid LTSS (institutional, HCBS waiver, or state-plan HCBS) was more than three times higher than spending per user on non-LTSS users ($90,327 vs. $28,687).
- Medicaid spending per user was generally higher than Medicare's for Medicaid LTSS users, except for users of state-plan HCBS. However, Medicare spending per user exceeded Medicaid's for non-LTSS users.

Exhibit 20

Medicare and Medicaid spending per user on FFS full-benefit dually eligible Medicaid LTSS users by age, CY 2022



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 dually eligible beneficiaries in Medicare FFS and Medicaid FFS. Beneficiaries with end-stage renal disease are excluded. Medicaid spending amounts for dually eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Medicare and Medicaid spending components sum to an amount greater than the total because combined spending per user includes a small number of individuals who used either Medicare or Medicaid services, but not both. Components may not sum to totals due to rounding.*

Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and claims data.*

- Among Medicaid LTSS users who were ages 65 and older, combined Medicare and Medicaid spending per user was higher for those who received Medicaid LTSS in an institution ($106,438) than for those who received Medicaid LTSS through HCBS waivers ($78,509) or through state-plan HCBS ($47,858).
- Among Medicaid LTSS users under age 65, Medicare spending per user was substantially higher for those who received Medicaid institutional LTSS compared with Medicare spending per user for those receiving Medicaid LTSS through HCBS waivers or through state-plan HCBS ($51,174 vs. $20,637 and $35,477).
- Medicaid spending per user on Medicaid institutional LTSS users under age 65 ($95,443) was higher than spending per user on any other subgroup of Medicaid LTSS users. It was also substantially higher than Medicaid spending per user on Medicaid institutional LTSS users who were ages 65 and older ($59,577).

Section

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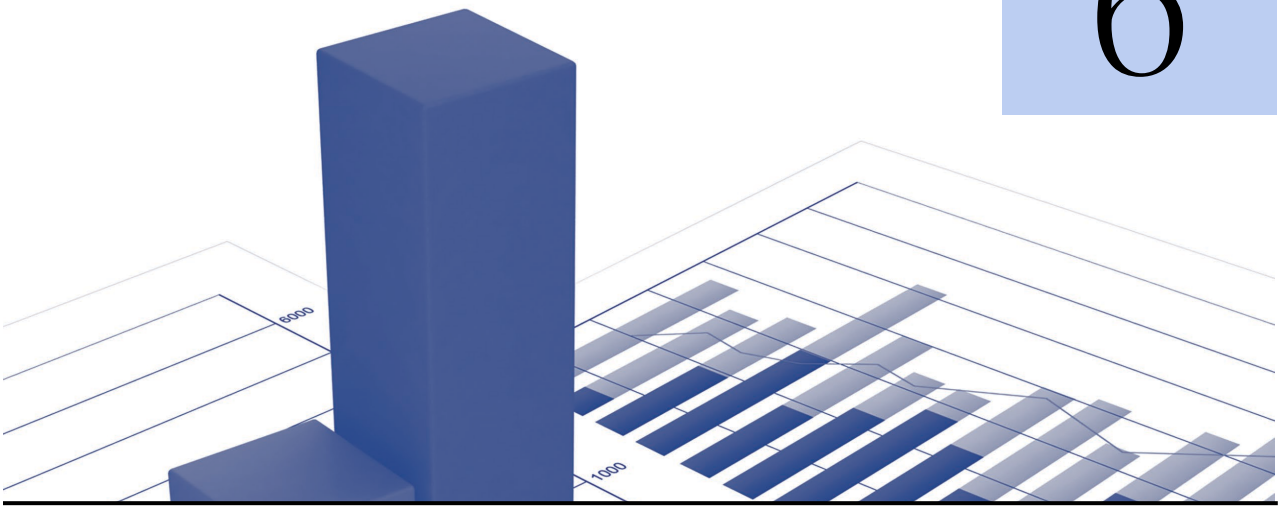


Trends in dually eligible population composition, spending, and service use

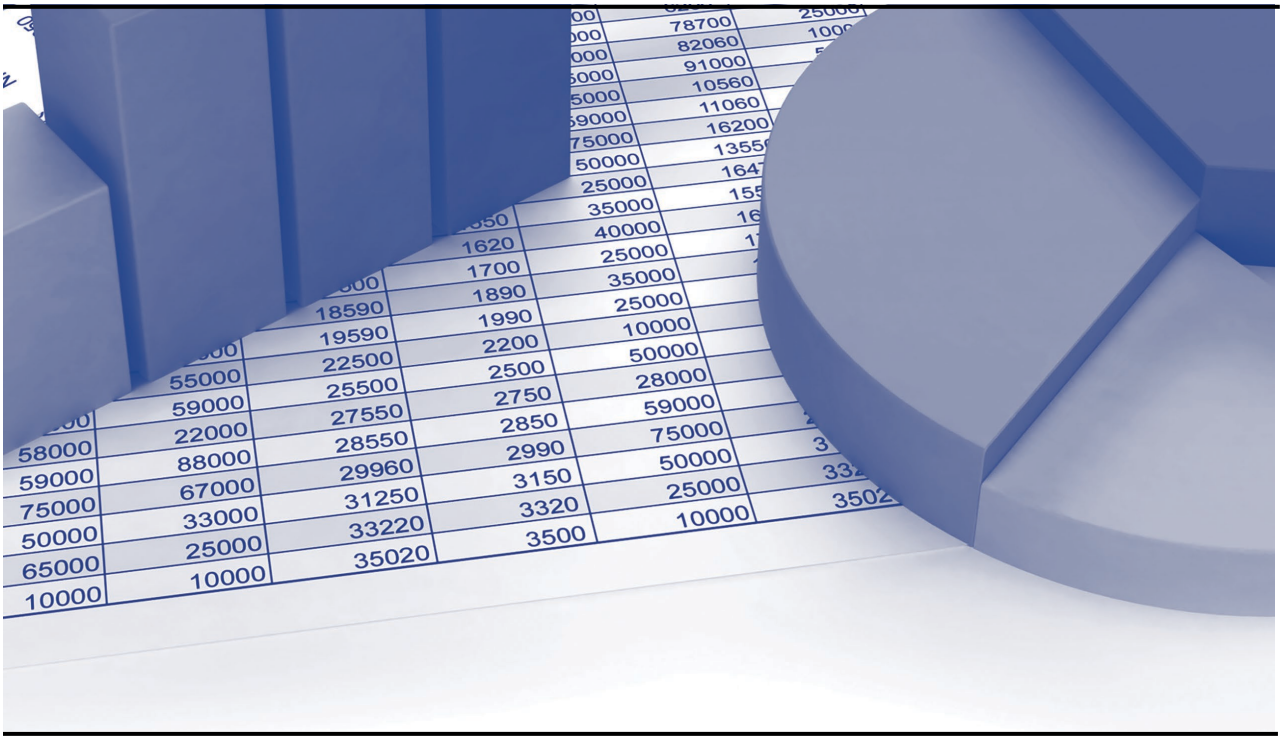
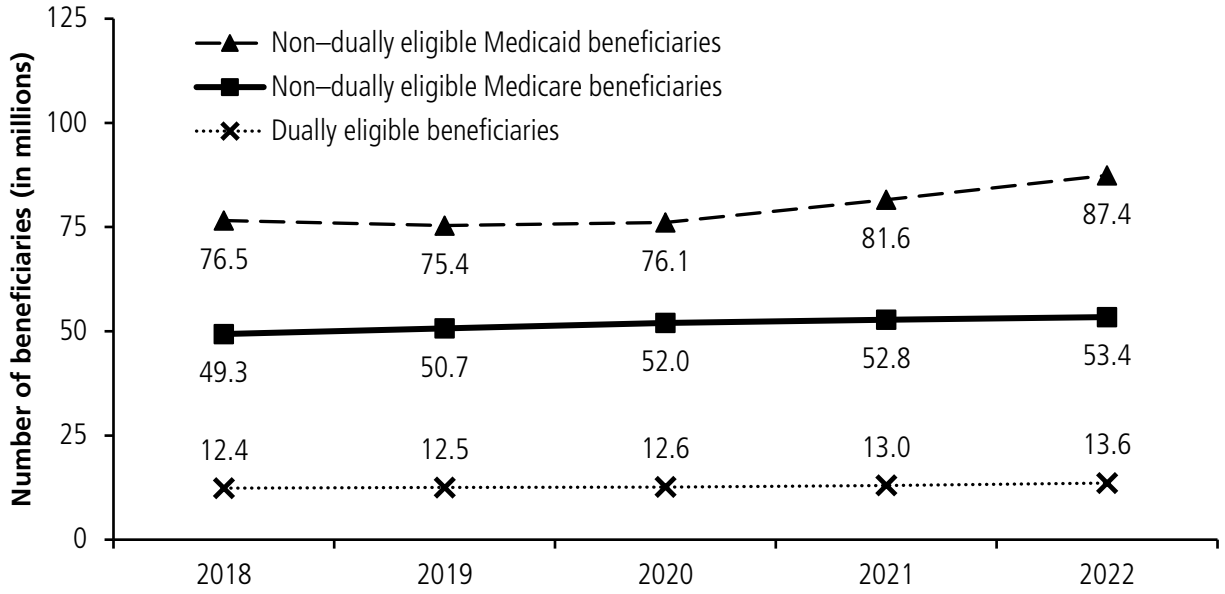


Exhibit 21

Number of dually eligible and non–dually eligible Medicare and Medicaid beneficiaries, CY 2018–2022



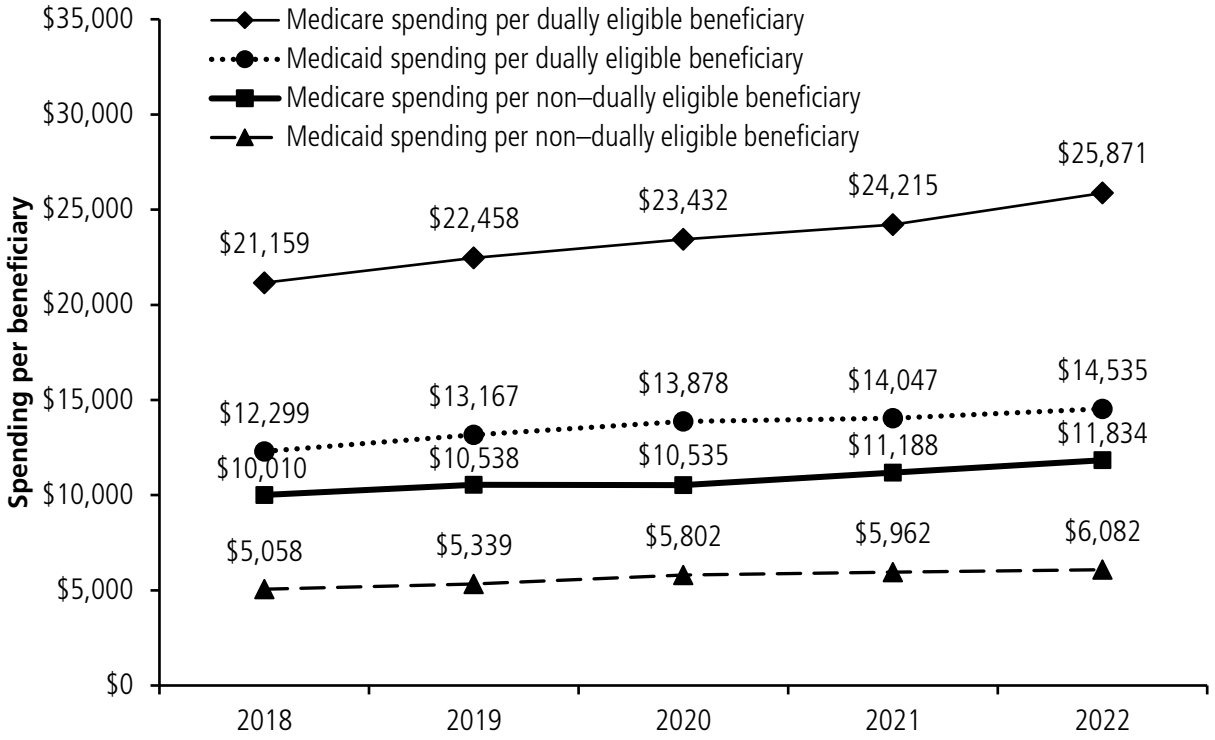
Category	Annual percentage growth in the number of beneficiaries				Cumulative growth	Average annual growth rate
	2019	2020	2021	2022		
Non–dually eligible Medicaid beneficiaries	–1.5%	1.0%	7.1%	7.2%	14.2%	3.4%
Non–dually eligible Medicare beneficiaries	2.7	2.6	1.4	1.2	8.2	2.0
Dually eligible beneficiaries	1.1	1.0	3.0	4.4	9.9	2.4

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

- The number of individuals dually eligible for Medicare and Medicaid grew from 12.4 million in 2018 to 13.6 million in 2022—cumulative growth of 9.9 percent over the period and an average annual growth rate of 2.4 percent.
- The number of non–dually eligible Medicare beneficiaries grew at a slightly slower rate, from 49.3 million in 2018 to 53.4 million in 2022, for a cumulative increase of 8.2 percent.
- The non–dually eligible Medicaid population grew at a faster rate than the dually eligible population, from 76.5 million in 2018 to 87.4 million in 2022—cumulative growth of 14.2 percent and an average annual growth of 3.4 percent.

Exhibit 22

Medicare and Medicaid spending per dually eligible and non–dually eligible beneficiary, CY 2018–2022



Category	Annual percentage growth in spending per beneficiary				Cumulative growth	Average annual growth rate
	2019	2020	2021	2022		
Medicare spending per dually eligible beneficiary	6.1%	4.3%	3.3%	6.8%	22.3%	5.2%
Medicaid spending per dually eligible beneficiary	7.1	5.4	1.2	3.5	18.2	4.3
Medicare spending per non–dually eligible beneficiary	5.3	–<0.1	6.2	5.8	18.2	4.3
Medicaid spending per non–dually eligible beneficiary	5.6	8.7	2.8	2.0	20.2	4.7

Note: *CY (calendar year). Exhibit includes all dually eligible and non–dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts include both federal and state spending, include Medicaid-expansion Children's Health Insurance Program amounts, and exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Individual figures shown are rounded; growth rates are computed using unrounded numbers.*

Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and spending data.*

(Continued next page)

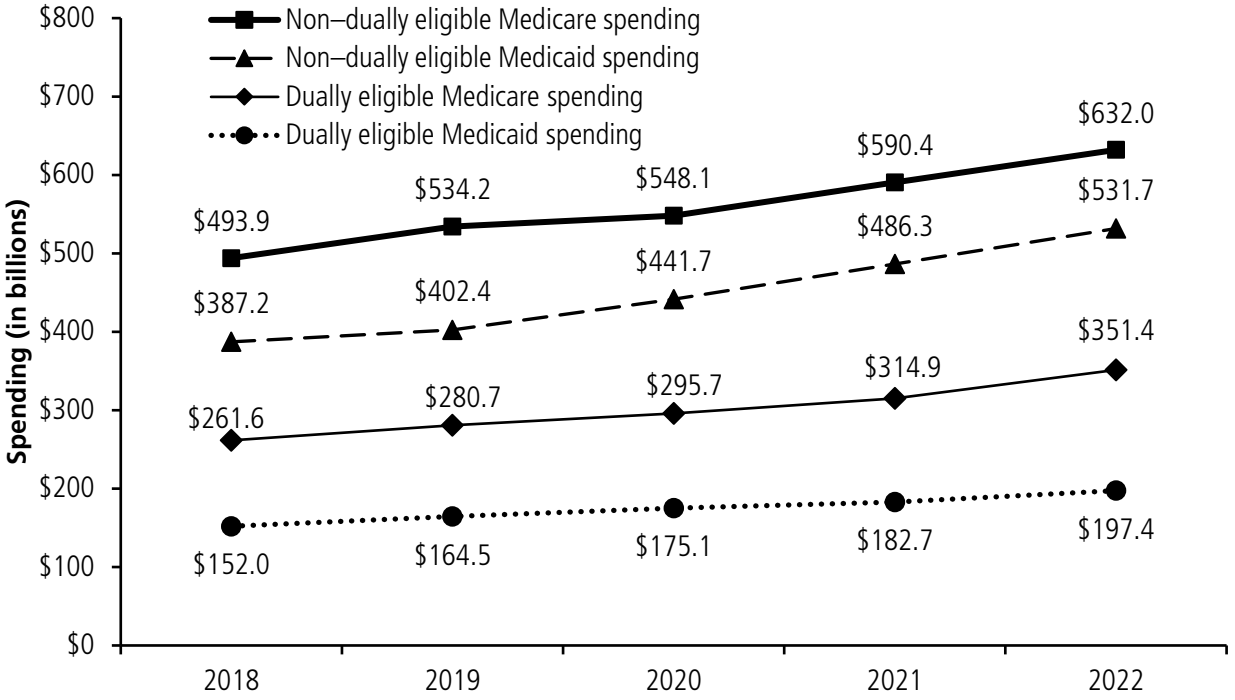
Exhibit 22

Medicare and Medicaid spending per dually eligible and non–dually eligible beneficiary, CY 2018–2022 (continued)

- Medicare spending per dually eligible beneficiary grew between 2018 and 2022 (22.3 percent cumulative growth and 5.2 percent average annual growth).
- Medicaid spending per dually eligible beneficiary (which includes both federal and state spending) increased at a slower rate between 2018 and 2022 (18.2 percent cumulative growth and 4.3 percent average annual growth).
- Medicare spending per dually eligible beneficiary increased at a faster rate than spending per non–dually eligible beneficiary. Cumulative growth in Medicare per beneficiary spending between 2018 and 2022 was 22.3 percent for dually eligible beneficiaries and 18.2 percent for non–dually eligible beneficiaries; average annual growth was 5.2 percent for dually eligible beneficiaries compared with 4.3 percent for non–dually eligible beneficiaries.
- In contrast, Medicaid spending per dually eligible beneficiary increased somewhat more slowly than spending per non–dually eligible beneficiary (18.2 percent cumulative growth and 4.3 percent average annual growth for dually eligible beneficiaries compared with 20.2 percent cumulative growth and 4.7 percent average annual growth for non–dually eligible beneficiaries).
- The growth in spending per dually eligible beneficiary slowed in both Medicare and Medicaid in 2020, likely due to the effects of the coronavirus pandemic. Spending growth also declined sharply for non–dually eligible Medicare beneficiaries but increased slightly for non–dually eligible Medicaid beneficiaries.

Exhibit 23

Medicare and Medicaid spending for dually eligible and non–dually eligible beneficiaries, CY 2018–2022



Category	Annual percentage growth in spending				Cumulative growth	Average annual growth rate
	2019	2020	2021	2022		
Non–dually eligible Medicare spending	8.2%	2.6%	7.7%	7.1%	28.0%	6.4%
Non–dually eligible Medicaid spending	3.9	9.8	10.1	9.3	37.3	8.3
Dually eligible Medicare spending	7.3	5.4	6.5	11.6	34.3	7.7
Dually eligible Medicaid spending	8.2	6.4	4.3	8.1	29.9	6.7

Note: *CY (calendar year). Exhibit includes all dually eligible and non–dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Medicaid spending amounts include both federal and state spending, include Medicaid-expansion Children's Health Insurance Program amounts, and exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Individual figures shown are rounded; growth rates are computed using unrounded numbers.*

Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and spending data.*

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Exhibit 23

Medicare and Medicaid spending for dually eligible and non–dually eligible beneficiaries, CY 2018–2022 (continued)

- Medicare spending on dually eligible beneficiaries increased from $261.6 billion in 2018 to $351.4 billion in 2022—cumulative growth of 34.3 percent and an average annual growth of 7.7 percent.
- Medicaid spent less than Medicare on dually eligible beneficiaries between 2018 and 2022. Medicaid spending on dually eligible beneficiaries (which includes both federal and state spending) was $152.0 billion in 2018 and $197.4 billion in 2022. Compared with the growth in Medicare spending on dually eligible beneficiaries, both the cumulative growth of Medicaid spending on this population and the average annual growth rate were lower (29.9 percent and 6.7 percent, respectively).
- Medicaid spending on non–dually eligible beneficiaries grew at a much faster rate than the rate of Medicaid spending on dually eligible beneficiaries, with cumulative growth of 37.3 percent and an average annual growth rate of 8.3 percent. This rapid growth was likely due to the effects of the coronavirus pandemic, when the number of eligible people increased and there was a pause on eligibility redeterminations.
- Although total Medicare spending was higher for non–dually eligible beneficiaries than for dually eligible beneficiaries between 2018 and 2022, Medicare spending on dually eligible beneficiaries grew faster over this period compared with Medicare spending on non–dually eligible beneficiaries. Cumulative growth in Medicare spending on dually eligible beneficiaries was 34.3 percent compared with 28.0 percent for non–dually eligible beneficiaries; average annual growth was 7.7 percent for dually eligible beneficiaries compared with 6.4 percent for non–dually eligible beneficiaries.

Exhibit 24

Share of dually eligible beneficiaries by selected beneficiary characteristics, CY 2018 and CY 2022

Beneficiary characteristic	2018	2022	2018–2022 percentage point change
Age			
65 and older	60.9%	65.5%	4.6%
Under 65	39.1	34.5	–4.6
Benefit level			
Full benefit	71.8%	73.8%	2.1%
Partial benefit	28.2	26.2	–2.1
Original reason for entitlement to Medicare			
Age	46.9%	49.3%	2.4%
ESRD	1.4	1.3	–0.1
Disability	51.8	49.4	–2.3
Medicaid eligibility pathway			
SSI	36.6%	34.1%	–2.5%
Poverty related	41.1	42.6	1.5
Medically needy	8.2	6.6	–1.6
Section 1115 waiver	0.2	0.4	0.1
Special income limit and other	13.9	16.4	2.5
FFS Medicare and managed care			
FFS only	55.6%	38.0%	–17.6%
MA only	32.7	50.7	18.1
Both FFS and MA	11.7	11.3	–0.4
FFS Medicaid and managed care			
FFS only	45.4%	39.8%	–5.5%
FFS and limited-benefit managed care only	19.9	16.7	–3.2
At least one month of comprehensive managed care	34.7	43.5	8.7

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

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Exhibit 24

Share of dually eligible beneficiaries by selected beneficiary characteristics, CY 2018 and CY 2022 (continued)

- Between CY 2018 and CY 2022, there was an increase in the share of dually eligible beneficiaries who were 65 and older (4.6 percentage point increase) and in the share who originally qualified for Medicare on the basis of age (2.4 percentage point increase). The share of dually eligible beneficiaries who received full benefits also increased (2.1 percentage point increase).
- The share of dually eligible beneficiaries who qualified for Medicaid through poverty-related pathways increased by 1.5 percentage points, from 41.1 percent of the dually eligible population in 2018 to 42.6 percent of the population in 2022.
- The share of dually eligible beneficiaries who were enrolled in FFS Medicare and the share who were enrolled in FFS Medicaid declined between 2018 and 2022 (decreases of 17.6 percentage points and 5.5 percentage points, respectively). The share whose only Medicaid enrollment was in FFS and a limited-benefit Medicaid managed care plan also decreased by 3.2 percentage points.
- The share of dually eligible beneficiaries whose only Medicare enrollment was in Medicare Advantage increased by 18.1 percentage points over the period, while the share of dually eligible beneficiaries with at least one month of comprehensive Medicaid managed care enrollment increased by 8.7 percentage points.

Exhibit 25

Use of Medicare services and spending per user for FFS beneficiaries, CY 2018 and CY 2022

Select Medicare services	Full-benefit FFS dually eligible beneficiaries			FFS non–dually eligible Medicare beneficiaries		
	2018	2022	2018–2022	2018	2022	2018–2022
Share using service in each year and percentage point change during period						
Inpatient hospital	25.0%	22.0%	–2.9%	15.0%	12.9%	–2.1%
Skilled nursing facility	9.5	11.3	1.8	3.9	3.2	–0.6
Home health	12.6	11.2	–1.5	9.1	8.6	–0.5
Other outpatient	94.4	93.1	–1.3	92.2	93.4	1.2
Part D drugs	92.7	90.5	–2.2	94.8	94.5	–0.3
FFS spending per user in each year and average annual growth during period						
Inpatient hospital	$22,494	$28,317	5.9%	$18,521	$22,717	5.2%
Skilled nursing facility	18,730	24,631	7.1	14,701	17,369	4.3
Home health	5,306	6,390	4.8	4,809	5,030	1.1
Other outpatient	7,019	8,114	3.7	5,515	6,774	5.3
Part D drugs	7,065	9,578	7.9	2,105	2,542	4.8

Note: *FFS (fee-for-service), CY (calendar year). "Dually eligible beneficiaries" in this table are limited to full-benefit dually eligible beneficiaries in FFS Medicare and FFS Medicaid. Beneficiaries with end-stage renal disease are excluded. Medicare "inpatient hospital" includes psychiatric hospital services. Medicare "other outpatient" includes physician services, hospice, durable medical equipment, hospital outpatient, emergency department not preceding an inpatient stay, and services in other outpatient facilities. The figures for "Part D drugs" are based only on beneficiaries who were covered by a Part D plan. Percentage point change is calculated using unrounded numbers.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and claims data.*

- The share of full-benefit dually eligible beneficiaries using skilled nursing facility services increased by 1.8 percentage points between 2018 and 2022. The share of full-benefit dually eligible beneficiaries using inpatient hospital services decreased by 2.9 percentage points, and the share using other outpatient services decreased by 1.3 percentage points.
- Medicare FFS spending per user for full-benefit dually eligible beneficiaries increased between 2018 and 2022 for inpatient hospital services (5.9 percent average annual growth), skilled nursing facility services (7.1 percent average annual growth), home health (4.8 percent average annual growth), other outpatient services (3.7 percent average annual growth) and prescription drugs under Medicare Part D (7.9 percent average annual growth).
- Comparing full-benefit dually eligible beneficiaries with non–dually eligible Medicare beneficiaries, FFS spending per user in 2018 and 2022 was higher for dually eligible beneficiaries for each type of service. Growth in spending per user was faster for dually eligible beneficiaries compared with non–dually eligible Medicare beneficiaries for inpatient hospital, skilled nursing facility services, home health, and Part D drugs; growth was faster for non–dually eligible Medicare beneficiaries for other outpatient services.
- In 2018 and 2022, a greater share of full-benefit dually eligible beneficiaries were users of the select Medicare services shown in this exhibit than were non–dually eligible Medicare beneficiaries. The only exceptions were other outpatient services (in 2022 only) and Part D drugs (in both years), where the share of dually eligible beneficiaries who used services or filled a prescription was slightly lower.

Exhibit 26

Use of Medicaid services and spending per user for FFS beneficiaries, CY 2018 and CY 2022

Select Medicaid services	Full-benefit FFS dually eligible beneficiaries			Full-benefit FFS non–dually eligible Medicaid beneficiaries (disabled, under age 65)		
	2018	2022	2018–2022	2018	2022	2018–2022
Share using service in each year and percentage point change during period						
Inpatient hospital	10.1%	10.2%	0.2%	14.8%	12.5%	–2.2%
Outpatient	83.7	84.5	0.8	81.7	80.4	–1.2
Institutional LTSS	16.2	16.0	–0.2	3.9	3.7	–0.2
HCBS state plan	14.9	16.3	1.4	13.9	16.7	2.9
HCBS waiver	18.4	20.0	1.6	15.8	18.5	2.7
Prescription drugs	27.2	26.6	–0.6	68.7	66.5	–2.1
Managed care capitation	46.7	44.8	–1.9	67.7	68.1	0.4
Spending per user in each year and average annual growth during period						
Inpatient hospital	$2,290	$2,838	5.5%	$22,761	$29,068	6.3%
Outpatient	2,404	2,561	1.6	6,852	7,410	2.0
Institutional LTSS	47,890	59,661	5.6	74,857	88,512	4.3
HCBS state plan	11,181	15,930	9.3	12,733	16,134	6.1
HCBS waiver	36,672	52,295	9.3	33,682	39,524	4.1
Prescription drugs	244	350	9.4	5,964	7,118	4.5
Managed care capitation	4,742	7,477	12.1	2,703	3,626	7.6

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

Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and claims data.*

- Medicaid FFS spending per user on full-benefit individuals who were dually eligible for Medicare and Medicaid increased between 2018 and 2022 for all services, with the greatest increase occurring in managed care capitation payments (12.1 percent average annual growth).
- The share of full-benefit dually eligible beneficiaries using institutional LTSS remained relatively stable between 2018 and 2022 (0.2 percentage point decrease), while the share of dually eligible beneficiaries using HCBS provided through a waiver increased by 1.6 percentage points over this period.

(Continued next page)

Exhibit 26

Use of Medicaid services and spending per user for FFS beneficiaries, CY 2018 and CY 2022 (continued)

- Medicaid spending per user on managed care had the largest percentage increase between 2018 and 2022 for both dually eligible and non–dually eligible Medicaid beneficiaries (12.1 percent and 7.6 percent average annual growth, respectively).
- The average annual growth in spending per user between 2018 and 2022 was generally higher among full-benefit dually eligible beneficiaries compared to non–dually eligible disabled Medicaid beneficiaries for all service categories except inpatient hospital (5.5 percent among dually eligible beneficiaries compared to 6.3 percent) and outpatient services (1.6 percent among dually eligible beneficiaries compared to 2.0 percent).
- The share of full-benefit dually eligible beneficiaries with managed care capitation payments decreased between 2018 and 2022 by 1.9 percentage points for dually eligible beneficiaries and remained relatively the same for non–dually eligible disabled beneficiaries, with a 0.4 percentage point increase.

Exhibit 27

Average annual growth in dually eligible enrollment by state, CY 2018–2022 (continued on next page)

State	Average annual growth in number of dually eligible beneficiaries			Number of dually eligible beneficiaries (in thousands)					
	CY 2018–2022			CY 2018			CY 2022		
	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit
National	2.4%	3.1%	0.5%	12,362	8,875	3,487	13,583	10,030	3,553
Alabama	1.1	1.5	0.9	234	95	139	245	101	145
Alaska	2.6	2.8	–0.7	21	20	1	23	22	1
Arizona	3.2	4.0	1.0	248	187	62	282	218	64
Arkansas	2.3	6.1	–2.6	147	76	70	160	97	63
California	1.9	2.3	–15.5	1,712	1,658	54	1,845	1,817	28
Colorado	3.0	5.9	–3.4	144	96	48	162	120	42
Connecticut	2.5	2.0	2.9	197	82	115	217	88	129
Delaware	3.0	8.3	–2.5	34	16	18	38	22	16
District of Columbia	16.0	17.6	12.5	22	15	7	40	28	11
Florida	2.9	5.5	0.4	935	448	486	1,049	555	494
Georgia	3.5	1.9	4.6	374	169	205	428	182	246
Hawaii	4.6	5.3	0.2	46	40	7	56	49	7
Idaho	3.2	5.3	–<0.1	53	31	21	60	39	21
Illinois	3.7	4.3	–0.7	426	373	52	492	441	51
Indiana	4.1	7.2	–3.0	233	154	78	273	204	69
Iowa	6.8	7.0	6.1	81	62	18	105	81	23
Kansas	2.7	4.3	0.1	75	45	30	83	53	30
Kentucky	0.9	2.3	–0.9	212	116	96	220	127	93
Louisiana	2.9	3.3	2.4	250	140	110	279	159	121
Maine	3.3	3.9	2.3	95	57	38	108	66	41
Maryland	2.7	5.4	–1.3	171	99	71	190	123	68
Massachusetts	1.2	0.5	9.2	349	324	25	365	330	35
Michigan	1.7	3.7	–9.3	378	312	66	405	360	45
Minnesota	1.2	1.8	–4.0	165	145	20	173	156	17
Mississippi	0.4	1.8	–0.9	176	85	91	179	92	88
Missouri	2.0	3.5	–4.1	205	160	46	222	183	39
Montana	2.6	6.2	–4.7	33	21	12	36	26	10
Nebraska	2.6	2.6	2.5	46	41	5	50	45	6
Nevada	4.7	5.1	4.4	83	36	47	100	44	56
New Hampshire	1.7	3.9	–2.7	40	26	15	43	30	13
New Jersey	3.3	1.8	23.1	241	228	13	274	245	29
New Mexico	1.4	–3.2	9.7	113	77	36	120	68	52
New York	2.9	3.8	–1.3	1,050	854	197	1,178	992	187
North Carolina	1.1	1.4	<0.1	369	280	89	385	297	89
North Dakota	2.1	1.5	4.2	18	14	4	19	15	4
Ohio	2.5	2.4	2.7	421	293	128	464	322	142
Oklahoma	2.5	1.7	5.7	132	106	26	146	114	32

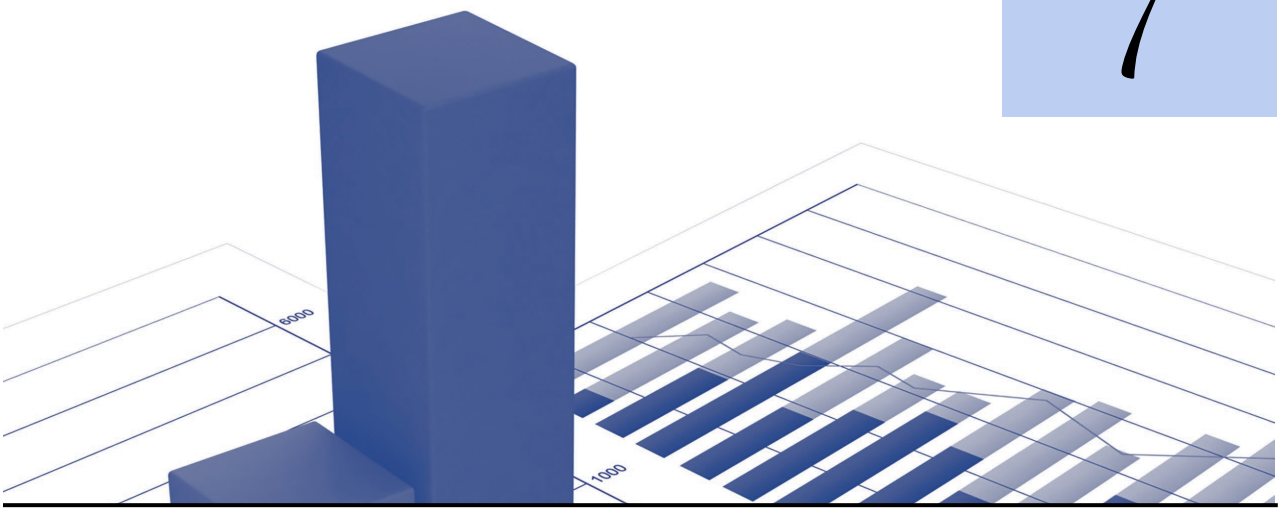
State	Average annual growth in number of dually eligible beneficiaries			Number of dually eligible beneficiaries (in thousands)					
	CY 2018–2022			CY 2018			CY 2022		
	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit	All	Full benefit	Partial benefit
Oregon	4.0	7.6	–2.3	154	93	61	180	125	55
Pennsylvania	1.5	1.6	1.1	523	421	102	556	449	107
Rhode Island	1.8	1.7	2.4	51	43	8	55	46	9
South Carolina	2.3	1.8	6.5	169	150	19	186	161	24
South Dakota	0.1	0.6	–0.9	23	14	9	23	15	9
Tennessee	0.4	2.8	–2.7	297	161	136	301	180	121
Texas	1.4	1.0	1.8	799	424	375	844	441	403
Utah	6.0	5.1	13.1	40	36	4	51	44	7
Vermont	–0.5	0.4	–2.6	31	22	9	31	23	8
Virginia	3.8	6.1	–1.4	219	147	72	254	187	68
Washington	3.3	5.0	–0.7	226	153	73	257	187	70
West Virginia	1.4	2.0	0.7	96	54	43	102	58	44
Wisconsin	2.3	4.2	–12.2	194	166	28	212	196	16
Wyoming	2.6	–1.3	11.2	13	9	3	14	9	5

Note: *CY (calendar year). Exhibit includes all dually eligible beneficiaries (fee-for-service, managed care, and end-stage renal disease). Beneficiaries are attributed to a state based on their most recent month of enrollment in the calendar year. The sum of the state counts exceeds the unduplicated national count because a small number (less than 1 percent) of beneficiaries were reported in more than one state for their most recent month of enrollment in the Medicaid program. Components may not sum to totals due to rounding.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- Between CY 2018 and CY 2022, national average annual growth in total dually eligible beneficiary enrollment was 2.4 percent: an increase of 3.1 percent for the full-benefit population and an increase of 0.5 percent for the partial-benefit population.
- At the state level, the average annual rate of change in total dually eligible enrollment ranged from a decrease of 0.5 percent in Vermont to an increase of 6.0 percent in Utah. (We exclude the 16.0 percent figure for the District of Columbia and the 6.8 percent figure for Iowa because a data error artificially reduced the number of full-benefit dually eligible beneficiaries in 2018.)
- No state had average annual growth in full-benefit dually eligible beneficiary enrollment of more than 8.3 percent (again, excluding the District of Columbia and Iowa). The number of full-benefit dually eligible beneficiaries increased in 48 states and the District of Columbia and declined in 2 states.
- In contrast, partial-benefit enrollment grew in 26 states and the District of Columbia but declined in 24 states.

Section

7



Dually eligible beneficiaries in comprehensive Medicaid managed care

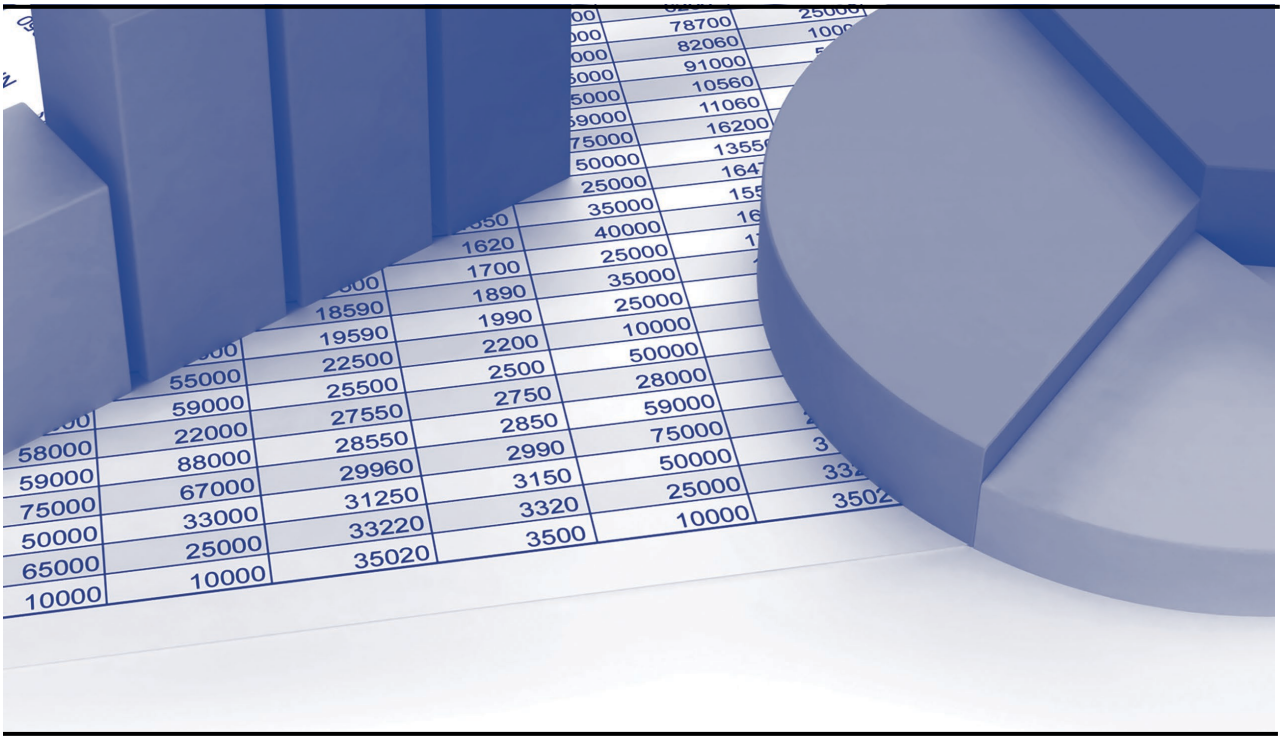


Exhibit 28

Use of Medicaid services and per user Medicaid managed care plan spending for dually eligible beneficiaries in comprehensive Medicaid managed care by age, CY 2022

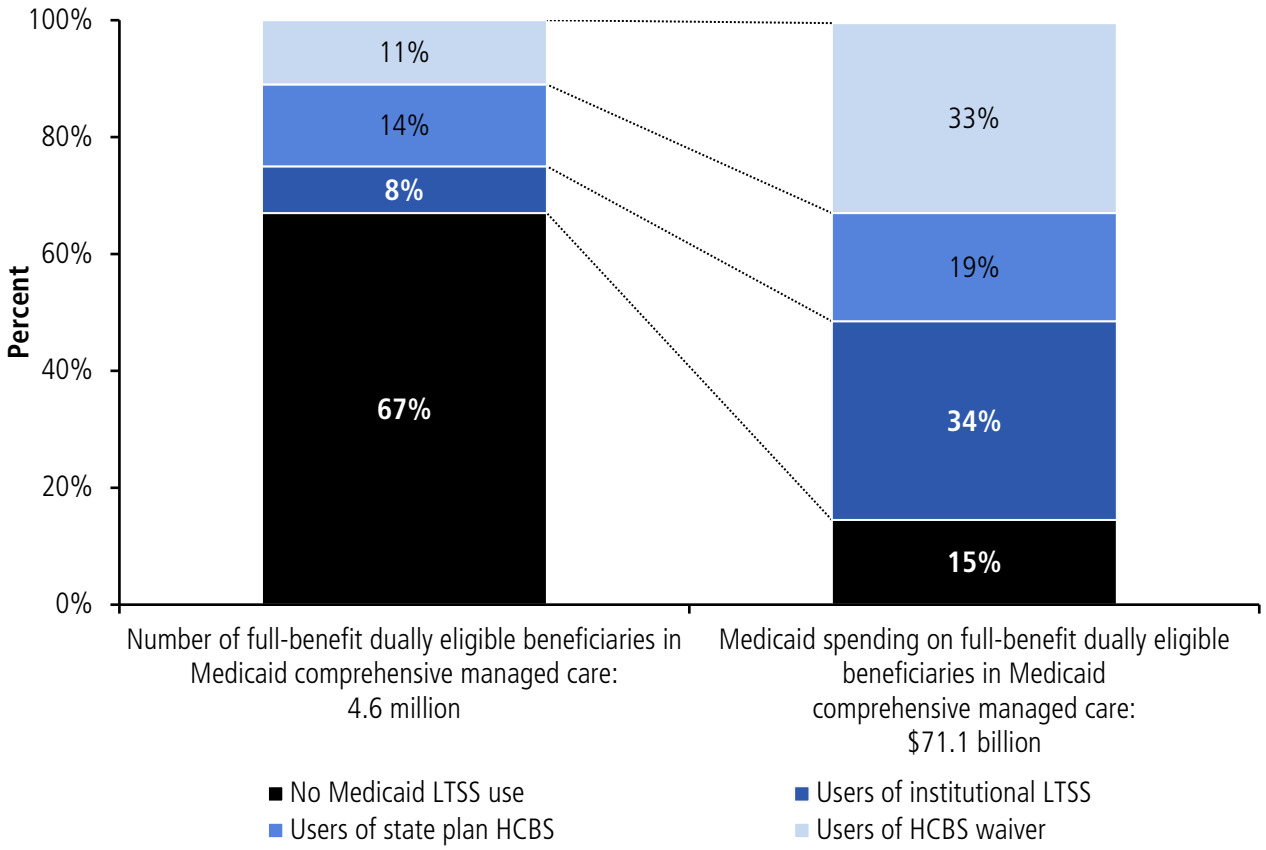
Medicaid services	Full-benefit Medicaid managed care dually eligible beneficiaries under age 65			Full-benefit Medicaid managed care dually eligible beneficiaries ages 65 and older		
	Percent using service	Spending per user	Percent of total spending	Percent using service	Spending per user	Percent of total spending
Inpatient hospital	7%	$9,052	4%	7%	$11,808	5%
Outpatient	82	4,471	23	75	3,685	18
Institutional LTSS	4	56,488	13	11	51,440	36
HCBS state plan	15	16,207	15	20	15,960	21
HCBS waiver	14	43,317	39	11	20,771	15
Prescription drugs	39	2,873	7	42	1,332	4

Note: *CY (calendar year), LTSS (long-term services and supports), HCBS (home- and community-based services). Exhibit is limited to full-benefit dually eligible beneficiaries enrolled only in comprehensive Medicaid managed care and who may be in Medicare fee-for-service or a Medicare Advantage plan. Beneficiaries with end-stage renal disease are excluded. "Outpatient" includes all Medicaid services that are not inpatient, LTSS (institutional or HCBS), or prescription drugs. Medicaid spending amounts exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. The figures in the "percent of total spending" columns may not sum to 100 due to rounding.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data and Medicaid encounter data.*

- Among individuals dually eligible for Medicare and Medicaid services in comprehensive Medicaid managed care in CY 2022, those who were under age 65 had lower use of Medicaid-covered institutional LTSS than those ages 65 and older (4 percent vs. 11 percent). Institutional LTSS also accounted for a lower portion of Medicaid managed care plan spending on dually eligible beneficiaries in comprehensive Medicaid managed care under age 65 than those age 65 and older (13 percent vs. 36 percent).
- Use of HCBS waiver services was slightly higher among individuals dually eligible for Medicare and Medicaid services enrolled in comprehensive Medicaid managed care under age 65 compared with those age 65 and older (14 percent vs. 11 percent). However, those who were under age 65 accounted for 39 percent of total managed care plan spending on HCBS waiver services and double the spending per user relative to those age 65 and older, who accounted for 15 percent of total spending on HCBS waiver services.

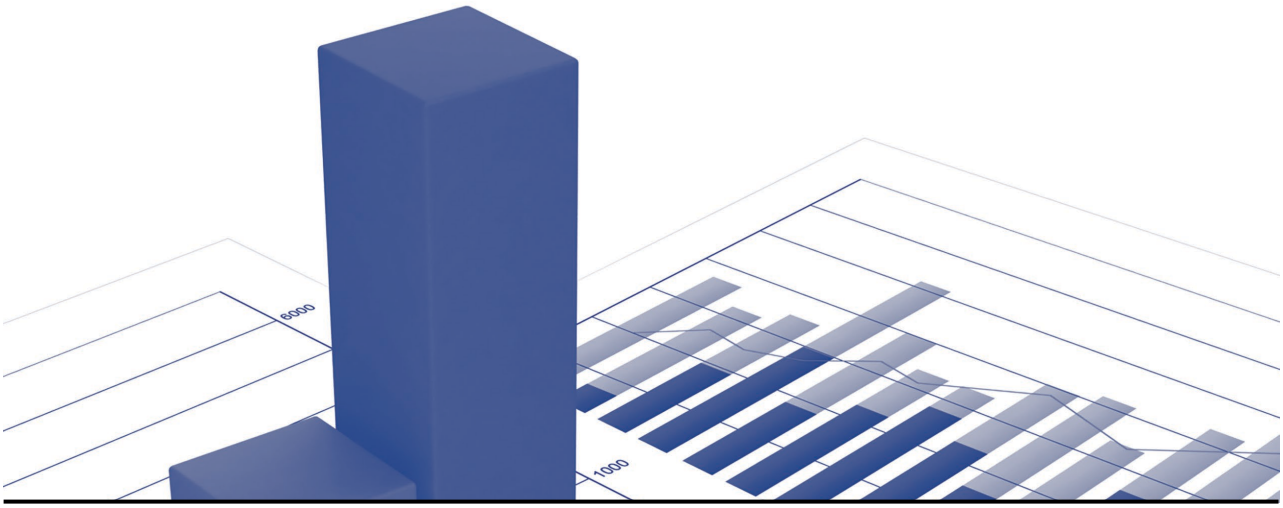
Exhibit 29

Medicaid managed care plan spending on full-benefit dually eligible beneficiaries in comprehensive Medicaid managed care by type of Medicaid LTSS, CY 2022

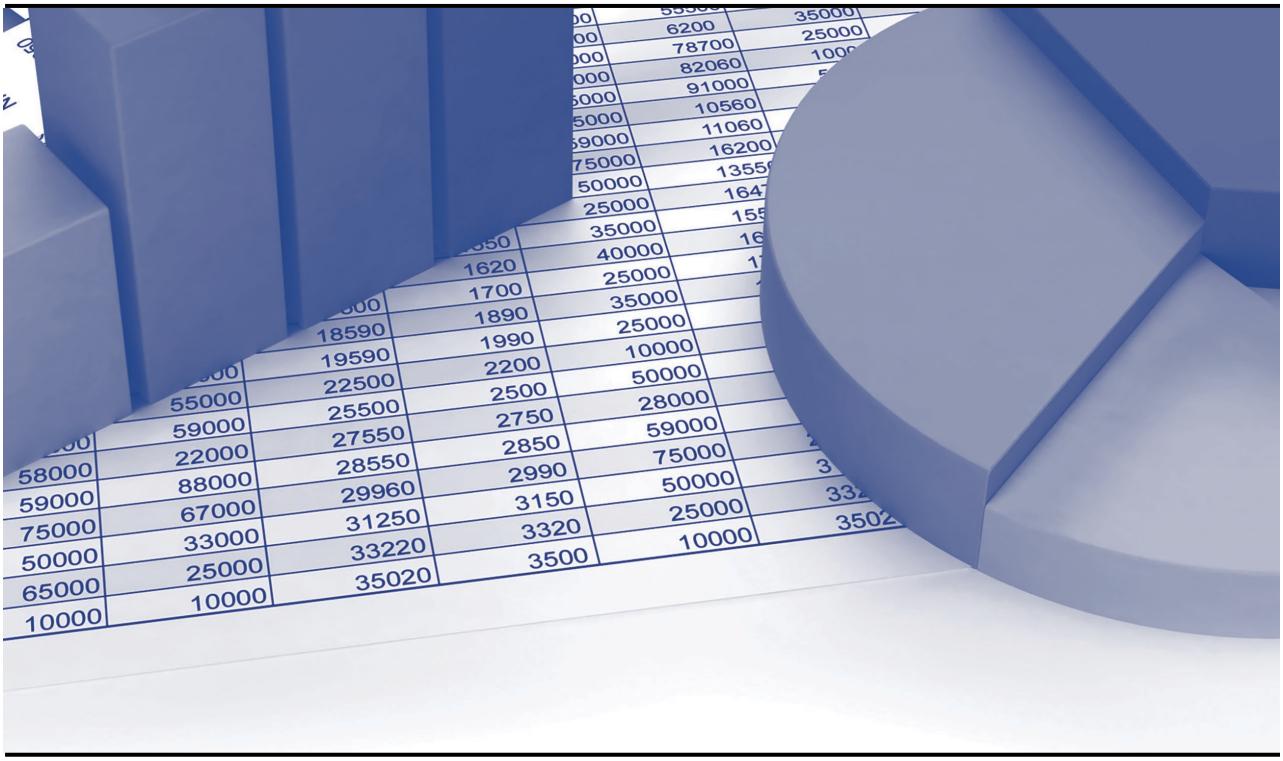


Note: *LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dually eligible beneficiaries enrolled only in comprehensive Medicaid managed care and who may be in Medicare fee-for-service or a Medicare Advantage plan. Beneficiaries with end-stage renal disease are excluded. Medicaid spending amounts exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Percentages may not sum to 100 due to rounding.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data and Medicaid encounter data.*

- In CY 2022, the majority (67 percent) of full-benefit dually eligible beneficiaries in comprehensive Medicaid managed care used no Medicaid LTSS.
- Users of institutional LTSS made up 8 percent of full-benefit dually eligible beneficiaries in comprehensive Medicaid managed care, but they accounted for 34 percent of Medicaid managed care plan spending on this population.
- In CY 2022, the share of full-benefit dually eligible beneficiaries in comprehensive Medicaid managed care who used HCBS was larger than the share who used institutional LTSS (25 percent vs. 8 percent), and HCBS users accounted for a larger share of Medicaid managed care plan spending than institutional LTSS users (52 percent vs. 34 percent).



Appendixes



Appendix A: Background on dually eligible beneficiaries

Medicare is the primary payer for dually 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. Dually 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 dually eligible beneficiaries in the form of payment of Medicare premiums and cost sharing, as well as coverage of some services not included in the Medicare benefit, most notably long-term services and supports (LTSS). Not all dually 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 dually 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 2026, the FMAP ranges from 50 percent to about 77 percent (Office of the Secretary, Department of Health and Human Services 2024).

Categories of dually eligible beneficiaries

Different types of dually eligible beneficiaries receive different levels of Medicaid assistance (Table 1). Under mandatory Medicaid eligibility pathways referred to as Medicare Savings Programs (MSPs), dually 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 dually eligible beneficiaries. In addition, individuals may qualify for full Medicaid benefits under separate non-MSP pathways. Those individuals—who may or may not receive assistance through the MSPs—are referred to as full-benefit dually eligible beneficiaries.

Table 1. Medicaid eligibility and benefits by type of dually eligible beneficiary

Type	Full or partial Medicaid benefits	Federal income and asset (individual / couple) limits for eligibility in 2025[1]	Entitled to Part A	Eligible for Medicaid through		Qualify for Medicaid payment of				
				MSP	Other eligibility pathway	Part A premiums	Part B premiums	Part C (MA) premiums (at state option)	Part A and Part B deductibles, coinsurance, and copayments	All Medicaid-covered services
Medicare Savings Program (MSP) beneficiaries										
Qualified Medicare beneficiary (QMB)	Partial: QMB only	At or below 100% FPL; $9,660 / $14,470	✓	✓		✓	✓	✓	✓	
	Full: QMB plus	At or below 100% FPL; $2,000 / $3,000[2]	✓	✓	✓	✓	✓	✓	✓	✓
Specified low-income Medicare beneficiary (SLMB)	Partial: SLMB only	101%–120% FPL; $9,660 / $14,470	✓	✓			✓			
	Full: SLMB plus	At or below 100% FPL; $2,000 / $3,000[2]	✓	✓	✓		✓	✓	✓‡	✓
Qualifying individual (QI)	Partial	121%–135% FPL; $9,660 / $14,470	✓	✓			✓			
Qualified disabled and working individuals (QDWI)	Partial	At or below 200% FPL; $4,000 / $6,000[3]	✓†	✓		✓				
Non-MSP beneficiaries										
Other full-benefit dually eligible beneficiaries	Full	Income limit varies, but generally at or below 300% of the federal SSI benefit rate (about 225% FPL for an individual); $2,000 / $3,000			✓			✓	✓‡	✓

Note: *MSP (Medicare Savings Program), MA (Medicare Advantage), FPL (federal poverty level), SSI (Supplemental Security Income). Medicaid benefits for dually eligible beneficiaries are jointly financed by states and the federal government. Although certain categories of dually 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 QMBs, SLMBs, and QIs 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.*

[1] These income limits do not include the $20 monthly SSI disregard.

[2] This asset limit is tied to the SSI program in Title XVI of the Social Security Act (the Act) and can be found in Section 1611(a)(3) of the Act.

[3] The asset limit for QDWIs is double the SSI amount, in accordance with Section 1905(s)(3) of the Act.

† Indicates beneficiaries who lost Medicare Part A benefits because of their return to work but are eligible to purchase Medicare Part A.

‡ Indicates the state may elect to pay only for Medicare services covered by Medicaid.

Source: *Centers for Medicare & Medicaid Services 2025c, 2024b, 2013a, 2013b; Medicaid and CHIP Payment and Access Commission 2015; Social Security Act; Social Security Administration 2025.*

States have the authority to expand eligibility for MSP benefits by using less restrictive methodologies for counting income and assets. As of August 2025, 18 states and the District of Columbia have expanded eligibility (Table 2).

Table 2. States with expanded income and asset levels in the Medicare Savings Program, as of August 2025

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%**	**$9,660**	**$14,470**	**120%**	**$9,660**	**$14,470**	**135%**	**$9,660**	**$14,470**
Alabama	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
Arizona	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
California	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
Colorado	100	$11,160	$17,470	120	$11,160	$17,470	135	$11,160	$17,470
Connecticut	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	300	No limit	No limit	N/A	N/A	N/A	N/A	N/A	N/A
Indiana	150	$9,660	$14,470	170	$9,660	$14,470	185	$9,660	$14,470
Louisiana	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit
Maine	185	No limit	No limit	N/A	N/A	N/A	250	No limit	No limit
Maryland	100	$9,660	$14,470	120	$9,660	$14,470	135	$9,660	$14,470
Massachusetts	190	No limit	No limit	210	No limit	No limit	225	No limit	No limit
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	138	No limit	No limit	N/A	N/A	N/A	186	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
Washington	100	No limit	No limit	120	No limit	No limit	135	No limit	No limit

Note: *QMB (qualified Medicare beneficiary), FPL (federal poverty level), SLMB (specified low-income Medicare beneficiary), QI (qualifying individual), N/A (not applicable). States may have different names for the QMB, SLMB, and QI programs. These income limits do not include the $20 monthly Supplemental Security Income (SSI) disregard. 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.*

Source: *Alabama Medicaid 2025, Arizona Health Care Cost Containment System 2025, California Department of Health Care Services 2025, Centers for Medicare & Medicaid Services 2025c, Colorado Department of Health Care Policy & Financing 2025, Delaware Health and Social Services 2025, District of Columbia Department of Health Care Finance 2025, Indiana Department of Insurance 2025, Louisiana Department of Health 2025, Maine Department of Health and Human Services 2025, Maryland Department of Health 2025, MassHealth 2025, Minnesota Department of Human Services 2025, Mississippi Division of Medicaid 2025, New Mexico Human Services Department 2025, New York State Department of Health 2025, Oregon Department of Human Services 2025, United Way of Connecticut 2025, Vermont Agency of Human Services 2025, Washington State Health Care Authority 2025.*

Medicare and Medicaid benefits for dually eligible beneficiaries

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

The Medicare entitlement gives most individuals premium-free Part A, but Part B is a voluntary program requiring monthly premiums that a beneficiary, or a party on behalf of the beneficiary, must pay to the federal government. Part D is also voluntary, and beneficiaries may pay a monthly premium to obtain the coverage through private plans. Almost all Medicare beneficiaries, including dually 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 dually eligible beneficiaries. Some D–SNPs cover certain Medicaid benefits for dually eligible beneficiaries, such as cost-sharing assistance, wraparound services (e.g., vision and dental services), behavioral health services, or LTSS.

Medicaid. The Medicaid benefit package varies depending on the type of dually eligible beneficiary (Table 1). For many beneficiaries, Medicaid pays Medicare premiums and is the secondary payer of Medicare-covered services. For full-benefit dually 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 that is 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 dually eligible beneficiaries depending on where they live.

As with Medicare, managed care plans may provide Medicaid benefits, but the range of services and populations covered by these plans varies across and within states. Comprehensive managed care plans generally include most of the acute care services covered by a state's Medicaid program, but certain items may be carved out and provided separately under FFS or a limited-benefit managed care plan. In states with limited-benefit Medicaid managed care, the plans most often provide transportation, behavioral health care, or dental services. States may contract with managed care plans to deliver LTSS, referred to as managed long-term services and supports programs.

Table 3. Items and services covered by Medicare and Medicaid

Category	Medicare	Medicaid
Inpatient and institutional	Inpatient hospital services, with limits on covered days in a benefit period (see Table 4)	Mandatory: Inpatient hospital services
	Inpatient psychiatric services, with limits on covered days and a lifetime limit on total covered days in a psychiatric hospital (see Table 4)	Optional: Inpatient psychiatric services for individuals under age 21 and mental health facility services for individuals ages 65 and older
	SNF, long-term care hospital, and inpatient rehabilitation facility services (all limited to post-acute care); SNF coverage has a limit on covered days (see Table 4), and other settings are subject to hospital covered-day limits	Mandatory: Nursing facility services (for both post-acute and long-term care)
		Optional: Intermediate care facility services for individuals with intellectual disabilities
Outpatient and home- and community-based	Home health services (limited to individuals who require skilled care)	Mandatory: Home health (not limited to individuals who require skilled care)
	Outpatient hospital, federally qualified health center, rural health clinic, ambulatory surgical center, preventive and screening services, and dialysis facility services	Mandatory: Outpatient hospital, federally qualified health center, rural health clinic, and freestanding birth center services
		Optional: Other clinic services
	Services of physicians and other practitioners and suppliers	Mandatory: Physician, nurse practitioner, nurse midwife, lab and X-ray, family planning services and supplies, and tobacco cessation counseling for pregnant women
		Optional: Chiropractor and other licensed-practitioner services
	Durable medical equipment	Optional: Durable medical equipment; hospice; prescription drugs; personal and other home- and community-based care; targeted case management; rehabilitation; private-duty nursing; dental; vision; speech and hearing; occupational and physical therapy; and other diagnostic, screening, preventive, and rehabilitative services
	Hospice services	
	Prescription drugs	
Other	Not applicable	Mandatory: Nonemergency medical transportation
		See Table 1 for Medicaid coverage of Medicare premiums and cost sharing for dually 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 dually 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 beneficiaries who are dually eligible.*
Source: *Social Security Act and Centers for Medicare & Medicaid Services 2025b.*

Medicare premiums and cost-sharing amounts vary based on a number of factors (Table 4). For Medicare premiums paid on behalf of dually 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 dually eligible and other low-income beneficiaries.

Table 4. Medicare premiums and cost-sharing amounts, 2025 and 2022

Part A	
Premium	Premium-free for insured individuals and their dependents and survivors; for uninsured individuals "buying in," $518 per month in 2025 or $285 for individuals with at least 30 quarters of coverage ($499 and $274, respectively, in 2022), plus the Part B premium (Part A cannot be purchased by itself)
Hospital stays	$1,676 deductible in 2025 for each benefit period ($1,556 in 2022)
	$419 per day in 2025 for days 61–90 of each benefit period (1/4 of hospital deductible each year) ($389 in 2022)
	$838 per "lifetime reserve day" in 2025 (1/2 of hospital deductible each year) after day 90 of each benefit period (up to 60 days over lifetime) ($778 in 2022)
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
	$209.50 per day in 2025 (1/8 of hospital deductible each year) for days 21–100 of each benefit period ($194.50 in 2022)
	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	$185 per month (the standard premium) in 2025 ($170.10 in 2022); Part B premiums have been higher for higher-income individuals since 2007
Deductible	The first $257 of Part B–covered services or items in 2025 ($233 in 2022)
Physician and other medical services	20% of the Medicare-approved amount for physician services and outpatient therapy (subject to limits); no cost sharing for annual wellness visits and many preventive services and screenings if the provider accepts payment of the Medicare fee schedule amount as payment in full (which is required for all Medicare claims for which Medicaid will be billed)
Outpatient hospital services	A coinsurance or copayment amount that varies by service, projected to average 20%; no copayment for a single service can be more than the Part A hospital deductible
Mental health services	20% of the Medicare-approved amount for outpatient mental health care
Clinical laboratory services	$0 for Medicare-approved services
Home health care	$0 for home health care services
Durable medical equipment	20% of the Medicare-approved amount
Blood	All costs for the first three pints, then 20% of the Medicare-approved amount for any additional pints (unless donated to replace what is used)

Part D, standard benefit	
Premium	Premiums vary from year to year and plan to plan in relation to the national average bid of sponsoring plans. The Part D basic beneficiary premium for 2025 is $36.78 ($33.37 in 2022); higher premiums for higher-income individuals as of 2011; dually eligible beneficiaries have access to at least one plan in which the premium is fully subsidized.
Deductible	$590 in 2025 ($480 in 2022); not applied to dually eligible beneficiaries; dually eligible beneficiaries pay only nominal copayments
Out-of-pocket threshold	$2,000 in 2025 ($7,050 in 2022); after this amount, beneficiaries have no financial obligation for covered drugs
Copayment rules	Copayments vary from plan to plan. For dually eligible beneficiaries, there are no copayments for institutionalized beneficiaries at any level of utilization. For other dually eligible beneficiaries, maximum copayment limits are set for utilization up to the out-of-pocket threshold, which in 2025 ranges from $1.60 for generic and preferred multisource drugs up to $12.15 for other drugs, depending on the person's subsidy category (a range of $1.35 to $9.85 in 2022).
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 dually 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 2024a, 2024c, 2024d, 2021a, 2021b, 2021c.*

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; dually eligible beneficiaries gain eligibility in the same manner as non–dually eligible 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 SSDI benefits have a 24-month waiting period before Medicare benefits begin. (The waiting period is waived for people with amyotrophic lateral sclerosis.) During the

waiting period, low-income individuals can qualify as disabled under the SSI program and can receive Medicaid coverage.

In this data book, we distinguish between two types of people with disabilities under age 65: those who qualify for Medicare based on their own work history and those who qualify for Medicare based on a spouse's or parent's work history. Individuals in the former group have worked enough quarters to qualify for Medicare benefits. Individuals in the latter group have not worked enough quarters to qualify for Medicare benefits. These individuals are often widow(er)s with disabilities and surviving divorced spouses (ages 50 and older) or adult children (ages 18 and older) who have a disabling condition that began before the age of 22. In most cases, these dependents and survivors of workers receive monthly dependent or survivor benefit payments from Social Security (or the Railroad Retirement Board).

Medicaid. Medicaid is an entitlement program for individuals meeting eligibility criteria defined by population characteristics and financial criteria. As noted earlier, the MSP pathways to limited Medicaid coverage of Medicare premiums and cost sharing are designed for low-income Medicare beneficiaries. In contrast, pathways to full Medicaid coverage do not specifically target Medicare beneficiaries. They instead cover groups that include low-income individuals ages 65 and older and younger persons with disabilities, many of whom happen to be Medicare beneficiaries. About half of dually 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 sufficiently high medical expenses.
- **Special income level.** States can cover individuals with incomes up to 300 percent of the SSI benefit rate (about 225 percent of the FPL for an individual) who are receiving LTSS in an institution. States may also extend this eligibility to individuals who use home- and community-based waiver services as an alternative to institutionalization.

The share of each state's population that is covered by Medicaid varies greatly as a result of differences in states' use of optional eligibility pathways such as the Affordable Care Act's extension of eligibility to adults under age 65 with income below 138 percent of the FPL, the extent to which eligible individuals are enrolled, and differences in demography at the state level (Table 5). 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.

Table 5. Dually eligible, Medicare, and Medicaid beneficiaries as a share of population by state, CY 2022 (continued next page)

State	Total population (thousands)	Dually eligible beneficiaries						All Medicare beneficiaries		All Medicaid beneficiaries	
		All		Full		Partial					
		Number (thousands)	Share of total population	Number (thousands)	Share of dually eligible population	Number (thousands)	Share of dually eligible population	Number (thousands)	Share of total population	Number (thousands)	Share of total population
National	**333,288**	**13,583**	**4%**	**10,030**	**74%**	**3,553**	**26%**	**66,989**	**20%**	**101,003**	**30%**
Alabama	5,074	245	5	101	41	145	59	1,139	22	1,362	27
Alaska	734	23	3	22	94	1	6	118	16	268	37
Arizona	7,359	282	4	218	77	64	23	1,495	20	2,476	34
Arkansas	3,046	160	5	97	60	63	40	693	23	1,128	37
California	39,029	1,845	5	1,817	98	28	2	6,961	18	16,217	42
Colorado	5,840	162	3	120	74	42	26	1,032	18	1,714	29
Connecticut	3,626	217	6	88	41	129	59	754	21	1,272	35
Delaware	1,018	38	4	22	58	16	42	241	24	315	31
District of Columbia	672	40	6	28	71	11	29	100	15	295	44
Florida	22,245	1,049	5	555	53	494	47	5,149	23	5,686	26
Georgia	10,913	428	4	182	43	246	57	1,945	18	2,644	24
Hawaii	1,440	56	4	49	88	7	12	309	21	477	33
Idaho	1,939	60	3	39	65	21	35	388	20	455	23
Illinois	12,582	492	4	441	90	51	10	2,440	19	3,903	31
Indiana	6,833	273	4	204	75	69	25	1,390	20	2,156	32
Iowa	3,201	105	3	81	78	23	22	691	22	838	26
Kansas	2,937	83	3	53	64	30	36	595	20	492	17
Kentucky	4,512	220	5	127	58	93	42	1,010	22	1,791	40
Louisiana	4,590	279	6	159	57	121	43	959	21	2,025	44
Maine	1,385	108	8	66	62	41	38	381	27	461	33
Maryland	6,165	190	3	123	64	68	36	1,153	19	1,785	29
Massachusetts	6,982	365	5	330	90	35	10	1,469	21	2,278	33
Michigan	10,034	405	4	360	89	45	11	2,271	23	3,204	32
Minnesota	5,717	173	3	156	90	17	10	1,147	20	1,434	25
Mississippi	2,940	179	6	92	51	88	49	656	22	854	29
Missouri	6,178	222	4	183	83	39	17	1,348	22	1,464	24

State	Total population (thousands)	Dually eligible beneficiaries						All Medicare beneficiaries		All Medicaid beneficiaries	
		All		Full		Partial					
		Number (thousands)	Share of total population	Number (thousands)	Share of dually eligible population	Number (thousands)	Share of dually eligible population	Number (thousands)	Share of total population	Number (thousands)	Share of total population
Montana	1,123	36	3	26	73	10	27	262	23	309	28
Nebraska	1,968	50	3	45	89	6	11	386	20	408	21
Nevada	3,178	100	3	44	44	56	56	603	19	925	29
New Hampshire	1,395	43	3	30	70	13	30	341	24	281	20
New Jersey	9,262	274	3	245	89	29	11	1,774	19	2,184	24
New Mexico	2,113	120	6	68	56	52	44	468	22	1,004	48
New York	19,677	1,178	6	992	84	187	16	3,955	20	7,943	40
North Carolina	10,699	385	4	297	77	89	23	2,226	21	2,905	27
North Dakota	779	19	2	15	77	4	23	148	19	137	18
Ohio	11,756	464	4	322	69	142	31	2,568	22	3,527	30
Oklahoma	4,020	146	4	114	78	32	22	817	20	1,352	34
Oregon	4,240	180	4	125	69	55	31	958	23	1,441	34
Pennsylvania	12,972	556	4	449	81	107	19	2,988	23	3,698	29
Rhode Island	1,094	55	5	46	84	9	16	244	22	385	35
South Carolina	5,283	186	4	161	87	24	13	1,219	23	1,550	29
South Dakota	910	23	3	15	63	9	37	198	22	154	17
Tennessee	7,051	301	4	180	60	121	40	1,500	21	1,832	26
Texas	30,030	844	3	441	52	403	48	4,743	16	6,635	22
Utah	3,381	51	2	44	87	7	13	461	14	523	15
Vermont	647	31	5	23	73	8	27	166	26	208	32
Virginia	8,684	254	3	187	73	68	27	1,689	19	2,083	24
Washington	7,786	257	3	187	73	70	27	1,529	20	2,259	29
West Virginia	1,775	102	6	58	57	44	43	467	26	664	37
Wisconsin	5,893	212	4	196	92	16	8	1,314	22	1,509	26
Wyoming	581	14	2	9	63	5	37	127	22	92	16

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

Source: *Acumen LLC analysis of ACS Demographic and Housing Estimates, 2021: ACS 5-Year Estimates Data Profiles and linked Medicare and Medicaid enrollment data for MedPAC and MACPAC.*

Appendix B: Methods

Sources of data

The data presented in this data book are for 2022. When the analytic work for this data book began, calendar year (CY) 2022 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, claims, and encounter data from Transformed Medicaid Statistical Information System (T-MSIS) files; and
- other data sources as warranted, noted in specific exhibits

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 CMS. However, differences in the timing and methodology for creating analytic files (such as the incorporation of updated T-MSIS data submitted by states, which may not always be reflected in 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 dually eligible beneficiaries using an ever-enrolled rather than an average monthly or point-in-time measure) may also explain differences among 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 dually eligible beneficiaries, and to create unduplicated beneficiary counts. Although dually eligible beneficiaries may be identified in several ways, this data book uses the dually 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 dually eligible population consists of individuals with at least one month of dually eligible enrollment during the year. Non–dually eligible Medicare and Medicaid beneficiaries were identified as individuals with zero months of dual 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 uses both Medicare FFS claims and Medicaid FFS claims to identify chronic conditions, but in this data book, we report chronic conditions based on Medicare FFS claims only. Chronic conditions among MA enrollees and non–dually eligible Medicaid beneficiaries, therefore, were not analyzed.

  Our data describe beneficiaries who currently have a particular condition rather than the larger group of beneficiaries who ever had that condition. For a beneficiary to be identified as having a

particular condition, the CCW has a condition-specific "look-back," or reference, period that requires continuous FFS enrollment during the period as well as the presence of FFS claims for the condition during the period. For example, there is a three-year reference period for Alzheimer's disease and a one-year reference period for the presence of anemia.

- *Medicare entitlement based on disability*. In this data book, primary claimant information was used to separate beneficiaries with disabilities with entitlement to Medicare based on their own work history from those with entitlement based on another individual's work history. We separated these groups because the latter includes a large number of individuals whose disabilities began in childhood and whose characteristics may therefore differ from those of individuals who became disabled as working-age adults. As discussed previously, beneficiaries who are disabled and entitled to Medicare based on another individual's work history include adult children who are disabled and receive benefits through a disabled, retired, or deceased parent as well as individuals ages 50 and older who are disabled and receive benefits through a deceased spouse or deceased former (divorced) spouse.

- *Medicaid LTSS.* Medicaid LTSS is defined by use of the following Medicaid services: institutional (nursing facility, intermediate care facility for individuals with intellectual disabilities, and mental health facility for individuals ages 65 and older or ages 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). Beneficiaries whose only Medicaid LTSS use was through a managed care entity are not captured in this definition, with the exception of Exhibits 28 and 29.

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 2023b). The T-MSIS data also exclude Medicaid payments for Medicare premiums ($26.1 billion in 2022, of which $17.4 billion was the federal share and $8.8 billion was the state share (Medicaid and CHIP Payment and Access Commission 2024a)) 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 2025a). 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 that the individual was in 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 they would have been 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 attributed to individual beneficiaries may depend on the purpose of a particular analysis. CMS analyses of dually 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 dually 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 dually eligible and non–dually eligible beneficiaries are available in Medicare claims data (Table 6). As noted earlier, most states pay Medicare cost sharing only 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 6. Fee-for-service Medicare Part A and Part B cost sharing incurred by dually eligible and non–dually eligible Medicare beneficiaries (dollars in billions), CY 2022

Type of cost sharing	Full-benefit dually eligible beneficiaries			Partial-benefit dually eligible beneficiaries		Non–dually eligible Medicare beneficiaries
	QMB plus	SLMB plus	Other full benefit	QMB only	SLMB only, QI, and QDWI	
Part A total	**$2.6**	**$0.3**	**$1.7**	**$0.3**	**$0.3**	**$9.1**
Hospital deductible	1.1	0.1	0.5	0.2	0.2	6.2
Hospital per day copayments	0.3	<0.1	0.1	<0.1	<0.1	0.5
SNF per day copayments	1.3	0.2	1.0	0.1	0.1	2.5
Part B total	**5.4**	**0.5**	**2.4**	**0.9**	**0.8**	**40.4**
Deductible	0.6	<0.1	0.2	0.1	0.1	5.3
Coinsurance	4.8	0.4	2.2	0.8	0.7	35.1
Part A and Part B total	**8.1**	**0.7**	**4.0**	**1.2**	**1.0**	**49.5**

Note: *CY (calendar year), 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 dually 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 dually 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: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and claims data.*

Managed care encounter data

When Medicare or Medicaid reimburse for services on a FFS basis, the claims that providers submit to receive payment provide detailed information about service use and program spending. Managed care does not, by itself, produce similar information because plans are paid using per member per month capitation rates and providers submit claims to the plan instead of to Medicare or the state. As a result, both Medicare and Medicaid require managed care plans to submit encounter records that have information that is analogous to a FFS claim such as the type of service, date of service, provider, and plan payment amount.

The importance of encounter data has increased over time due to the substantial growth in managed care enrollment in both programs. In 2012, only 24 percent of dually eligible beneficiaries had any enrollment in MA and 16 percent had any enrollment in comprehensive Medicaid managed care. By 2022, those figures had risen to 62 percent and 43 percent, respectively (Exhibit 11 and Exhibit 12). Only 24 percent of dually eligible beneficiaries had no enrollment in either MA or comprehensive Medicaid managed care (Exhibit 13).

At present, the encounter data submitted by MA plans are not sufficiently complete to use in this data book. For example, comparisons of MA encounter data with other information on service use—such as hospital discharge data and assessment data for skilled nursing care and for home health—have found

that the MA encounter data do not include some service use that appears in those other data sources. The reverse is also true: The other data sources do not include some service use that appears in the encounter data. The discrepancies between the encounter data and these other data sources have narrowed over time, but gaps remain. The MA encounter data are also challenging to use for other reasons, such as missing payment amounts on some records, difficulties in identifying records for non-Medicare services, and difficulties in identifying records for services where plans did not make any payment.

In contrast, the encounter data submitted by Medicaid managed care plans are suitable for use in this data book. For example, we found that the payment amounts on the encounter records, in aggregate, equaled nearly 85 percent of the total capitation payments made to Medicaid plans, which is roughly consistent with the statutory requirement that plans spend at least 85 percent of their Medicaid revenues on medical costs. In addition, we calculated utilization rates and spending on several major services (such as inpatient hospital care, institutional LTSS, HCBS waiver services, and prescription drugs) for both dually eligible and non–dually eligible individuals, and found that the figures for managed care enrollees (based on encounter data) and FFS enrollees (based on claims data) were comparable.

Given the differences in the completeness of the MA and Medicaid encounter data, we have produced two exhibits (Exhibit 28 and Exhibit 29) that present data on utilization and spending on individuals enrolled in managed care but include solely Medicaid encounter data. These exhibits aim to provide some insight into service use and spending for dually eligible beneficiaries in managed care but do not provide a comprehensive view given the current limitations of MA encounter data. As noted below, they are also not directly comparable with other exhibits because they use a different population. In the future, we hope to incorporate encounter data more broadly as the quality and completeness of both MA and Medicaid encounter data continues to improve.

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 the factors 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 dually eligible beneficiaries.* For most Medicare beneficiaries, including dually 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 dually eligible beneficiaries, the status change can be from partial-benefit to full-benefit Medicaid coverage or vice versa.

  In this data book, the dually eligible population consists of individuals with at least one month of dual enrollment during the year. Dually eligible beneficiaries are categorized as having full or partial Medicaid benefits based on their most recent month of dual enrollment. Non–dually eligible Medicare and Medicaid beneficiaries are individuals with zero months of dual

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 slightly larger difference for the Medicaid population (where average monthly beneficiary counts were 94 percent of ever-enrolled counts) than the Medicare population (where average monthly counts were 97 percent of ever-enrolled counts) (Table 7). For dually eligible beneficiaries, average monthly counts were 92 percent of ever-enrolled counts.

Table 7. Comparison of dually eligible and non–dually eligible Medicare and Medicaid beneficiary counts using ever-enrolled and average monthly measures, CY 2022

	Number of beneficiaries (millions)		Average monthly as a percentage of ever enrolled
	Ever enrolled	Average monthly	
Dually eligible beneficiaries	**13.6**	**12.5**	**92%**
Under age 65	4.7	4.4	94
Ages 65 and older	8.9	8.1	91
Medicare beneficiaries with no dually eligible enrollment	**53.4**	**51.7**	**97**
Under age 65	3.3	3.2	96
Ages 65 and older	50.1	48.5	97
Medicaid beneficiaries with no dually eligible enrollment	**87.4**	**81.7**	**93**
Nondisabled under age 65	81.1	75.8	93
Disabled under age 65	5.3	5.0	95
Ages 65 and older	1.0	0.9	87
All Medicare beneficiaries	**67.0**	**64.9**	**97**
All Medicaid beneficiaries	**101.0**	**94.6**	**94**

Note: *CY (calendar year). "Medicaid beneficiaries" include Medicaid-expansion Children's Health Insurance Program enrollees. Figures may not sum to subtotals due to rounding.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment data.*

- *Attributing spending and utilization.* We attributed spending and utilization to beneficiaries after they are counted and categorized as dually eligible beneficiaries, non–dually eligible Medicare beneficiaries, or non–dually eligible 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 dually eligible beneficiaries, their dual type (full or partial) is assigned based on their most recent month of dual enrollment, and their spending and utilization for the entire year are attributed to that individual and counted as spending for a dually eligible beneficiary. The advantage of this methodology is that spending and utilization are not double-counted. However, some dually eligible beneficiaries switched between non–dually eligible and dually eligible status during the year or between subgroups of dually eligible beneficiaries.

A limitation of this methodology is that we are at times attributing spending and utilization to a category (e.g., dually eligible beneficiary, non–dually eligible beneficiary) when in fact that spending and utilization were incurred while the individual was in a different category. Most dually eligible beneficiaries did not switch between dually eligible and non–dually eligible or full-benefit and partial-benefit categories in 2022 (Exhibit 14). Therefore, our method for attributing beneficiaries, spending, and utilization likely does not have a large impact on our results.

- *Fee-for-service and managed care enrollment status.* Many of the tables in this data book provide information about expenditures and utilization for particular categories of services. Due to our concerns about the completeness of the encounter data submitted by MA plans, 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 typically 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 comprehensive Medicaid managed care. An additional segment of the population consists of individuals who were managed care enrollees for a portion of the year but were Medicare or Medicaid FFS enrollees for the remaining portion of the year. The only exceptions to this approach are Exhibit 28 and Exhibit 29, which are limited to individuals for whom all Medicaid enrollment months were in comprehensive Medicaid managed care, regardless of whether their Medicare enrollment months were in FFS, MA, or some mix of the two.

  About 62 percent of the dually eligible population was enrolled in a Medicare managed care plan for all or part of the year in 2022 (Exhibit 11). Dually eligible beneficiaries were more likely to have been managed care enrollees and more likely than non–dually eligible Medicare beneficiaries to have had a mix of managed care and FFS enrollment in the year (11 percent vs. 4 percent). This difference reflects the fact that dually eligible beneficiaries were able to enroll in or disenroll from managed care on a quarterly basis (whereas non–dually eligible Medicare beneficiaries generally can make changes only during a limited open enrollment period each year). Starting in 2025, the ability of dually eligible beneficiaries to enroll in managed care outside of open enrollment is limited to certain types of D–SNPs. (As a reminder, this data book reflects CY 2022 data.) Dually eligible beneficiaries were less likely to have been in comprehensive Medicaid managed care plans than non–dually eligible disabled Medicaid beneficiaries under age 65 (43 percent vs. 74 percent, Exhibit 12).

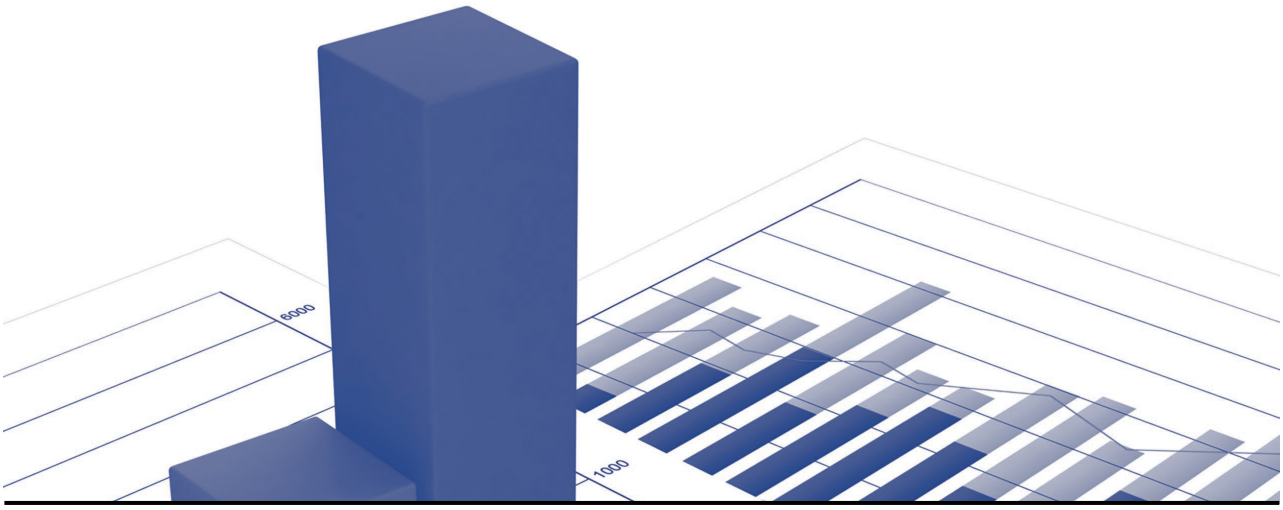
- *Beneficiaries with ESRD.* About 0.9 percent of all Medicare beneficiaries and 2.1 percent of dually eligible beneficiaries had ESRD in 2022 (Table 8). Unless otherwise indicated, the tables in this data book showing utilization and expenditure statistics exclude beneficiaries with ESRD because of the disproportionate share of Medicare spending they represent.

Table 8. Beneficiaries with and without end-stage renal disease and their expenditures, CY 2022

	All beneficiaries	Non-ESRD	ESRD	ESRD as share of total
Population				
All Medicare beneficiaries (in millions)	67.0	66.4	0.6	0.9%
Dually eligible beneficiaries (in millions)	13.6	13.3	0.3	2.1
Dually eligible beneficiaries as share of category	20%	20%	47%	
Medicare expenditures				
Total spending (in billions)	$983.4	$932.3	$51.2	5.2%
Per person per year	14,680	14,044	84,479	
Spending on dually eligible beneficiaries (in billions)	351.4	323.0	28.4	8.1
Per person per year	25,871	24,289	99,619	
Spending on non–dually eligible beneficiaries (in billions)	632.0	609.3	22.7	3.6
Per person per year	11,834	11,477	71,001	
Medicaid expenditures				
Spending on dually eligible beneficiaries (in billions)	$197.4	$192.0	$5.4	2.8%
Per person per year	14,535	14,437	19,077	

Note: *CY (calendar year), ESRD (end-stage renal disease). ESRD status in this table is based on at least one month of having ESRD in the year. Components may not sum to totals due to rounding.*
Source: *MedPAC and MACPAC analysis of linked Medicare and Medicaid enrollment and spending data.*

The share of spending on beneficiaries with ESRD is disproportionate 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 dually eligible beneficiaries. In 2022, annual per capita Medicare spending for dually eligible beneficiaries with ESRD was $99,619; per capita Medicaid spending for the same population was $19,077. With the ESRD population included, annual per capita Medicare spending for dually eligible beneficiaries averaged $25,871 in 2022; excluding beneficiaries with ESRD, per capita Medicare spending on dually eligible beneficiaries averaged $24,289 for the year. In comparison, Medicaid per capita spending on dually eligible beneficiaries including the ESRD population was $14,535; excluding these individuals, the amount was $14,437.



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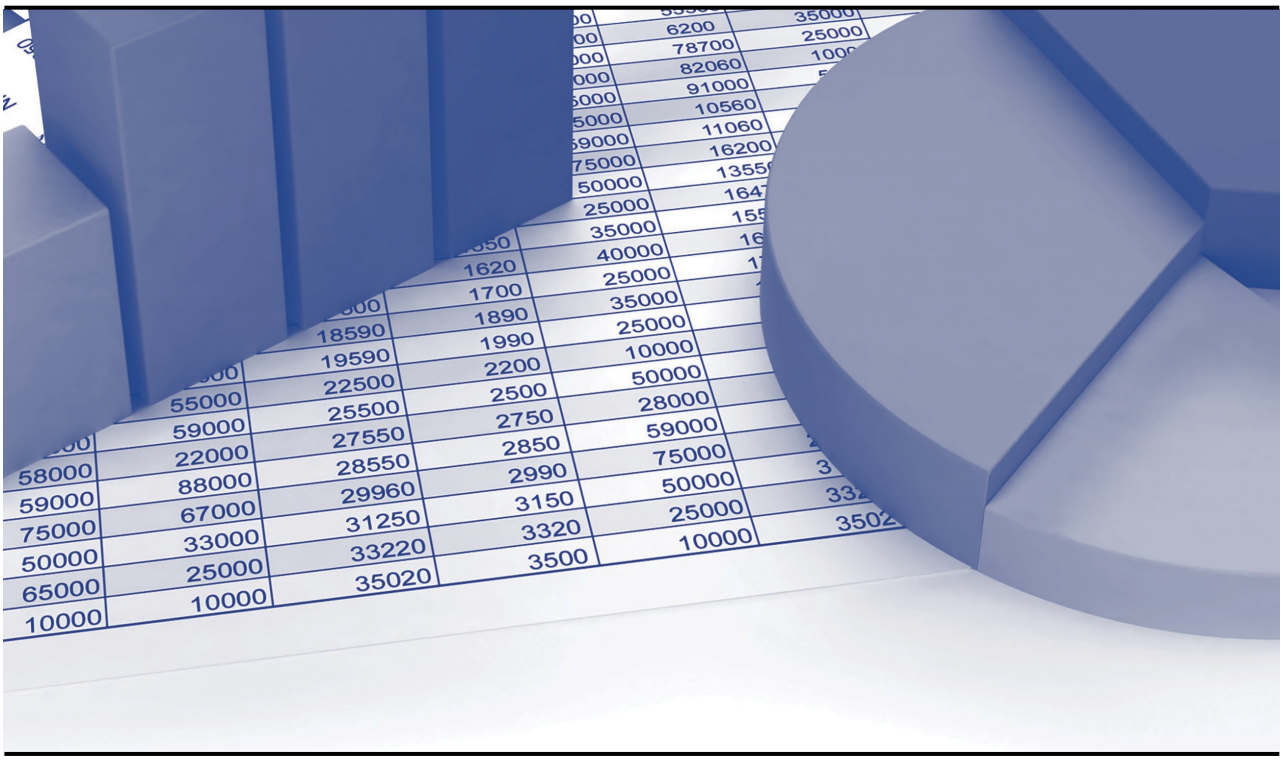
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