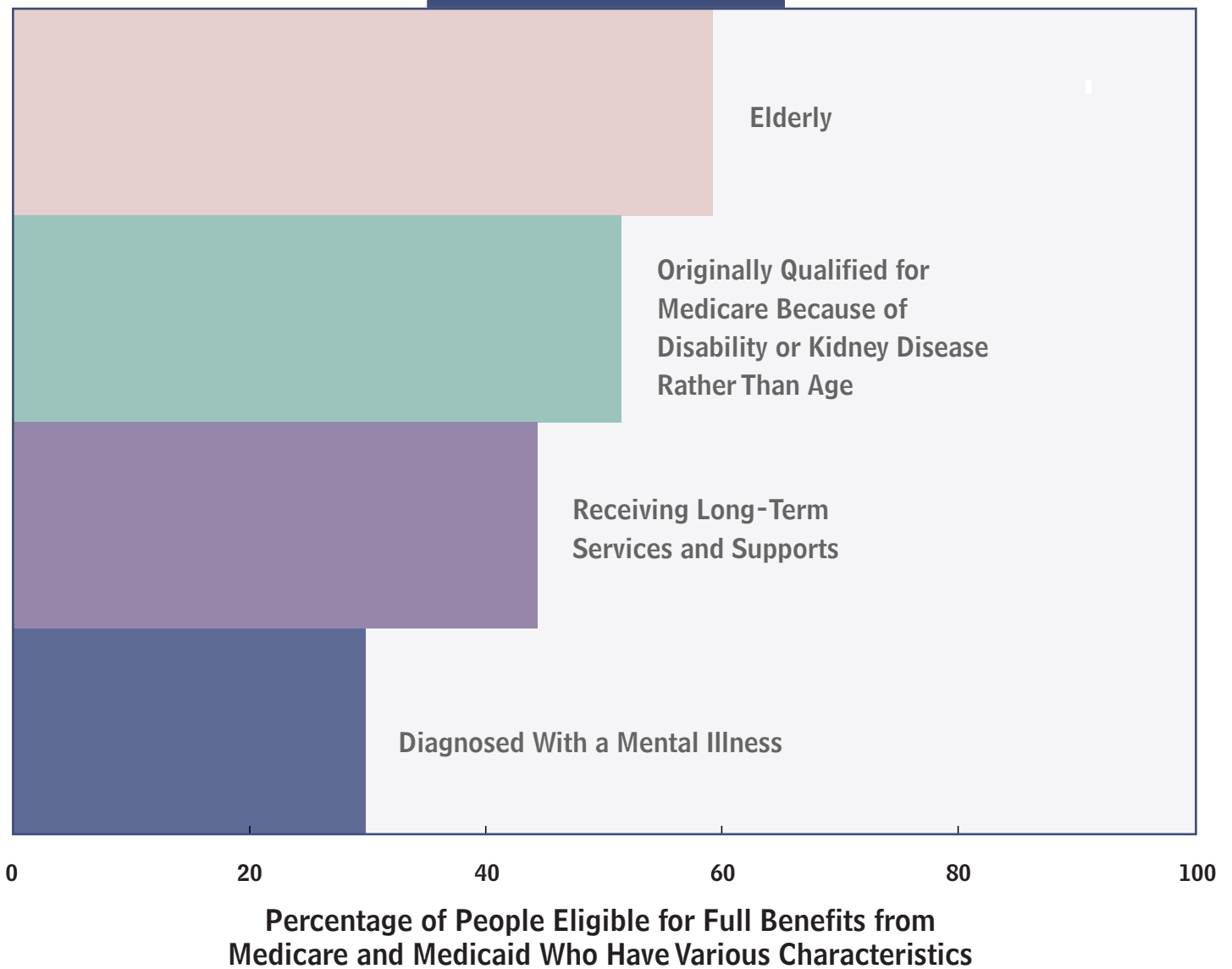


CBO

Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies



JUNE 2013

Notes

Unless otherwise indicated, all of the calculations in this report are based on analysis by the Congressional Budget Office (CBO) and reflect spending by Medicare (by the federal government) and Medicaid (by the federal and state governments). CBO does not have access to data on spending by other payers. Out-of-pocket payments by Medicare and Medicaid enrollees are excluded from the analysis. Most cost sharing incurred under Medicare for dual-eligible beneficiaries is paid by Medicaid, and those payments are counted as Medicaid spending. However, payments by Medicaid to cover the Medicare premiums of dual-eligible beneficiaries are not included in estimates of Medicaid spending in this report because of data constraints. Information about the data used in the analysis appears in the appendix.

Numbers in the text, tables, and figures may not add up to totals because of rounding.

Definitions of various terms used in this report appear in the glossary at the end of the report.

Correction:

On March 27, 2014, CBO reposted this document with various small corrections. Misclassifying some people as eligible beneficiaries of Medicaid and misclassifying the reason for some others' eligibility affected the results of various calculations, which are reported mostly in Tables 1 and 2 and Figure 3 and in the passages in the text that discuss those results. Corrections are noted on the pages where they occurred.



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Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies

Summary

In 2009, the federal and state governments spent a total of more than \$250 billion on health care benefits for the 9 million low-income elderly or disabled people who are jointly enrolled in Medicare and Medicaid. Medicare is a federal program that provides health insurance coverage to people who have disabilities, are diagnosed with certain medical conditions, or are age 65 or older (50 million people in 2009). Medicaid, which is funded jointly by the federal government and the states, provides health care coverage to low-income people who meet specific requirements for income and assets and other eligibility criteria (65 million in 2009).¹ People who are eligible to receive benefits from both programs at the same time are known as “dual-eligible beneficiaries.” All of those beneficiaries qualify for full Medicare benefits, but they differ in the amount of Medicaid benefits for which they are eligible. Seven million are “full duals,” who qualify for full benefits from both programs. The other 2 million are “partial duals,” who do not meet the eligibility requirements for full Medicaid benefits but qualify to have Medicaid pay some of the costs they incur under Medicare.

This report examines the characteristics and costs of dual-eligible beneficiaries, focusing on 2009, the most recent year for which comprehensive data were available when the Congressional Budget Office (CBO) began this

analysis. The report also examines the different payment systems that Medicare and Medicaid use to fund care for dual-eligible beneficiaries and recent efforts at the federal and state levels to integrate those payment systems and to coordinate the care that such beneficiaries receive from the two programs.

Why Are Policymakers Concerned About Dual-Eligible Beneficiaries?

Federal and state policymakers have growing concerns about the high costs of dual-eligible beneficiaries—particularly full duals—as well as about the appropriateness of the care they receive and the ways in which the separate structures of Medicare and Medicaid may affect their costs and care. Medicare generally pays for acute care (hospitalization and other short-term care) and postacute care (services provided in skilled nursing facilities or elsewhere to help people recover from an acute illness or surgery). Medicaid pays for long-term services and supports (LTSS)—which includes long-term care as well as social support services designed to help people stay in their homes rather than move to institutions—and other benefits that Medicare does not cover, such as dental and vision services.

Those separate funding streams, and the different payment rates and coverage rules within them, create conflicting financial incentives for the federal and state governments and for health care providers, potentially increasing the costs of care. In addition, receiving care through separate programs with different payment and approval procedures increases the likelihood that full duals—especially those who have many chronic

1. Those enrollment figures are based on total annual enrollment rather than on average monthly enrollment or enrollment at a particular point in time.

conditions and functional limitations—will be treated by a variety of health care providers who are not coordinating their care, potentially increasing costs and worsening outcomes.

What Characteristics and Spending Patterns Distinguish the Dual-Eligible Population?

Dual-eligible beneficiaries are a varied group, but many have extensive health care needs, stemming from multiple illnesses and disabilities. In the case of full duals, for example, half initially qualified for Medicare because of disability rather than age, and nearly one-fifth have three or more chronic conditions (see Figure 1). Consequently, a sizable share of full duals, more than 40 percent, use long-term services and supports—a far greater percentage than for other Medicare or Medicaid beneficiaries.

Although some full duals are fairly healthy and have relatively low health care costs, full duals as a group account for a disproportionate share of federal and state spending for Medicare and Medicaid. Full duals make up 13 percent of the combined population of Medicare enrollees and aged, blind, or disabled Medicaid enrollees (the categories of Medicaid participants who might also qualify for Medicare), but they account for 34 percent of the two programs' total spending on those enrollees.²

What Strategies Are States and the Federal Government Pursuing to Reduce Costs and Improve the Quality of Care for Dual-Eligible Beneficiaries?

Many states are working to eliminate differences in the financial incentives that health care providers face under Medicare and Medicaid and to improve the coordination and quality of care for dual-eligible beneficiaries within the scope of current law. States' efforts include establishing initiatives under which Medicare, Medicaid, and private insurers pay fees to the same primary care practice to manage care for patients; contracting with plans in Medicare's managed care program (Medicare Advantage) to provide services covered by Medicaid; coordinating physical and behavioral health care for dual-eligible

beneficiaries who have chronic mental illnesses; and developing managed LTSS programs.³ At the same time, the federal government, through the Medicare Advantage program, has encouraged the establishment of special health plans for full duals that target their particular needs.

The Affordable Care Act (ACA) created new options for addressing financing and quality-of-care issues for dual-eligible beneficiaries.⁴ The largest initiative in that area under the new law is a three-year demonstration project to integrate Medicare's and Medicaid's financing for full duals, which 26 states applied to participate in. The first state projects are due to begin this summer.

What Actions Might Federal Lawmakers Take and How Might They Affect the Budget?

Various restrictions exist under current law that impede efforts to reduce costs and improve the quality of care for dual-eligible beneficiaries by more fully integrating that care. For example, participation in Medicare's managed care program is optional for dual-eligible beneficiaries, as it is for other Medicare beneficiaries. In addition, states generally have little information about, and limited control over, the provision of services covered by Medicare. Moreover, Medicare and Medicaid contract separately with managed care organizations even if a beneficiary receives services from both programs through the same managed care organization.⁵ Federal lawmakers might choose to relax those and other restrictions—or enact broader program changes—in an effort to more fully integrate the care provided to full duals.

The impact of such policy changes on the federal budget would be likely to depend on multiple factors, such as how payment rates to providers would compare with the rates under current law, whether certain complex services (such as behavioral health care) would be included in

2. Age and blindness or disability are two of the eligibility categories for Medicaid; the dual-eligible population is a subset of those categories of beneficiaries. (The remaining Medicaid population consists largely of children and their parents as well as pregnant women. In addition, a new category of participants—non-disabled, nonelderly, childless adults—will begin enrolling in Medicaid in 2014 because eligibility for that group is expanding under current law. Those other populations tend to have lower health care costs than the aged, blind, or disabled.)

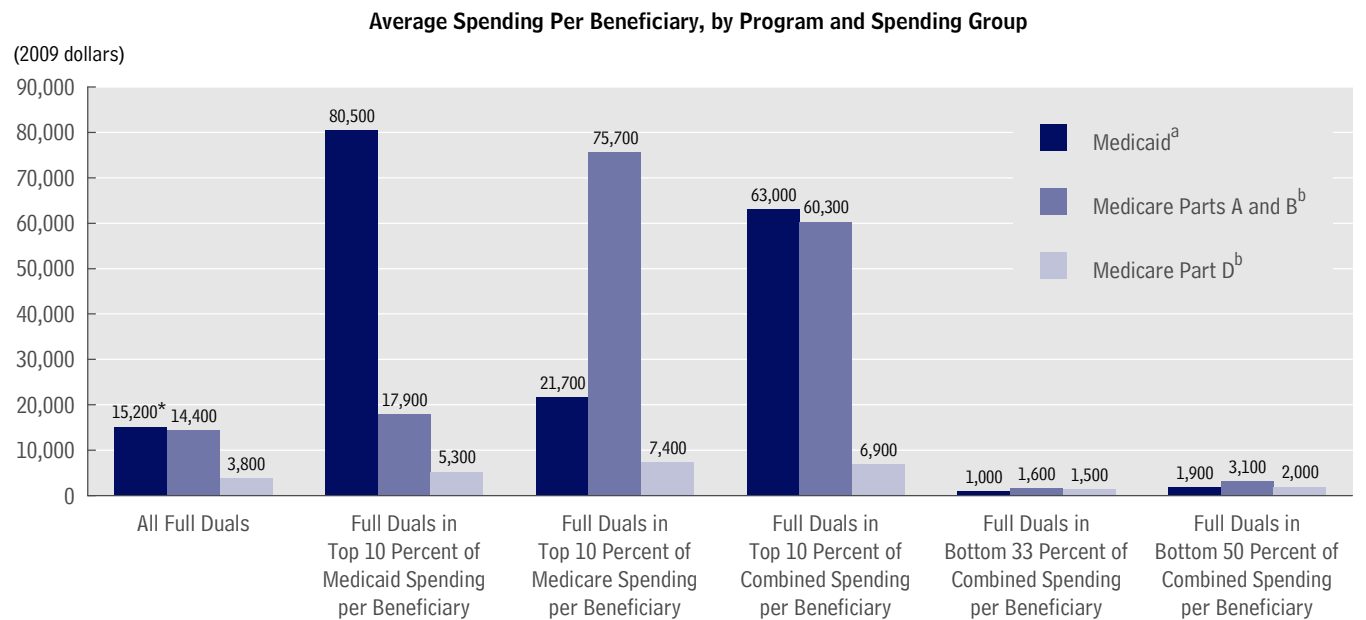
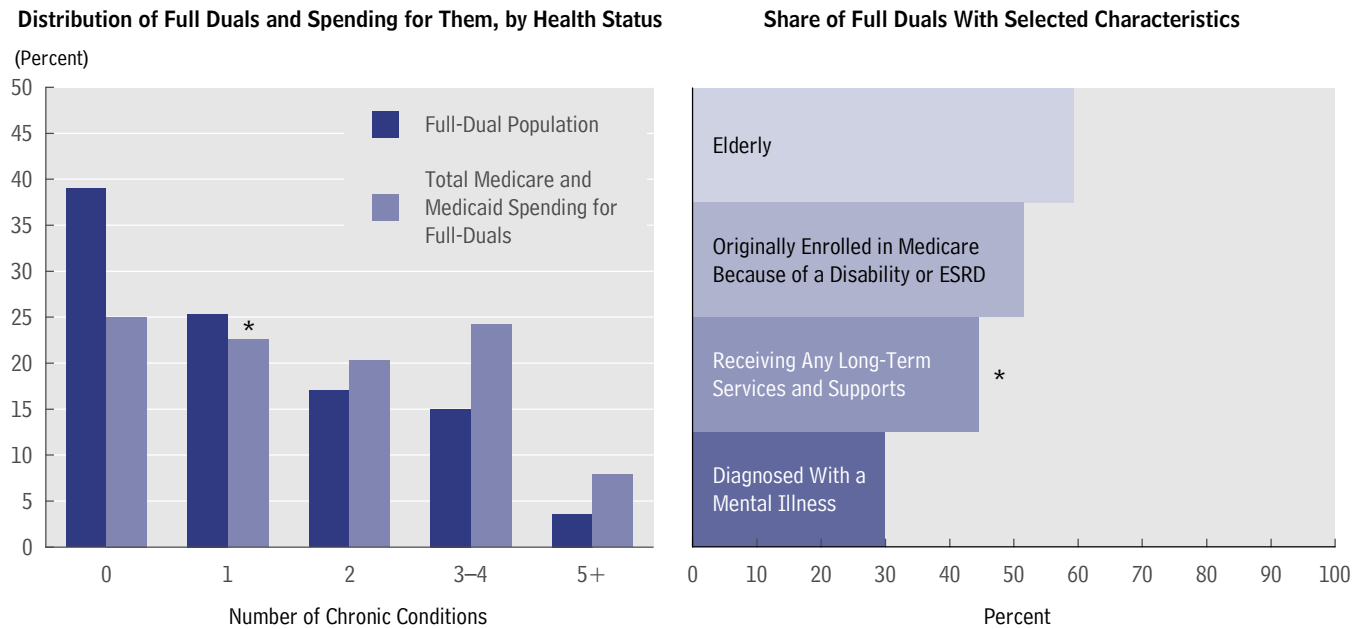
3. Behavioral health care includes mental health and substance abuse services.

4. The ACA comprises the Patient Protection and Affordable Care Act (Public Law 111-148), the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and, in the case of this report, the effects of subsequent related judicial decisions, statutory changes, and administrative actions.

5. One exception is PACE (Program of All-Inclusive Care for the Elderly) programs, which can use combined Medicaid and Medicare funds for the full set of services they provide.

Figure 1.

Characteristics of Full Dual-Eligible Beneficiaries, 2009



Source: Congressional Budget Office.

Notes: Dual-eligible beneficiaries are people who are enrolled in Medicare and Medicaid at the same time and who are eligible to receive benefits from both programs. "Full duals" qualify for full benefits from both programs.

ESRD = end-stage renal disease.

- a. Includes federal and state spending for Medicaid but excludes Medicaid payments for Medicare premiums.
- b. The Medicare program consists of three parts: Hospital Insurance (Part A), Medical Insurance (Part B), and prescription drug coverage (Part D). Medicare Part C (known as Medicare Advantage) specifies the rules under which private health care plans can assume responsibility for, and be compensated for, providing benefits covered under Parts A, B, and D.

[* Value corrected]

overall payment rates or be paid for separately, and whether beneficiaries' participation in new models for delivering care would be voluntary or mandatory.

Characteristics of Dual-Eligible Beneficiaries That Affect Health Care Needs and Spending

Both Medicare and Medicaid serve a broad range of elderly and disabled beneficiaries. Some of them (full duals) receive full benefits from both programs. Others (partial duals) receive full Medicare benefits but limited assistance from Medicaid, and the remainder (nonduals) receive benefits only from Medicare or only from Medicaid. The need for health care services varies widely both within and among those groups of beneficiaries, reflecting differences in the prevalence of disabilities and health conditions. Those differences lead to large variation in average spending per beneficiary: In 2009, total Medicare and Medicaid spending per beneficiary (including both state and federal spending) ranged from an average of about \$8,300 for nondual Medicare beneficiaries to \$33,400* for full duals (see Table 1).

This report focuses on full duals, who are the main target of recent policy initiatives and who account for a significant share of spending by Medicare and Medicaid. Partial duals share some of the characteristics of full duals, but they are much less likely to use nursing facilities and other types of long-term services and supports. That difference causes average Medicaid spending for them to be much lower—and average Medicare spending to be somewhat lower—than for full duals. (More information about the partial-dual population is presented in Box 1.)

A detailed analysis of the ways in which people become dual-eligible beneficiaries is beyond the scope of this report. However, one large group of dual-eligible beneficiaries consists of Medicare enrollees who became eligible for Medicaid by spending down their resources, in many cases while they were in nursing facilities. In general, such beneficiaries have high health care costs. Other dual-eligible beneficiaries are Medicare enrollees who gained Medicaid coverage because they had low income and met Medicaid's specific eligibility criteria for age, blindness, or disability; that group may not initially incur large medical expenses. Still other dual-eligible beneficiaries became disabled and had low income; they usually qualified for Medicaid quickly and became eligible for Medicare later

[* Value corrected]

(because a waiting period exists between qualifying for Social Security's Disability Insurance program and qualifying for Medicare coverage).⁶

Prevalence of Disabilities and Health Risks

Full duals are much more likely than other Medicare beneficiaries to have initially qualified for Medicare because of physical or mental disabilities—factors that increase people's need for health care, rehabilitation services, and long-term care and that may reduce their ability to navigate the health care system.⁷ Specifically, just over half of the people who were full duals in 2009 originally became eligible for Medicare on the basis of disability or end-stage renal disease (ESRD) rather than age, compared with just 17 percent of nondual Medicare beneficiaries. Reflecting that reason for Medicare eligibility, 41 percent of full duals in 2009 were under age 65, compared with only 11 percent of nondual Medicare beneficiaries. Looked at another way, disabled Medicare beneficiaries were more than three times as likely as elderly Medicare beneficiaries to be full duals.

In conjunction with higher rates of disability, full duals were about twice as likely as nondual Medicare beneficiaries to have at least three chronic conditions, and they were nearly three times as likely to have been diagnosed with a mental illness.⁸ Consequently, medical risk scores—which indicate differences in expected spending by Parts A and B of Medicare for different beneficiaries based on diagnosed conditions and demographic characteristics—were about 55 percent higher for full duals, on average, than for nondual Medicare beneficiaries.

6. People who receive benefits from the Disability Insurance program are eligible for Medicare coverage after two years of receiving disability benefits, regardless of their age. In certain cases, such as with a diagnosis of end-stage renal disease, the waiting period depends on the stage of the illness. In addition, some people with end-stage renal disease are eligible for Medicare without participating in the Disability Insurance program.

7. See, for example, Linda P. Fried and others, "Untangling the Concepts of Disability, Frailty, and Comorbidity: Implications for Improved Targeting and Care," *Journals of Gerontology: Medical Sciences*, vol. 59, no. 3 (March 2004), pp. M255–M263, <http://dx.doi.org/10.1093/gerona/59.3.M255>.

8. CBO identified mental illness using risk-adjustment data (described in the appendix). Medicare enrollees were classified for this analysis as having a mental illness if they were listed as having a diagnosis from the previous year of schizophrenia; major depressive, bipolar, and paranoid disorders; or other major psychiatric disorders.

Table 1.

Demographic Characteristics of Dual-Eligible Beneficiaries, Compared With Those of Certain Other Medicare and Medicaid Beneficiaries, 2009

	Dual-Eligible Beneficiaries ^a		Nondual Medicare Beneficiaries	Nondual Aged, Blind, or Disabled Medicaid Beneficiaries
	Full Duals	Partial Duals		
Number of Beneficiaries (Millions)	7.1	2.1	39.6	6.3 **
Distribution by Age (Percent)				
Nonelderly (Under age 65)	41	40	11	88 **
Elderly (Age 65 or older)	59	60	89	12 **
Percentage With Various Characteristics				
Female	62	61	54	51
Black	20	22	8	30 **
Hispanic	8	4	1	14 **
Living in a rural area	21	29	20	20
Originally enrolled in Medicare because of a disability or end-stage renal disease	52	54	17	n.a.
Diagnosed with three or more chronic conditions	19	14	9	N.A.
Institutionalized	15	*	1	4
Receiving any long-term services and supports	44	14	9	18 **
Diagnosed with a mental illness	30	25	11	N.A.
Average Community Medical Risk Score ^b	1.5	1.3	1.0	n.a.
Average Spending per Beneficiary, by Program (Dollars)				
Medicaid ^c	15,200 **	800	n.a.	15,500 **
Medicare ^d				
Parts A and B	14,400	11,800	7,800	n.a.
Part D	3,800	3,200	400	n.a.
Total Average Spending by Medicaid and Medicare ^c	33,400 **	15,700	8,300	15,500 **

Source: Congressional Budget Office.

Note: n.a. = not applicable; N.A. = not available; * = between zero and 0.5 percent.

- Dual-eligible beneficiaries are people who are enrolled in Medicare and Medicaid at the same time and who are eligible to receive benefits from both programs. "Full duals" qualify for full benefits from both programs; "partial duals" qualify for full benefits from Medicare but only partial benefits from Medicaid (meaning that Medicaid pays some of the expenses they incur under Medicare, such as premiums, but does not cover additional health care services, such as long-term services and supports). "Nonduals" qualify for benefits only from Medicare or only from Medicaid. (For more details, see the glossary.)
- The Centers for Medicare & Medicaid Services calculates a risk score for each Medicare enrollee on the basis of his or her medical diagnoses and demographic characteristics. The scores are used to adjust Medicare's payments to managed care plans to reflect enrollees' expected costs for Parts A and B of Medicare. Risk scores are normalized such that the average assigned risk score for enrollees in fee-for-service Medicare is 1.0. In order to use a common framework for comparing the health status of various beneficiaries, CBO only reports risk scores from the community version of the CMS-HCC model (see the appendix for details). For that reason and because CBO includes people enrolled in Medicare Advantage plans (not just fee-for-service Medicare), the average risk score for the whole Medicare population, as reported above, will not equal 1.0.
- Includes federal and state spending for Medicaid but excludes Medicaid payments for Medicare premiums.
- The Medicare program consists of three parts: Hospital Insurance (Part A), Medical Insurance (Part B), and prescription drug coverage (Part D). Medicare Part C (known as Medicare Advantage) specifies the rules under which private health care plans can assume responsibility for, and be compensated for, providing benefits covered under Parts A, B, and D.

[** Value corrected]

Box 1.**Partial Dual-Eligible Beneficiaries**

Partial duals are eligible for complete benefits from Medicare but only limited benefits from Medicaid. Those limited benefits consist of having Medicaid pay some of the expenses they incur under Medicare, such as premiums and, in many cases, cost sharing for services covered by Medicare. The extent of the assistance that partial duals receive from Medicaid varies with their income and assets and, to some extent, with differences in state policies. (Some states' Medicaid programs have higher ceilings on income and assets for both full and partial duals than the federal government requires.)

In certain ways, partial duals are very similar to full duals: About 40 percent of both populations are under age 65, roughly 60 percent of both populations are female, and just over half of both populations qualified for Medicare because of a disability or end-stage renal disease (see Table 1 on page 5). On average, however, partial duals tend to be healthier and have less need for services than full duals. For example, fewer of them have at least three chronic conditions (14 percent of partial duals, compared with 19 percent of full duals), and their average medical risk score is nearly 15 percent lower than that of full duals. (Medical risk scores, which the Centers for Medicare & Medicaid Services calculate to adjust Medicare's payments to managed care and prescription drug plans, reflect enrollees' expected costs for Parts A and B of Medicare.) That difference in average risk scores, and thus in the predicted use of acute

and postacute care services, is reflected in the fact that Medicare spent an average of \$15,000 per beneficiary for partial duals in 2009 but \$18,200 for full duals.

The key difference in use of services, however, between those two groups involves long-term services and supports: Partial duals are 70 percent less likely to use those services than full duals are.¹ In addition, less than 0.5 percent of partial duals are institutionalized, compared with 15 percent of full duals. To some extent, differences between the two groups in the use of nursing facilities reflect the factors that make someone a full or partial dual-eligible beneficiary. Partial duals may become eligible for full Medicaid benefits—and thus become full duals—if they develop the need for long-term nursing home care, which is very expensive. Specifically, such beneficiaries may gain full Medicaid eligibility because of spending down their assets or because of higher ceilings on income and assets for people living in nursing facilities, depending on states' eligibility rules for Medicaid.

1. In fact, a comparison of full duals and partial duals who do not use long-term services and supports shows that those two populations are similar; the partial duals have slightly more chronic conditions, somewhat higher medical risk scores, and somewhat higher Medicare spending, on average. Those differences may stem from the fact that partial duals who do not use long-term services and supports are more likely than their full-dual counterparts to be elderly.

Among both full duals and nondual Medicare beneficiaries, those age 65 or older were much more likely than younger beneficiaries to have been diagnosed with three or more chronic conditions, and they had correspondingly higher average medical risk scores (see Table 2). Those differences between age groups were larger, however, for the full-dual population. By contrast, beneficiaries under age 65 in both groups were more likely than elderly beneficiaries to have been diagnosed with a mental illness.

Use of Long-Term Care and Related Services

One notable characteristic that distinguishes full duals from their nondual counterparts in Medicare and Medicaid is their high rate of use of both community-based and institutional long-term services and supports.⁹ LTSS

9. All discussion in this report of use of services refers to services covered by Medicare or Medicaid; CBO does not have access to data on beneficiaries' use of other services. Therefore, this analysis may underestimate LTSS use by partial duals and nondual Medicare beneficiaries if those services are paid for by the beneficiary or by another payer other than Medicare.

Table 2.**Demographic Characteristics of Dual-Eligible Beneficiaries, Compared With Those of Certain Other Medicare and Medicaid Beneficiaries, 2009, by Age**

	Full Duals ^a		Partial Duals ^a		Nondual Medicare Beneficiaries		Nondual Aged, Blind, or Disabled Medicaid Beneficiaries	
	Under Age 65	Age 65 or Older	Under Age 65	Age 65 or Older	Under Age 65	Age 65 or Older	Under Age 65	Age 65 or Older
Number of Beneficiaries (Millions)	2.9	4.2	0.8	1.2	4.3	35.3	5.6 **	0.8 **
Percentage With Various Characteristics								
Female	52	69	51	68	44	55	49	66
Black	23	17	26	20	16	7	31 **	18
Hispanic	6	9	3	4	3	1	13 **	22
Living in a rural area	22	20	29	29	22	20	20	14
Originally enrolled in Medicare because of a disability or end-stage renal disease	100	18	100	23	100	8	n.a.	n.a.
Diagnosed with three or more chronic conditions	8	26	10	17	6	10	N.A.	N.A.
Institutionalized	4	23	*	1	*	1	2	17
Receiving any long-term services and supports	31	54	10	16	4	9	16 **	28
Diagnosed with a mental illness	37	25	37	17	19	10	N.A.	N.A.
Average Community Medical Risk Score ^b	1.2	1.8	1.2	1.4	0.8	1.0	n.a.	n.a.
Average Spending per Beneficiary, by Program (Dollars)								
Medicaid ^c	14,600	15,500	1,100	600	n.a.	n.a.	16,200 **	9,900 **
Medicare ^d								
Parts A and B	12,100	16,100	11,100	12,200	6,600	8,000	n.a.	n.a.
Part D	4,500	3,300	4,200	2,500	800	400	n.a.	n.a.
Total Average Spending by Medicaid and Medicare ^c	31,100	34,800	16,400	15,300	7,400	8,400	16,200 **	9,900 **

Source: Congressional Budget Office.

Note: n.a. = not applicable; N.A. = not available; * = between zero and 0.5 percent.

- Dual-eligible beneficiaries are people who are enrolled in Medicare and Medicaid at the same time and who are eligible to receive benefits from both programs. "Full duals" qualify for full benefits from both programs; "partial duals" qualify for full benefits from Medicare but only partial benefits from Medicaid (meaning that Medicaid pays some of the expenses they incur under Medicare, such as premiums, but does not cover additional health care services, such as long-term services and supports). "Nonduals" qualify for benefits only from Medicare or only from Medicaid. (For more details, see the glossary.)
- The Centers for Medicare & Medicaid Services calculates a risk score for each Medicare enrollee on the basis of his or her medical diagnoses and demographic characteristics. The scores are used to adjust Medicare's payments to managed care plans to reflect enrollees' expected costs for Parts A and B of Medicare. Risk scores are normalized such that the average assigned risk score for enrollees in fee-for-service Medicare is 1.0. In order to use a common framework for comparing the health status of various beneficiaries, CBO only reports risk scores from the community version of the CMS-HCC model (see the appendix for details). For that reason and because CBO includes people enrolled in Medicare Advantage plans (not just fee-for-service Medicare), the average risk score for the whole Medicare population, as reported above, will not equal 1.0.
- Includes federal and state spending for Medicaid but excludes Medicaid payments for Medicare premiums.
- The Medicare program consists of three parts: Hospital Insurance (Part A), Medical Insurance (Part B), and prescription drug coverage (Part D). Medicare Part C (known as Medicare Advantage) specifies the rules under which private health care plans can assume responsibility for, and be compensated for, providing benefits covered under Parts A, B, and D.

[** Value corrected]

includes long-term care provided in nursing homes and skilled nursing facilities, as well as hospice care, home health care, and other social support services that enable beneficiaries to continue living in the community (that is, outside institutions).¹⁰ In 2009, full duals were about five times as likely to use LTSS as nondual Medicare beneficiaries (44 percent versus 9 percent) and more than twice as likely to use those services as nondual aged, blind, or disabled (ABD) Medicaid beneficiaries (44 percent versus 18 percent).^{*} Those differences were reflected in the various groups' rates of institutionalization: 15 percent for full duals, compared with 1 percent for nondual Medicare beneficiaries and 4 percent for nondual ABD Medicaid beneficiaries. Use of LTSS was particularly high among elderly full duals, more than half of whom used such services. Likewise, nearly one-quarter of elderly full duals lived in an institution.

Diversity of Services Needed

Designing cost-effective programs to provide care for full duals is challenging in part because those beneficiaries vary widely in their needs for medical treatment, long-term care, and social services. For example, 85 percent of full duals lived outside nursing homes in 2009. Of them, 35 percent received community-based long-term services and supports, 14 percent had multiple chronic conditions but did not use such services, and the other 51 percent had no more than one chronic condition and also did not use any of those services.¹¹

The need for services can also vary considerably within such subgroups. For instance, more than half of full duals who used community-based LTSS in 2009—and one-third of those in institutions—had no more than one chronic condition. (However, some disabling conditions for which beneficiaries may need nursing home care or community-based services, such as physical, intellectual,

or developmental disabilities, may not be represented in data on chronic conditions.) In addition, some beneficiaries with multiple chronic conditions have behavioral health problems, cognitive impairments, or developmental disabilities that compound the effects of other chronic illnesses and complicate the management of their care.

Given that diversity of needs, using any single approach to deliver care to all dual-eligible beneficiaries may be infeasible. An alternative would be to target subgroups with the particular services they need, using the models of care that are most appropriate for them.¹² Such targeting might require more resources and data than a “one size fits all” approach, however, which would increase the administrative costs of providing care.

Spending by Medicare and Medicaid for Dual-Eligible Beneficiaries

Among full duals, Medicare is the primary payer for acute care services (such as inpatient and outpatient hospital services, physicians' services, and prescription drugs) and for postacute care (such as care in skilled nursing facilities and home health services).¹³ Medicaid is the primary payer for full duals' long-term services and supports (including nursing home care), and it also pays for some of their acute care costs, such as cost sharing under Medicare and some acute care services that Medicare does not cover (such as dental and vision care). That division of responsibilities, and the health status and service needs of full duals, are reflected in the amount that each program pays per full dual-eligible beneficiary.

In part because full duals have higher-than-average health risks, they cost Medicare much more, per person, than other Medicare beneficiaries did in 2009: an average of about \$18,200 (including spending by all parts of the program), compared with about \$8,300 for nondual Medicare beneficiaries (see Table 1 on page 5). Likewise, because full duals use long-term services and supports at a relatively high rate, state and federal Medicaid spending was almost as high for that population as it was for the nondual aged, blind, or disabled Medicaid population:

10. Medicare covers care in skilled nursing facilities, hospice care, and home health services under certain circumstances when a beneficiary meets the requirement for Medicare's postacute care benefits. That Medicare coverage is typically short term in nature and is intended to help beneficiaries recover from acute conditions for which they are also receiving medical care. Medicaid's provision of nursing home, hospice, and home health services could substitute for those postacute care services for full duals if the Medicare benefit was not available.

11. That breakdown of beneficiaries follows one used in Randall Brown and David R. Mann, *Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence* (Kaiser Family Foundation, October 2012), www.kff.org/medicare/8353.cfm.

12. *Ibid.*

13. The primary payer of a health care bill is the first organization to pay what it owes for that bill; secondary and other payers make payments based on any remaining amount owed beyond what the primary payer covered.

[* Sentence corrected]

about \$15,200 per beneficiary, on average, versus \$15,500.^{14*} That difference is particularly notable because it means that Medicaid is spending about as much for only a portion of the health care services that full duals receive (its share) as for *all* of the services that nondual ABD beneficiaries receive.*

Together, Medicare and Medicaid paid an average of \$33,400* per full dual in 2009, with Medicare's share being slightly more than half (see Table 3). Of that amount, 61 percent was for acute care services, 6 percent was for postacute care, and 33 percent was for long-term care (including both institutional care and community-based services).¹⁵ That average for the entire full-dual population masks wide variation in spending for individuals. For the most costly 10 percent of full duals, Medicare and Medicaid paid a combined \$130,200 per beneficiary, on average. At the other end of the cost spectrum, a substantial share of full duals used relatively few services: Medicare and Medicaid paid a combined \$4,100 per beneficiary, on average, for people in the least costly 33 percent of full duals (see Figure 1 on page 3).

The distribution of spending between the two programs also varied by beneficiary. In general, dual-eligible beneficiaries for whom Medicaid spent especially large amounts in 2009 had much lower spending by Medicare, and vice versa. For example, Medicaid was responsible for nearly 80 percent of the combined spending for full duals who were in the top 10 percent of Medicaid spending per beneficiary—people who typically had high long-term care expenses but close-to-average acute care costs (see Table 3). Similarly, Medicare covered nearly 80 percent of total spending for full duals who were in the top 10 percent of Medicare spending—individuals whose average acute care costs were high but whose long-term care expenses were relatively low. Spending for full duals who

were in the top 10 percent of combined spending per beneficiary was more evenly distributed between the two programs (averaging \$63,000 for Medicaid and \$67,200 for Medicare in 2009) and among the types of services paid for. About 54 percent of spending for that costliest group was for acute care, 38 percent was for long-term care, and the other 8 percent was for postacute care.

Differences in spending and service use among subgroups of the full-dual population are partly attributable to differences in the prevalence of various chronic conditions. Among full duals who were in the top 10 percent of Medicaid spending in 2009, for instance, 41 percent had dementia, compared with 14 percent of the overall full-dual population. Likewise, although full duals in the top 10 percent of Medicare spending or the top 10 percent of combined spending had much the same set of common chronic conditions as the total full-dual population, the prevalence of specific conditions varied substantially among those groups. Almost half of full duals in the top 10 percent of Medicare spending had diabetes, and 39 percent had congestive heart failure—roughly twice the prevalence of those conditions among all full duals.

Other factors drive differences in spending as well. For example, average spending for elderly and nonelderly full duals was much closer in 2009 than might be expected, given how much the two age groups differ in prevalence of chronic conditions, average medical risk scores, and use of LTSS (see Table 2 on page 7). Medicaid spending for the two groups was especially close, partly because Medicaid spends more on non-LTSS services for the nonelderly population than for the elderly population, but also because average Medicaid spending on LTSS among users of those services is about 40 percent higher for the nonelderly than for the elderly (not shown in Table 2). That pattern suggests that chronic conditions may be less useful predictors of spending for the disabled population than for the elderly and that other factors also contribute to disabled beneficiaries' use of services.

Spending on dual-eligible beneficiaries also varies substantially among states. That variation may result from differences in the payment rates, covered services, and eligibility rules of state Medicaid programs as well as from differences in the share of beneficiaries who have multiple chronic conditions.

14. All figures for Medicaid spending in this report include both the state and federal shares of Medicaid spending but exclude Medicaid payments for Medicare premiums.

15. Spending for long-term care includes only the long-term care portion of LTSS. Notably, Medicaid's institutional and community-based long-term care is included in this category, but Medicare's skilled nursing and home health services are included in the postacute care category. Hospice care—provided through both Medicare and Medicaid—is included in the acute care category. See the appendix for more details.

[* Sentence or value corrected]

Table 3.**Spending for Full Dual-Eligible Beneficiaries, by Program and Type of Service, 2009**

	All Full Duals	Full Duals in Top 10 Percent of Medicaid Spending per Beneficiary	Full Duals in Top 10 Percent of Medicare Spending per Beneficiary	Full Duals in Top 10 Percent of Combined Spending per Beneficiary
Average Spending per Beneficiary, by Program (Dollars)				
Medicaid ^a	15,200 **	80,500	21,700	63,000
Medicare ^b				
Parts A and B	14,400	17,900	75,700	60,300
Part D	3,800	5,300	7,400	6,900
Total Average Spending by Medicaid and Medicare ^a	33,400 **	103,700	104,800	130,200
Distribution of Spending by Type of Service (Percent) ^c				
Acute care	61	33	74	54
Inpatient care	16	8	35	24
Ambulatory care	15	7	19	13
Prescription drugs	12	6	7	6
Other (Includes capitation payments)	18	12	13	12
Postacute care	6	2	13	8
Skilled nursing facility care	4	2	9	6
Home health care	2	*	4	2
Long-term care	33	65	13	38
Institutional care	21	45	9	25
Community-based long-term care	12	20	4	13
Five Most Common Chronic Conditions (Percentage with that condition)				
Most common	Diabetes (29)	Dementia (41)	Diabetes (49)	Diabetes (42)
Second most common	COPD (17)	Diabetes (31)	Congestive heart failure (39)	Congestive heart failure (33)
Third most common	Congestive heart failure (15)	Congestive heart failure (22)	COPD (33)	Dementia (31)
Fourth most common	Dementia (14)	COPD (17)	Dementia (24)	COPD (27)
Fifth most common	Osteoporosis (10)	Depression (14)	Ischemic heart disease (21)	Ischemic heart disease (16)

Source: Congressional Budget Office.

Notes: Dual-eligible beneficiaries are people who are enrolled in Medicare and Medicaid at the same time and who are eligible to receive benefits from both programs. "Full duals" qualify for full benefits from both programs.

* = between zero and 0.5 percent; COPD = chronic obstructive pulmonary disease.

- Includes federal and state spending for Medicaid but excludes Medicaid payments for Medicare premiums.
- The Medicare program consists of three parts: Hospital Insurance (Part A), Medical Insurance (Part B), and prescription drug coverage (Part D). Medicare Part C (known as Medicare Advantage) specifies the rules under which private health care plans can assume responsibility for, and be compensated for, providing benefits covered under Parts A, B, and D.
- For details about what types of services are included in these categories, see the appendix.

Medicare's and Medicaid's Current Payment Systems for Dual-Eligible Beneficiaries

The Medicare and Medicaid programs use two types of payment systems—fee for service (FFS) and risk-based managed care—to pay for covered benefits for their enrollees. Under FFS, the programs pay health care providers a fee for each service performed, whereas under risk-based managed care, the programs contract with health plans, most of which are sponsored by private insurance companies, to provide a set of covered benefits for a fixed amount per beneficiary. (Those amounts may be adjusted to reflect the health risks of beneficiaries, as explained in Box 2.) Both programs have encouraged managed care systems in an effort to reduce spending and improve the quality of care by improving beneficiaries' access to services and increasing the management of their care.

Managed Care Plans in Medicare and Medicaid

A minority of Medicare beneficiaries and of aged, blind, or disabled Medicaid beneficiaries are enrolled in risk-based managed care plans, and the percentages are lower among dual-eligible beneficiaries.¹⁶ In Medicare, about 25 percent of beneficiaries in 2009 were enrolled in Medicare Advantage plans—private health plans that assume the responsibility and financial risk for providing Medicare benefits. A smaller share of full duals, about 17 percent, were enrolled in Medicare Advantage plans, and 60 percent of those beneficiaries were enrolled in special-needs plans (SNPs)—Medicare Advantage plans that specialize in dual-eligible beneficiaries, people in institutions, or those with certain chronic conditions. In Medicaid, enrollment in risk-based managed care plans has been more common among children and non-disabled adults than among other beneficiaries; in 2009, about 35 percent* of nondual aged, blind, or disabled Medicaid beneficiaries and 15 percent of full duals were enrolled in such plans. Unlike Medicare's managed care plans, which are responsible for providing the full set of benefits covered by Parts A and B of that program,

16. Some states' Medicaid programs use primary care case management or prepaid health plans as an alternative form of managed care. Enrollment in primary care case management is counted as part of fee-for-service Medicaid in this analysis because states continue to pay providers for each claim, in addition to making a fixed payment for management activities. Enrollment in prepaid health plans is also counted under fee-for-service Medicaid because those plans cover only a limited set of services.

[* Value corrected]

Medicaid's risk-based managed care plans are often not required to cover certain Medicaid benefits, such as behavioral health care or long-term care. Medicaid may cover those "carved-out" services on a fee-for-service basis or in special managed care arrangements.

Plans that participate in Medicare Advantage submit bids indicating the per-enrollee payment they are willing to accept in return for providing all Medicare benefits to an average Medicare beneficiary enrolling in their plan in each region where they operate. Medicare makes a capitated payment to each participating plan (a single payment that covers all care within a specified set of benefits) on the basis of the plan's bid and an administratively determined benchmark that varies geographically with fee-for-service spending per beneficiary.¹⁷ Payments to Medicare Advantage plans are adjusted for the risk profile of a plan's enrollees, which reflects their expected relative costs (see Box 2).¹⁸ In addition, since 2012, plans that reach a certain quality threshold (based on a star rating system) are eligible for bonuses in the form of higher benchmarks.

Medicaid's contracts with risk-based managed care plans vary considerably by state. In most cases, a state either sets a payment rate for all plans operating in the state or negotiates a payment rate with each plan individually.

17. Before 2012, Medicare Advantage benchmarks were, on average, roughly 13 percent higher than average FFS spending. The Affordable Care Act changed how benchmarks are set beginning in 2012, with those changes phased in until 2017; at that point, the new benchmarks will range from 95 percent to 115 percent of average FFS spending. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2011), http://medpac.gov/documents/Mar11_EntireReport.pdf (6 MB).

18. That payment system does not apply to two types of Medicare Advantage plans: PACE (Program of All-Inclusive Care for the Elderly) and cost plans, neither of which submits bids. PACE programs are paid on the basis of risk scores, benchmarks, and an adjustment for the frailty of their enrollees, and cost plans are paid on the basis of submitted claims (that is, they are reimbursed according to the costs they incur in delivering covered benefits). The benchmark revisions enacted in the ACA do not apply to PACE programs; thus, if those revisions were fully implemented for Medicare Advantage plans in 2013 (rather than being phased in until 2017), benchmarks for PACE programs would be about 8 percent to 18 percent higher than benchmarks for Medicare Advantage plans, depending on the county. (That difference does not include quality adjustments for Medicare Advantage plans through the star rating system.)

Box 2.**Adjusting Medicare's Payments for the Health Risks of Beneficiaries**

Health care costs vary substantially among Medicare beneficiaries. Some of that variation comes from unexpected medical problems, and some reflects differences in the prevalence of chronic conditions. The process by which beneficiaries choose health care plans in Medicare is unlikely to spread costs evenly among plans—both because some plans may attract sicker beneficiaries than others do and because unexpected health events may not be distributed evenly among different plans' enrollees. Thus, to help ensure that some Medicare Advantage (managed care) and Medicare Part D (prescription drug) plans do not end up leaving the market because they had to cover a more expensive population—and, similarly, to make sure that plans are not overpaid for a less expensive population—Medicare adjusts payments to plans to account for the likely health care costs of their enrollees.

To do that, the Centers for Medicare & Medicaid Services (CMS) has developed two models: the Hierarchical Condition Category (CMS-HCC) model, which is used for Medicare Advantage plans, and the Prescription Drug Hierarchical Condition Category (CMS-RxHCC) model, which is used for Part D plans. The output of each model is a risk score for every beneficiary that depends on the person's set of diagnoses and demographic characteristics. Payments to plans are adjusted with those risk scores to account for differences in expected spending for different beneficiaries.

CMS calculates the parameters of the models using a statistical analysis that relates spending by Parts A and B of Medicare (for the CMS-HCC model) or Part D (for the CMS-RxHCC model) for a given year to a set of characteristics of fee-for-service or Part D beneficiaries from the previous year. Those characteristics include demographic indicators (such as age group and sex), indicators of chronic conditions, and a set of interaction terms. The interaction terms involve either two demographic indicators, two chronic conditions, or a chronic condition and a demographic indicator. The CMS-HCC model currently includes 70 chronic conditions—called hierarchical condition categories—and the CMS-RxHCC model includes 78 prescription drug hierarchical condition categories.¹ As the name implies, some categories include

1. For more information about the two models, see Gregory C. Pope and others, *Evaluation of the CMS-HCC Risk Adjustment Model: Final Report* (prepared by RTI International for the Centers for Medicare & Medicaid Services, March 2011), <http://go.usa.gov/TpRV> (pdf, 1 MB); Centers for Medicare & Medicaid Services, "Advance Notice of Methodological Changes for Calendar Year (CY) 2014 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2014 Call Letter" (February 15, 2013), <http://go.usa.gov/TuQG> (pdf, 1 MB), and "Advance Notice of Methodological Changes for Calendar Year (CY) 2011 for Medicare Advantage (MA) Capitation Rates, Part C and Part D Payment Policies and 2011 Call Letter" (February 19, 2010), <http://go.usa.gov/TuUR> (pdf, 813 KB); John Robst, Jesse M. Levy, and Melvin J. Ingber, "Diagnosis-Based Risk Adjustment for Medicare Prescription Drug Plan Payments," *Health Care Financing Review*, vol. 28, no. 4 (Summer 2007), pp. 15–30, <http://go.usa.gov/TpRH> (pdf, 483 KB).

Continued

Those rates must be certified by the Centers for Medicare & Medicaid Services (CMS) as being adequate to cover average expected costs for the covered population (including administrative expenses).

Dual-Eligible Beneficiaries' Enrollment in Different Service-Delivery Systems

The mix of fee-for-service care and risk-based managed care used in both Medicare and Medicaid means that

full duals receive covered benefits through an array of fee-for-service and capitated payment systems, with major differences both within and among states. Those differences reflect several factors: variation in the availability of Medicare and Medicaid managed care plans; state policies governing whether full duals can enroll in risk-based managed care for Medicaid and, if so, whether enrollment is mandatory or voluntary; states' use of multiple waivers and authority for demonstration projects

Box 2.**Continued****Adjusting Medicare's Payments for the Health Risks of Beneficiaries**

a hierarchy of conditions, and only the most severe condition in the hierarchy that a beneficiary has is included in the risk score. (For instance, if someone has been diagnosed with acute myocardial infarction as well as with unstable angina or other acute ischemic heart disease, only the more severe condition, acute myocardial infarction, is included for that person.) Other conditions are not part of a hierarchy and are not subject to being overridden by another condition. The relationships between spending and the various condition categories, demographic characteristics, and interactions used in the model are recalibrated periodically as the relationship between chronic conditions and fee-for-service spending changes over time.

For Medicare Advantage, CMS maintains two versions of the CMS-HCC model: the “community” version described above and an “institutional” version that is intended to reflect the fact that nursing facilities often take on some of the care delivered by medical professionals. The institutional CMS-HCC model includes the same set of hierarchical condition categories, demographic characteristics, and interactions as the community model, but it uses different model parameters, which are based on the relationships between those characteristics and spending that

are calculated for institutionalized beneficiaries. In addition, because CMS does not have diagnostic information for new Medicare enrollees, it uses “new enrollee” models to create Medicare Advantage and Part D risk scores that reflect the relationship between spending and demographic characteristics (but not chronic conditions).

Besides their use in adjusting payments, medical risk scores are also helpful tools for characterizing the average health status of various groups. For example, in 2009, the average risk score from the community version of the CMS-HCC model was 1.534 for full dual-eligible beneficiaries, compared with 0.985 for nondual Medicare beneficiaries (see Table 1 on page 5). That difference suggests that full duals are in much worse health, on average, than other Medicare beneficiaries.¹

1. CMS normalizes risk scores such that the average assigned risk score for the fee-for-service Medicare population is 1.0. In this analysis, the Congressional Budget Office reports risk scores only from the community version of the CMS-HCC model in order to use a common framework for comparing the health status of various groups. In addition, the average risk scores reported here include Medicare Advantage enrollees as well as enrollees in fee-for-service Medicare. For those reasons, the risk scores reported here do not average 1.0.

granted by Medicare and Medicaid to integrate the delivery of services under the two programs; and the capacity of local Medicaid managed care plans to manage the services needed by full duals in addition to those used by other subsets of the Medicaid population.

In 2009, nearly three-quarters of full duals received Medicare and Medicaid services through the FFS delivery systems in both programs (see Table 4). Only about 5 percent were enrolled in risk-based managed care plans for both programs (which may have been the same or separate plans) or in PACE (Program of All-Inclusive Care for the Elderly) programs, which receive a combined Medicare and Medicaid payment for full duals who need the degree of care typically provided in nursing homes.¹⁹ The other 21 percent of full duals were enrolled in either

risk-based Medicaid plans with FFS Medicare, or FFS Medicaid with Medicare managed care.

19. PACE programs receive capitated payments from Medicare and Medicaid that are combined into a single payment to provide all services for both programs—including LTSS—to beneficiaries who are age 55 or older and not living in institutions at the time of enrollment but who meet the standards of need for institutional care. PACE programs also receive a frailty adjustment from Medicare to account for the additional service needs of their enrollees. Less than 1 percent of full duals nationwide are enrolled in PACE programs. For more details, see Dana B. Mukamel and others, “Program Characteristics and Enrollees’ Outcomes in the Program of All-Inclusive Care for the Elderly (PACE),” *Milbank Quarterly*, vol. 85, no. 3 (September 2007), pp. 499–531, <http://dx.doi.org/10.1111/j.1468-0009.2007.00497.x>; and California HealthCare Foundation, *Aging in PACE: The Case for California Expansion* (July 2010), <http://tinyurl.com/clbqrm8>.

Table 4.**Demographic Characteristics of and Spending for Full Dual-Eligible Beneficiaries, by Type of Medicare and Medicaid Payment System Enrolled in, 2009**

	Fee-for-Service Medicare and Medicaid	Fee-for-Service Medicare and Medicaid Managed Care ^a	Medicare Managed Care (Medicare Advantage) and Fee-for-Service Medicaid	Medicare and Medicaid Managed Care Managed Care Plans Other Than PACE	PACE
Percentage of Full Duals	73	9	12	5	*
Distribution by Age (Percent)					
Nonelderly (Under age 65)	42	51	29	38	3
Elderly (Age 65 or older)	58	49	71	62	97
Distribution by Number of Chronic Conditions (Percent)					
None	38	56	31	42	14
1–2	43	32	47	43	46
3–4	15	10	18	12	30
5–6	3	2	4	2	9
More than 6	*	*	1	*	1
Average Community Medical Risk Score ^b	1.5	1.3	1.6	1.4	2.1
Percentage Who Are Institutionalized	17	6	15	7	14
Percentage Receiving Any LTSS ^c	49	28	38	23	N.A.
Percentage With a Mental Illness	31	20	31	27	42
Average Spending per Beneficiary, by Program (Dollars)					
Medicaid ^d	16,700	9,900	11,200	10,200	30,600
Medicare ^e					
Parts A and B	14,500	11,500	16,700	13,000	20,700
Part D	4,000	3,000	3,300	3,100	3,100
Total Medicaid and Medicare Spending per Beneficiary at Various Points in the Distribution of Spending (Dollars)					
10th percentile	1,800	3,000	6,400 **	7,400	12,600
50th percentile	18,200	11,700	19,100	17,500	54,400
90th percentile	86,300	61,600	75,100 **	58,300	97,200

Source: Congressional Budget Office.

Notes: Dual-eligible beneficiaries are people who are enrolled in Medicare and Medicaid at the same time and who are eligible to receive benefits from both programs. "Full duals" qualify for full benefits from both programs.

PACE = Program of All-Inclusive Care for the Elderly; * = between zero and 0.5 percent; N.A. = not available; LTSS = long-term services and supports.

- For Medicaid, includes only people enrolled in comprehensive risk-based managed care plans. Medicaid beneficiaries enrolled in other types of managed care, such as primary care case management, or enrolled in service-specific managed care plans that are not comprehensive are counted with the fee-for-service Medicaid population.
- The Centers for Medicare & Medicaid Services calculates a risk score for each Medicare enrollee on the basis of his or her medical diagnoses and demographic characteristics. The scores are used to adjust Medicare's payments to managed care plans to reflect enrollees' expected costs for Parts A and B of Medicare.
- Use of LTSS is based on fee-for-service claims; thus, any use of LTSS within Medicare Advantage or Medicaid managed care (including PACE programs) is not included in this table.
- Includes federal and state spending for Medicaid but excludes Medicaid payments for Medicare premiums.
- The Medicare program consists of three parts: Hospital Insurance (Part A), Medical Insurance (Part B), and prescription drug coverage (Part D). Medicare Part C (known as Medicare Advantage) specifies the rules under which private health care plans can assume responsibility for, and be compensated for, providing benefits covered under Parts A, B, and D.

[** Value corrected]

Considerable diversity exists within those groups as well. For example, some of the full duals enrolled in FFS Medicaid have their care managed by a primary care case manager, a medical home (a team-based care delivery model, led by a primary care provider, that coordinates care), or another type of care manager, with those different approaches sometimes used in the same state. In other cases, full duals receive most of their Medicaid-covered services from FFS providers but are enrolled in managed care plans for specific services, such as dental care or behavioral health care. Similarly, states' Medicaid managed care programs may include carve-outs (separate payment arrangements) for behavioral health care, long-term care, or other services—in many cases, when the Medicaid managed care plans in a state have little experience with those services. In Medicare, full duals may be enrolled in managed care through regular Medicare Advantage plans or special-needs plans. For full duals who are enrolled in both Medicare and Medicaid risk-based plans, the degree of integration between those plans—administrative, financial, and care-related—also varies from state to state.²⁰

Among the many possible combinations of Medicare and Medicaid payment systems, full duals enrolled in risk-based managed care for Medicaid—and either FFS or managed care for Medicare—are less likely than other full duals to be institutionalized or to receive long-term services and supports (see Table 4).²¹ Those enrolled in risk-based Medicaid managed care and FFS Medicare also have the lowest average risk score, the lowest prevalence of chronic conditions, and the lowest combined spending by Medicare and Medicaid among full duals (a median of \$11,700 in 2009). In contrast, spending was highest for the small share of full duals enrolled in PACE programs (a median of \$54,400). That group, which receives LTSS by definition, has the highest average risk score, reflecting a population with a large burden of chronic disease—40 percent have at least three chronic conditions, and more than 40 percent have mental illness.

20. See Kaiser Commission on Medicaid and the Uninsured, *Medicaid and Managed Care: Key Data, Trends, and Issues* (Kaiser Family Foundation, February 2012), www.kff.org/medicaid/8046.cfm.

21. LTSS use is based on fee-for-service claims; thus, any use of LTSS within Medicare Advantage or Medicaid managed care (including PACE programs) is not captured in Table 4. However, Medicaid provides most LTSS, and those services are often carved out of Medicaid's managed care contracts (and are usually provided by fee-for-service Medicaid).

Such variation in spending and health status reflects, at least in part, the differences between the beneficiary populations enrolled in managed care and FFS. Enrollment in Medicare Advantage is voluntary—as is enrollment in Medicaid managed care for many dual-eligible beneficiaries—and healthier beneficiaries appear to be more likely to enroll in managed care plans. Recent evidence about whether risk scores fully adjust for that difference is mixed.²² (Special-needs plans and PACE programs are exceptions, in that their eligibility requirements cause them to enroll less healthy beneficiaries.) Because differences in spending are related to differences in health status that also affect beneficiaries' enrollment decisions, it is difficult to tell from the relationship between spending and health status alone whether one managed care arrangement would produce lower costs for a given beneficiary than another arrangement would.

Efforts to Integrate Medicare's and Medicaid's Financing and Coordinate Care for Dual-Eligible Beneficiaries

To reduce spending on dual-eligible beneficiaries and improve the quality of their care, federal and state policymakers are focusing on two interrelated approaches: integrating Medicare's and Medicaid's financing for those beneficiaries, and having some entity coordinate the care that dual-eligible beneficiaries receive from multiple health care providers. Coordinating care effectively may be difficult as long as payers and providers face different financial incentives under the two programs, but aligning

22. See, for example, Sherry Glied and others, *Selection, Marketing, and Medicaid Managed Care*, Working Paper 6164 (National Bureau of Economic Research, September 1997), www.nber.org/papers/w6164; Jason Brown and others, *How Does Risk Selection Respond to Risk Adjustment? Evidence From the Medicare Advantage Program*, Working Paper 16977 (National Bureau of Economic Research, April 2011), www.nber.org/papers/w16977; Joseph P. Newhouse and others, "Steps to Reduce Favorable Risk Selection in Medicare Advantage Largely Succeeded, Boding Well for Health Insurance Exchanges," *Health Affairs*, vol. 31, no. 12 (December 2012), pp. 2618–2628, <http://dx.doi.org/10.1377/hlthaff.2012.0345>; J. Michael McWilliams, John Hsu, and Joseph P. Newhouse, "New Risk-Adjustment System Was Associated With Reduced Favorable Selection in Medicare Advantage," *Health Affairs*, vol. 31, no. 12 (December 2012), pp. 2630–2640, <http://dx.doi.org/10.1377/hlthaff.2011.1344>; and Gerald F. Riley, "Impact of Continued Biased Disenrollment from the Medicare Advantage Program to Fee-For-Service," *Medicare and Medicaid Research Review*, vol. 2, no. 4 (2012), pp. E1–E16, <http://go.usa.gov/b8M4>.

those incentives alone is no guarantee that such coordination will occur. Successfully implementing both approaches could improve the quality of care and decrease spending by reducing duplication of services, minimizing the extent to which beneficiaries are shifted between acute and institutional sites of care, and reducing the provision of conflicting services that may result in complications and other health problems.

For full duals, although Medicare primarily covers acute care and Medicaid primarily covers long-term services and supports, the distinction between the two programs is not absolute: Some of the services covered by Medicare and Medicaid overlap, and some may be substituted for one another. In addition, payment rates for such services are generally lower in Medicaid than in Medicare. Those factors—combined with the fact that Medicare is funded entirely by the federal government whereas Medicaid is funded partly by the states—create conflicting financial incentives under the two programs for the federal and state governments and for health care providers.²³

States, for example, do not have a strong financial incentive to reduce spending on acute care for full duals because that spending is largely covered by the federal government through Medicare (although the states, through Medicaid, generally contribute to paying dual-eligible beneficiaries' cost-sharing amounts for acute care).²⁴ Moreover, both programs cover home health care services, so states may try to maximize the share of such services paid by Medicare. In addition, Medicare's payment rates for postacute care in skilled nursing facilities (SNFs) are typically higher than Medicaid's payment rates to nursing homes. Therefore, nursing homes that are certified SNFs have a financial incentive for their full-dual residents to be hospitalized for at least three days, thereby triggering eligibility for up to 100 days of SNF

benefits provided by Medicare, for which the nursing home can receive the higher Medicare payment rates. As a result, nursing home residents may be inappropriately hospitalized, again shifting financial responsibility from Medicaid to Medicare.

Recently, both the federal government and state Medicaid programs have been looking for ways to integrate Medicare's and Medicaid's financing and service delivery for dual-eligible beneficiaries to lessen financial incentives that can lead to inappropriate care—or care in inappropriate settings—and thereby reduce unnecessary program spending. But full duals with multiple chronic or disabling conditions might continue to be at risk for lower-quality, fragmented care, stemming from a lack of communication between health care providers that better financial integration might not solve. Poor coordination among providers can cause full duals to receive duplicative services, contradictory advice or procedures for a particular diagnosis, or poor transitions between settings for care, all of which reduce the overall quality of their care. As a result, state Medicaid programs and the federal government are also looking to design care coordination programs—either in conjunction with or separate from efforts to align financial incentives—using a variety of options available under current law.²⁵ Many care coordination initiatives include elements to improve the flow of information among providers, assist patients in making the transition from one care setting to another (such as when they are discharged from a hospital to another facility or to their home), and help patients gain access to medical and social support services.²⁶

Spurred in part by new opportunities authorized under the Affordable Care Act, care and financing arrangements for full duals are changing rapidly, and more changes are likely in the next few years. Governments are trying a variety of approaches, including establishing multipayer programs, requiring Medicare's special-needs plans for dual-eligible beneficiaries to have contracts with state Medicaid agencies, integrating behavioral and physical

23. See David C. Grabowski, "Medicare and Medicaid: Conflicting Incentives for Long-Term Care," *Milbank Quarterly*, vol. 85, no. 4 (December 2007), pp. 579–610, <http://dx.doi.org/10.1111/j.1468-0009.2007.00502.x>.

24. State Medicaid programs are not required to cover the full amount of Medicare cost sharing for services provided to dual-eligible beneficiaries if Medicaid's payment rate is lower than Medicare's payment rate. Therefore, in states that do not opt to cover the full cost-sharing amount, overall payments to providers on behalf of dual-eligible beneficiaries are lower than payments on behalf of other Medicare beneficiaries. That difference may make providers less willing to accept dual-eligible beneficiaries as new patients, thus limiting those patients' access to care.

25. See, for example, Michelle Herman and Brianna Ensslin, *Innovations in Integration: State Approaches to Improving Care for Medicare-Medicaid Enrollees* (Center for Health Care Strategies, February 2013), <http://tinyurl.com/d87c5oq>.

26. See Lyle Nelson, *Lessons From Medicare's Demonstration Projects on Disease Management and Care Coordination*, Working Paper 2012-01 (Congressional Budget Office, January 2012), www.cbo.gov/publication/42924.

health care, offering managed long-term services and supports, and taking part in financial alignment demonstration projects authorized under the ACA.

Multipayer Medical-Home Programs

Various efforts are under way in the Medicaid program at the federal and state levels to establish so-called medical homes to improve the quality and coordination of health care services for Medicaid beneficiaries. (A medical home is not a facility but a model for delivering health care in which a team of health care professionals, led by a primary care provider, coordinates the care given to an individual or family.) In recent years, nearly half of state Medicaid programs have launched initiatives to create patient-centered medical homes.²⁷ As part of those efforts, some states and the federal government are developing multipayer initiatives that include private insurers, Medicare, and Medicaid.

CMS recently announced a three-year initiative—the Multi-payer Advanced Primary Care Practice demonstration—in which Medicare will participate in some states' multipayer medical-home programs (see Table 5).²⁸ Eight states are taking part in that demonstration, under which Medicare, Medicaid, and private insurers will generally pay a per-beneficiary care management fee or a bonus to advanced primary care practices (another name for patient-centered medical homes). The fee or bonus is supposed to cover the cost of services, such as coordinating care among providers, that are intended to improve the quality and efficiency of care for chronically ill patients.

Fully Integrated Dual-Eligible Special-Needs Plans

Another approach for coordinating the care received by full duals and aligning the financial incentives created by Medicare and Medicaid involves a subset of Medicare Advantage special-needs plans for dual-eligible beneficiaries (or D-SNPs) known as fully integrated dual-eligible special-needs plans (FIDE-SNPs). As of 2013, regular D-SNPs are generally required to have risk-based contracts with states to provide, at a minimum, a subset of

services covered by Medicaid, in addition to providing Medicare services.²⁹ FIDE-SNPs, by comparison, are generally required to have risk-based contracts with states to provide most or all Medicaid services for dual-eligible beneficiaries—including long-term care—as well as providing Medicare services.³⁰ Capitated payments from Medicare to a FIDE-SNP may be adjusted (beyond the adjustment for health risks) to reflect the frailty of the plan's enrollees, if the average disability level of those enrollees is similar to that of participants in PACE programs.³¹ Participation in FIDE-SNPs is low thus far: In January 2013, those integrated plans were operating in only seven states and enrolled less than 5 percent of the 1.6 million dual-eligible beneficiaries who were enrolled in SNPs nationwide.³²

Initiatives to Integrate Behavioral and Physical Health Care

More than half of the dual-eligible beneficiaries who have chronic physical conditions, many of whom are full duals, also have diagnoses of mental illness. Those beneficiaries tend to have high health care costs.³³ For example, CBO found that in 2009, total Medicare and Medicaid spending was much higher for full duals who had a mental illness and at least one other chronic condition than for other full duals (\$48,200, on average, versus \$28,600). States are experimenting with a variety of

27. See Mary Takach, "About Half of the States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations," *Health Affairs*, vol. 31, no. 11 (November 2012), pp. 2432–2440, <http://dx.doi.org/10.1377/hlthaff.2012.0447>.

28. See Centers for Medicare & Medicaid Services, "Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration Fact Sheet" (April 5, 2012), <http://go.usa.gov/Tw93> (pdf, 22 KB).

29. See Centers for Medicare & Medicaid Services, *Announcement of Calendar Year (CY) 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter* (April 2, 2012), p. 114, <http://go.usa.gov/TwT3>.

30. Originally, FIDE-SNPs were responsible for providing all primary, acute, and long-term care services for dual-eligible beneficiaries. CMS modified that requirement in April 2012 to limit the required coverage of nursing facility services to a minimum of six months. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2012), Chapter 3, p. 82, www.medpac.gov/documents/Jun12_EntireReport.pdf (2 MB).

31. Memorandum from Cheri Rice, Director, Medicare Plan Payment Group, Centers for Medicare & Medicaid Services, to Medicare Advantage plans, November 2, 2012, <http://tinyurl.com/d9rxuks> (pdf, 96 KB).

32. See Centers for Medicare & Medicaid Services, *SNP Comprehensive Report* (January 2013), <http://go.usa.gov/Tw5H>.

33. See Richard G. Kronick, Melanie Bella, and Todd P. Gilmer, *The Faces of Medicaid III: Refining the Portrait of People With Multiple Chronic Conditions* (Center for Health Care Strategies, October 2009), p. 8, <http://tinyurl.com/n47r9qx>.

Table 5.

Selected Federal and State Initiatives to Integrate Medicare's and Medicaid's Financing and Coordinate Care for Dual-Eligible Beneficiaries

Initiative	Financial Alignment Components	Care Coordination Components	States Involved
Multi-payer Advanced Primary Care Practice (Three-year demonstration launched by CMS)	None	Advanced primary care practices are paid a care management fee by the relevant payer (Medicare, Medicaid, or a private health plan) to establish relationships with beneficiaries and coordinate their care from a wide range of providers. Fees and payments vary among payers, but some fraction of Medicaid, Medicare, and private insurers must participate in the demonstration.	Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, Vermont
Fully Integrated Dual-Eligible Special-Needs Plans (FIDE-SNPs) in Medicare Advantage	FIDE-SNPs contract with both Medicare and Medicaid to provide an integrated set of services to dual-eligible beneficiaries	Until 2012, FIDE-SNPs were required to cover the full range of acute and long-term care services; in April 2012, CMS revised the requirement so that plans must cover at least six months of nursing facility services	Arizona, California, Hawaii, Massachusetts, Minnesota, New York, Wisconsin
Health Home State Plan Option	None	The initiatives require coordination between providers of behavioral health care (such as mental health and substance abuse services) and other providers of acute care	Alabama, Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, Wisconsin
Managed Long-Term Services and Supports for Medicaid and Dual-Eligible Beneficiaries	Range from none to full integration with Medicare's payments	Limited coordination of care in some states, but many states require some degree of coordination with Medicare providers or Medicare Advantage plans	As of July 2012, Arizona, California, Delaware, Florida, Hawaii, Massachusetts, Michigan, Minnesota, New Mexico, New York, North Carolina, Pennsylvania, Tennessee, Texas, Wisconsin, Washington

Continued

models to address the particularly fragmented care that those beneficiaries typically receive.³⁴

Provisions in the ACA promote the coordination of behavioral and physical health care for Medicaid beneficiaries, building on the initiatives to establish patient-centered medical homes that many states have

implemented in recent years. Most providers in those initiatives receive a monthly per capita payment for coordinating the care of their Medicaid patients.³⁵ The ACA created a new state plan option, through which states can receive a 90 percent federal matching rate for two years for “health homes”—a type of medical home that serves Medicaid beneficiaries with a particular set of chronic

34. See Allison Hamblin, James Verdier, and Melanie Au, *State Options for Integrating Physical and Behavioral Health Care*, Technical Assistance Brief (Integrated Care Resource Center, October 2011), <http://tinyurl.com/cbeehyq> (pdf, 298 KB).

35. See Mary Takach, “About Half of the States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations,” *Health Affairs*, vol. 31, no. 11 (November 2012), pp. 2432–2440, <http://dx.doi.org/10.1377/hlthaff.2012.0447>.

Table 5. **Continued**

Selected Federal and State Initiatives to Integrate Medicare’s and Medicaid’s Financing and Coordinate Care for Dual-Eligible Beneficiaries

Initiative	Financial Alignment Components	Care Coordination Components	States Involved
Financial Alignment Demonstration Projects ^a			
Capitation model	Medicare’s and Medicaid’s payments to a managed care organization are combined	Combined payments and limited service carve-outs are intended to facilitate coordinated care because the managed care organization is responsible for delivering most or all services	Arizona, California, Hawaii, Idaho, Illinois, Massachusetts, Michigan, Minnesota, New Mexico, New York, Ohio, Oklahoma (for school of community medicine and PACE-like initiatives), Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, Wisconsin
Managed fee-for-service model	Medicare’s and Medicaid’s payments are not combined into a single stream, but states receive reimbursements for demonstrated Medicare savings	States are responsible for ensuring that beneficiaries receive integrated access to all acute and long-term care services covered by Medicare and Medicaid	Colorado, Connecticut, Iowa, Missouri, New York (for beneficiaries with several chronic conditions), North Carolina, Oklahoma, Washington (for high-cost and high-risk beneficiaries)

Source: Congressional Budget Office.

a. New York, Oklahoma, and Washington proposed testing both models in their demonstration projects. For the purposes of this table, those states are listed without comment under the model that would be used for the larger population. They are also listed under the other model with a parenthetical note describing the smaller population to which that model would apply.

conditions and addresses their behavioral and physical health care needs as well as their needs for institutional or community-based long-term care. As of May 2013, 11 states had received approval from CMS for their Health Home State Plan Amendments, and others had received planning grants.³⁶

Managed Long-Term Services and Supports

Only a small fraction of full duals who receive long-term services and supports from Medicaid do so through managed care programs, but the number of states with such programs is growing rapidly.³⁷ In July 2012, 16 states had some kind of managed LTSS program; that

number is expected to rise to 26 states by 2014.³⁸ That expansion is accompanied by growth in the number of health care organizations and plans that are capable of managing such services. Managed LTSS programs vary in several ways, including the extent to which they coordinate with Medicare, the comprehensiveness of the services they provide, the size of the geographic area they serve within a state, and whether enrollment is mandatory or voluntary for eligible Medicaid beneficiaries.

36. See Centers for Medicare & Medicaid Services, “Approved Health Home State Plan Amendments” (accessed May 23, 2013), <http://go.usa.gov/bYqm>; and Charles Townley and Mary Takach, *Developing and Implementing the Section 2703 Health Home State Option: State Strategies to Address Key Issues* (National Academy for State Health Policy, July 2012), <http://tinyurl.com/c23mzw6>.

37. The information in this and the next paragraph is based on Paul Saucier and others, *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update* (report prepared by Truven Health Analytics for the Centers for Medicare & Medicaid Services, July 2012), <http://go.usa.gov/Tf5B> (pdf, 3 MB).

38. Since July 2012, two additional states have implemented managed LTSS programs, according to CMS. See Centers for Medicare & Medicaid Services, “Summary—Essential Elements of Managed Long Term Services and Supports Programs” (accessed June 3, 2013), <http://go.usa.gov/bYcx> (pdf, 179 KB).

Some managed LTSS programs incorporate both financial alignment and care coordination components. For example, 5 of the 16 states that had programs in 2012 require plans to offer options that are fully integrated with the Medicare program. In those cases, plans are responsible for covering both Medicaid and Medicare services, aligning the financial incentives that exist under the two programs and providing an incentive to coordinate care among providers. An additional 7 of those 16 states require some coordination with Medicare; 2 of the 7 require that a managed LTSS plan also offer an SNP so the plan can provide Medicare services as well as Medicaid services. Such plans may not align financial incentives because the funding streams for Medicaid and Medicare are not integrated, but they may promote better coordination of care among providers. The other 4 states with managed LTSS programs do not require any coordination with Medicare. Those programs are also the most likely to exclude a major service, such as prescription drugs or primary care, and therefore may have minimal coordination among providers even within Medicaid. Going forward, most states that are setting up new managed LTSS programs intend to require full capitation for Medicaid and Medicare services, as 5 states do now.

Financial Alignment Demonstration Projects

The Affordable Care Act established two organizations within CMS that have the potential to affect the financing and quality of care received by full duals. The Medicare-Medicaid Coordination Office is specifically responsible for improving the coordination of care for dual-eligible beneficiaries. The Center for Medicare and Medicaid Innovation (CMMI) has a broader mission: to develop innovative payment and service-delivery models for Medicare and Medicaid. It operates under new authority created by the ACA to waive the two programs' rules for the purposes of conducting demonstrations. Under that authority, CMMI may test and evaluate methods to modify care and financing—including full integration of all Medicare and Medicaid funds—for full duals.³⁹

39. See MaryBeth Musumeci, *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS* (Kaiser Family Foundation, October 2012), <http://tinyurl.com/a9u9ucr>.

In 2011, using the combined authority of those two organizations, CMS awarded design grants of up to \$1 million each to 15 states to develop approaches to coordinate care for all of the Medicare and Medicaid benefits that full duals receive. Later in 2011, CMS announced a three-year demonstration in which states can experiment with different ways of integrating Medicare's and Medicaid's financing for full duals. Twenty-six states (including the 15 that received the earlier planning grants) applied to take part in the demonstration, and the first state projects are scheduled to begin this summer. The demonstration allows for a notable change to the regulations that govern Medicare and Medicaid: Beneficiaries may be enrolled automatically in managed care plans for Medicare benefits (a process known as passive enrollment), provided that they have the option of disenrolling or switching plans.⁴⁰

The demonstration projects will operate in two phases. During the first phase, which CMS has stated will last for three years, CMMI will assess a project's effects on spending for Medicare and Medicaid and on the quality of care that dual-eligible beneficiaries receive.⁴¹ On the basis of the findings from phase one, a state may be allowed in phase two to expand its project to cover more or all of its full-dual population—provided that the Chief Actuary of CMS certifies that such an expansion would not increase net spending for Medicare and Medicaid and that the Secretary of Health and Human Services (HHS) certifies that the program would provide the same or better quality of care than beneficiaries receive now.

Most of the states that applied for the financial alignment demonstration said they wanted to eventually include all full duals in the geographic areas covered by their projects, although a few states planned to limit their demonstration projects to subsets of the full-dual population.

40. CMS is encouraging states to allow participating beneficiaries to choose up front whether to enroll in a managed care plan rather than enrolling them automatically, particularly in the first year of the demonstration. See Mindy Yochelson, "CMS Encourages Use of Opt-In Enrollment by States Involved in Dual Eligibles Demo," *Health Care Daily Report*, Bloomberg BNA (May 8, 2013).

41. See the letter from Cindy Mann, Director, Center for Medicaid, CHIP, and Survey & Certification, and Melanie Bella, Director, Medicare-Medicaid Coordination Office, to state Medicaid directors, July 8, 2011, <http://go.usa.gov/Th3F> (pdf, 209 KB).

A majority of applicants also said that they planned to implement part or all of their initiatives on a statewide basis, in some cases using a phased-in approach. If all of the proposed projects were approved for the populations included in the applications, the first phase of the demonstration would include about 3 million of the nation's 7 million full duals. However, CMS has set an enrollment target of 1 million to 2 million beneficiaries.⁴²

Capitation Versus Managed Fee for Service. CMS's demonstration is designed to test two alternative models of financial alignment: capitation and managed fee-for-service, which are described below.⁴³ Of the 26 states that applied to participate in the demonstration, 18 proposed capitated models, 5 opted for managed FFS, and 3 proposed testing both approaches.

The capitation model will employ three-way contracts between CMS, a state, and participating health plans to cover the full range of Medicare and Medicaid benefits.⁴⁴ CMS and the state will jointly set payment rates for the health plans at levels that are estimated to result in lower combined Medicare and Medicaid spending for the plans' enrollees than would occur under current law. CMS has asserted that payment rates must provide projected up-front savings for both the federal and state governments and that without such projected savings, demonstration projects will not go forward.

Besides allowing full duals to be automatically enrolled in managed care plans, the demonstration's guidelines also suggest that each state establish standards for the quality of care and for measuring improvement in plans' performance with regard to full duals, rather than try to follow Medicaid's and Medicare's differing guidelines simultaneously. Health care plans that take part in the demonstration (which are distinct from other Medicare Advantage or Medicaid managed care plans that may be offered by the same plan sponsors) will be ineligible for quality-related bonuses under Medicare Advantage's star rating

system. However, some portion of a plan's combined Medicare-Medicaid payment will be withheld during phase one of the demonstration, and the plan can earn that portion by meeting certain quality objectives. Many states' proposals for the demonstration projects also include "shared savings" provisions, in which states and the federal government share the savings if the costs of a demonstration project are below the agreed-on baseline of what would have been spent on the demonstration population in the absence of the project.

Under the managed fee-for-service model, CMS will allow states to build on their existing FFS delivery systems. States will be held accountable for ensuring effective coordination of the services that Medicare and Medicaid cover for full duals. Specifically, states will be responsible for ensuring that beneficiaries receive integrated access to all acute care and long-term care services covered by the two programs, possibly using accountable care organizations and Medicaid health homes.⁴⁵ States will make the up-front investment in developing approaches to coordinate care, but CMS will make retroactive payments to states that can demonstrate savings to Medicare (net of any increase in federal Medicaid costs), so long as the care provided meets certain quality standards.⁴⁶

Progress of the Demonstration Projects to Date. The timing of the financial alignment demonstration projects is uncertain because the approval process has progressed more slowly than CMS anticipated. In their applications, 2 states proposed starting their projects in 2012; 13 states, in 2013; and 11 states, in 2014. As of May 2013, however, only 6 states (California, Illinois, Massachusetts, Ohio, Virginia, and Washington) had memorandums of understanding from CMS approving their plans for the demonstration projects, with planned implementation dates ranging from July 2013 to early

42. Ibid.

43. Ibid.

44. See the memorandum from Melanie Bella, Director, Medicare-Medicaid Coordination Office, and Jonathan Blum, Director, Center for Medicare, to organizations interested in offering capitated financial alignment demonstration plans in interested states, January 25, 2012, <http://go.usa.gov/T7Ww> (pdf, 333 KB).

45. Accountable care organizations are groups of doctors, hospitals, and other health care providers who join together to provide coordinated care to a set of patients and who agree to be held accountable for the quality and total cost of those patients' care.

46. See the letter from Cindy Mann, Director, Center for Medicaid, CHIP, and Survey & Certification, and Melanie Bella, Director, Medicare-Medicaid Coordination Office, to state Medicaid directors, July 8, 2011, <http://go.usa.gov/Th3F> (pdf, 209 KB).

2014.⁴⁷ Furthermore, a recent survey indicates that some states that have applied for the demonstration but do not yet have approved memorandums of understanding with CMS expect to postpone their implementation dates.⁴⁸

In addition, as of May 2013, 7 of the 26 applicants (Arizona, Hawaii, Minnesota, New Mexico, Oregon, Tennessee, and Wisconsin) had withdrawn from the financial alignment demonstration or were working on alternative demonstration projects to coordinate care for full duals. One of the main reasons that states have given for dropping out of the financial alignment demonstration is that they already have a robust market for Medicare Advantage plans that serve full duals, and payments to those plans would be likely to decline under the financial alignment demonstration. Lower payments could cause plans to drop out of the Medicare Advantage program, leaving fewer options for beneficiaries.⁴⁹

Moreover, New York, one of the states planning to test both models, has announced that it is dropping the

managed fee-for-service portion of its demonstration because of the difficulty of trying to manage two new programs simultaneously. The state is opting instead to focus its efforts on the capitated portion of the demonstration.⁵⁰

Differences Between Applicant and Nonapplicant States.

States' decisions about whether to participate in the demonstration—and if so, what model of financial alignment to adopt—probably depended in part on their experience with managed care, the characteristics of their full-dual population, and concerns about making costly changes to their health care programs that could prove temporary. Those same factors may also play a role in the success of the demonstration projects.

Existing managed care programs in Medicare and Medicaid may be useful building blocks for states that participate in the demonstration, so the amount and type of managed care infrastructure in a state probably played a role in the state's decision about whether to apply for the demonstration. For example, states with relatively high rates of enrollment in Medicare Advantage plans and Medicaid managed care plans (more than 20 percent of eligible beneficiaries) were more likely to apply for the capitated portion of the demonstration than other states were (see Figure 2). Further differences in managed care enrollment are also apparent between states that applied to test a capitation model and those that applied to test a managed fee-for-service model. For instance, applicants that proposed a managed FFS model had lower participation in Medicare managed care plans in 2009 (including regular Medicare Advantage plans and SNPs) by all Medicare beneficiaries and by full duals than did applicants proposing capitation or states that did not apply (see Figure 3). Applicants that proposed a managed FFS model also had lower enrollment in comprehensive Medicaid managed care plans by their full duals—and higher enrollment in primary care case management programs—than other states did. Although the three groups of states (those primarily testing capitation, those primarily testing managed FFS, and states that did not apply for the demonstration) differed in various ways in 2009, their Medicaid programs shared some notable features: considerable

47. The memorandum of understanding with the State of Washington, one of the three states proposing to test both a managed FFS and a capitation model, relates only to the managed FFS component of its proposal. Washington and Massachusetts initially planned to begin their demonstration projects in April 2013 but later agreed to delay implementation until July 2013. See Kaiser Commission on Medicaid and the Uninsured, *Financial Alignment Demonstrations for Dual Eligible Beneficiaries Compared: California, Illinois, Massachusetts, Ohio, and Washington* (May 2013), <http://tinyurl.com/ldd9fbc> (pdf, 739 KB). California initially planned to begin its demonstration project in October 2013 but has agreed to delay implementation until at least January 2014. See David Gorn, “So Many Moving Parts’ to Fit Together,” *California Healthline* (May 10, 2013), <http://tinyurl.com/cgpunxl>.

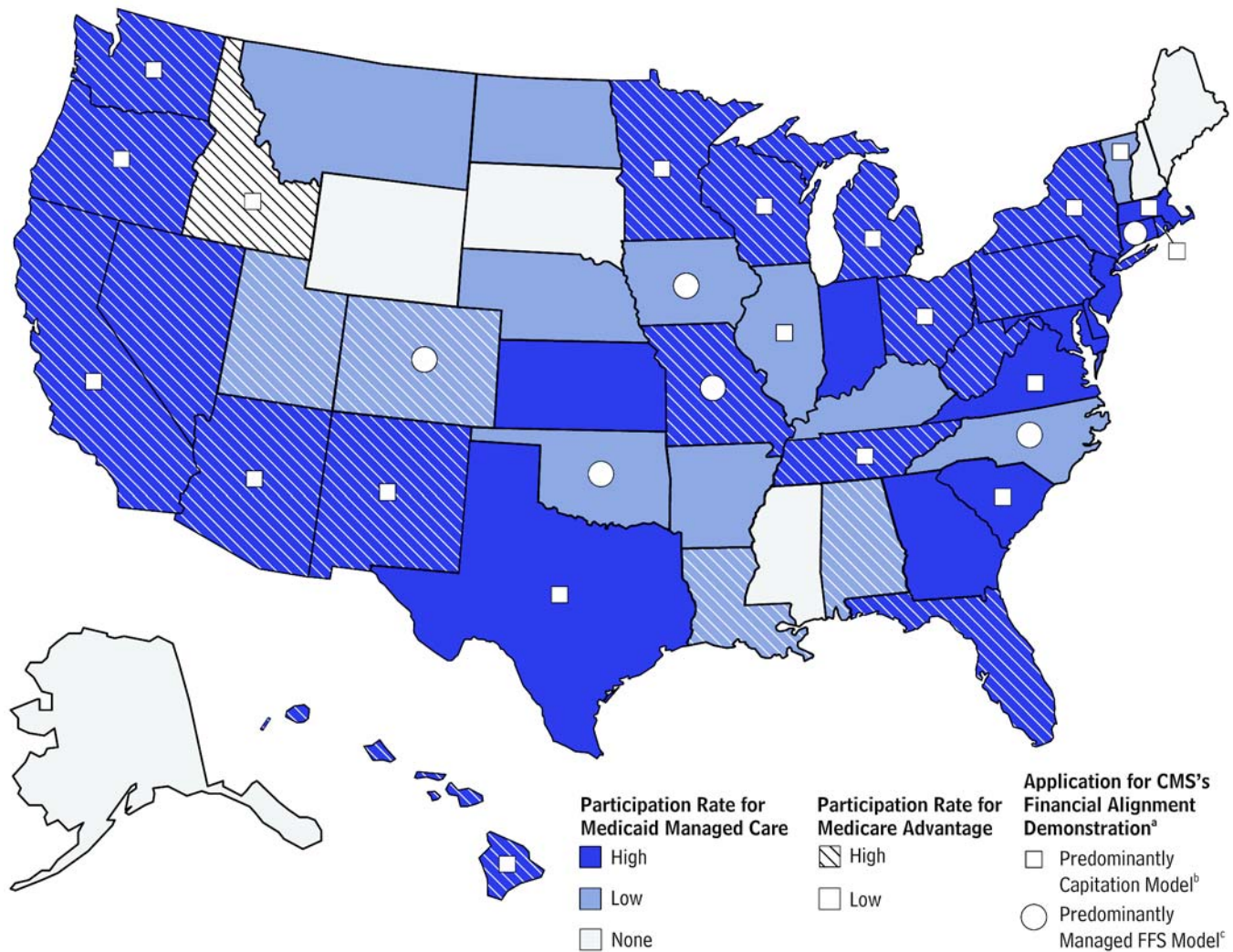
48. See Vernon K. Smith and others, *Medicaid Today; Preparing for Tomorrow—A Look at State Medicaid Program Spending, Enrollment, and Policy Trends* (Kaiser Family Foundation, October 2012), <http://tinyurl.com/cmw82pq>.

49. Michelle Herman and Brianna Ensslin, *Innovations in Integration: State Approaches to Improving Care for Medicare-Medicaid Enrollees* (Center for Health Care Strategies, February 2013), <http://tinyurl.com/d87c5oq>; Michelle Herman and Brianna Ensslin, personal communications, March 14, 2013; letter from Janice K. Brewer, Governor of Arizona, and Thomas J. Betlach, Director, Arizona Health Care Cost Containment System, to Melanie Bella, Director, Medicare-Medicaid Coordination Office, April 10, 2013, <http://tinyurl.com/bpe8odx> (pdf, 24 KB); and letter from Julie B. Weinberg, Director, New Mexico Human Services Department, to Melanie Bella, Director, Medicare-Medicaid Coordination Office, August 17, 2012, <http://tinyurl.com/qa7pvwt> (pdf, 41 KB).

50. See the letter from Gregory S. Allen, Director, Division of Program Development and Management, New York Office of Health Insurance Programs, to Melanie Bella, Director, Medicare-Medicaid Coordination Office, March 21, 2013, <http://go.usa.gov/Thc9> (pdf, 87 KB).

Figure 2.

States' Participation Rates for Medicare and Medicaid Managed Care and Application for CMS's Financial Alignment Demonstration



Source: Congressional Budget Office.

Notes: "High" participation means that more than 20 percent of a state's eligible beneficiaries were enrolled in Medicare Advantage plans or Medicaid managed care plans; "low" participation means that 20 percent or fewer eligible beneficiaries were enrolled.

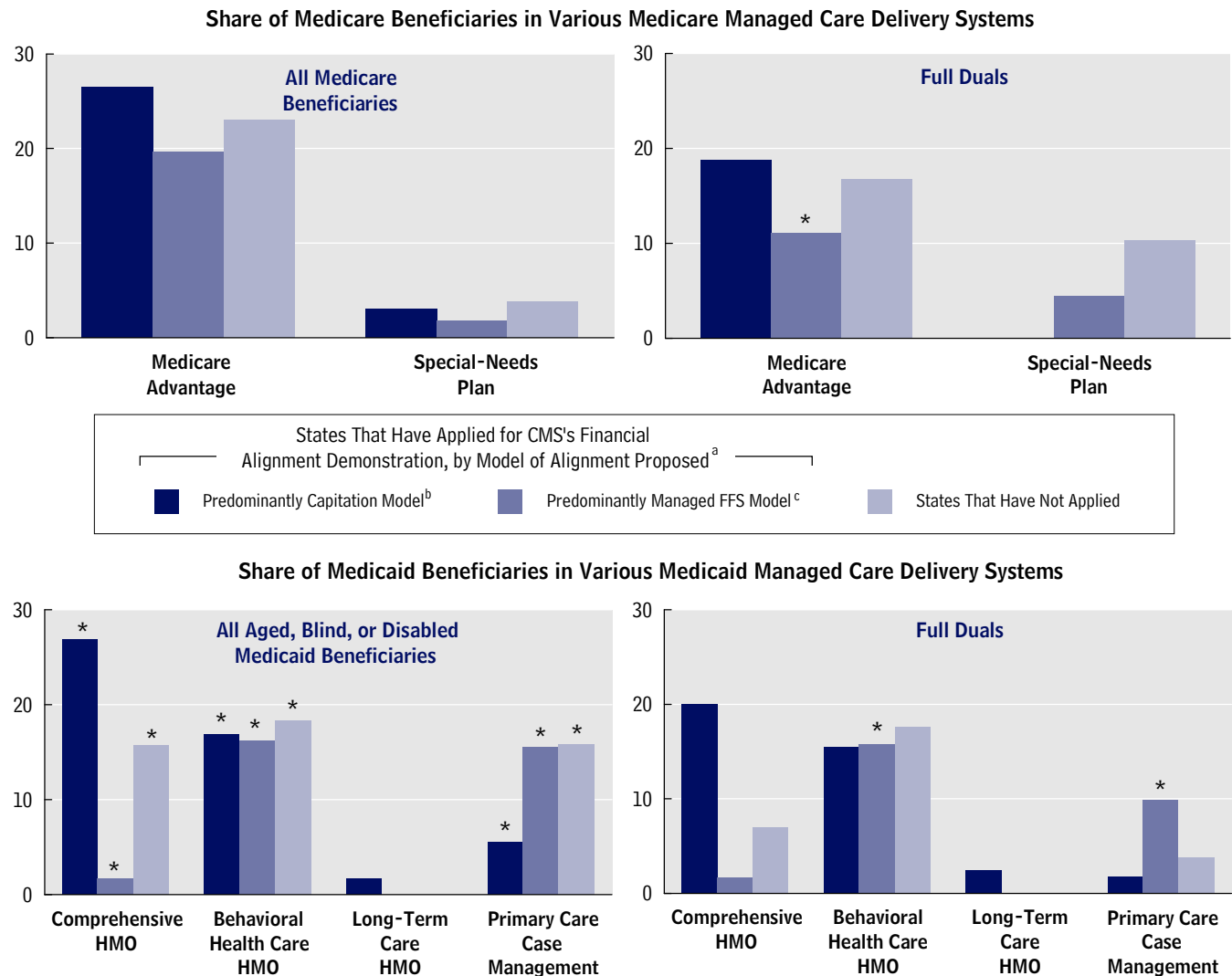
CMS = Centers for Medicare & Medicaid Services; FFS = fee for service.

- a. Three states (New York, Oklahoma, and Washington) proposed testing both the capitation model and the managed FFS model in their demonstration projects. For the purposes of this figure, those states are categorized by whichever model would be used for the larger population of beneficiaries.
- b. Capitation involves making a single payment, generally to a managed care plan, to cover all care that beneficiaries receive within a specified set of benefits. The capitation model in the demonstration projects will employ three-way contracts between CMS, a state, and participating health plans to cover the full range of Medicare and Medicaid benefits. CMS and the state will jointly set payment rates for the health plans at levels that are estimated to result in lower combined Medicare and Medicaid spending for the plans' enrollees than would occur under current law.
- c. Fee for service involves paying health care providers a fee for each covered service performed for beneficiaries. The managed FFS model in the demonstration projects will require states to ensure that beneficiaries receive integrated access to all acute care and long-term care services covered by Medicare and Medicaid, building on the states' existing FFS delivery systems.

Figure 3.

Enrollment in Medicare and Medicaid Managed Care, 2009, by States' Application Status in CMS's Financial Alignment Demonstration

(Percent)



Source: Congressional Budget Office.

Notes: Dual-eligible beneficiaries are people who are enrolled in Medicare and Medicaid at the same time and who are eligible to receive benefits from both programs. "Full duals" qualify for full benefits from both programs.

CMS = Centers for Medicare & Medicaid Services; FFS = fee for service; HMO = health maintenance organization.

- a. For a list of applicant states, see Table 5. Three states (New York, Oklahoma, and Washington) proposed testing both the capitation model and the managed FFS model in their demonstration projects. For the purposes of this figure, those states are categorized by whichever model would be used for the larger population of beneficiaries.
- b. Capitation involves making a single payment, generally to a managed care plan, to cover all care that beneficiaries receive within a specified set of benefits. The capitation model in the demonstration projects will employ three-way contracts between CMS, a state, and participating health plans to cover the full range of Medicare and Medicaid benefits. CMS and the state will jointly set payment rates for the health plans at levels that are estimated to result in lower combined Medicare and Medicaid spending for the plans' enrollees than would occur under current law.
- c. Fee for service involves paying health care providers a fee for each covered service performed for beneficiaries. The managed FFS model in the demonstration projects will require states to ensure that beneficiaries receive integrated access to all acute care and long-term care services covered by Medicare and Medicaid, building on the states' existing FFS delivery systems.

use of managed behavioral health care—indicating that some states were handling those services separately from other services and contracting with specialized plans for them—and almost no managed long-term care.

Full duals' health status and use of services differ between applicant and nonapplicant states, which suggests that differences in health characteristics may also have factored into states' decisionmaking process. Although nonelderly full duals in the three groups of states appear to be similar in terms of prevalence of chronic conditions, medical risk scores, and use of long-term services and supports, more variation exists among the 60 percent of full duals who are age 65 or older (see Table 6).⁵¹ On average, elderly full duals in the states that applied to test a capitation model appear to be somewhat healthier—as measured by the prevalence of chronic conditions and dementia and by average risk scores—than those in the other two groups of states. They also appear less likely to be using LTSS, both in institutions and overall.

The possibility that the changes allowed under a state's financial alignment demonstration project might be rescinded after three years—if the project is not approved for phase two—may have discouraged some states from applying. In particular, some states may have chosen not to participate because adapting their managed care or care management infrastructure to fit the demonstration's options, or creating new infrastructure altogether, would require a significant investment that might not generate a return.

Challenges Facing Efforts to Integrate Financing and Coordinate Care

The federal government and the states face a host of obstacles in trying to integrate Medicare's and Medicaid's financing and service delivery for dual-eligible beneficiaries, mitigate the current financial incentives that can lead to inappropriate care, and thereby reduce unnecessary spending and improve the quality of care. Those challenges—which are partly reflected in the many different federal and state efforts that are under way—include the following:

- Because Medicare and Medicaid evolved independently over time, they differ in their program rules,

payment rates, appeals procedures, and monitoring and reporting requirements. Those differences, combined with the two programs' complexity, make integration difficult.⁵²

- Even when fully integrated plans are established, states lack effective mechanisms to ensure enough enrollment for those plans to operate effectively. Several analysts have pointed out the difficulties of enrolling dual-eligible beneficiaries in a single plan for all Medicare and Medicaid services as long as enrollment in Medicare managed care is voluntary.⁵³ Enrollment is voluntary because policymakers have decided, at least to date, that giving Medicare beneficiaries a choice about whether to participate in a managed care plan is more important than other considerations.⁵⁴ Indeed, some analysts have noted the importance of choice in decisions about participation and plan selection to ensure that frail beneficiaries with multiple needs can maintain their current care arrangements.⁵⁵ As a result, observers have emphasized the importance of gaining support and cooperation from stakeholders early in the process when developing an integrated care initiative that may involve managed LTSS or restrictions on choice.⁵⁶

52. See Barbara Coulter Edwards and others, *Integrating Medicare and Medicaid: State Experience With Dual Eligible Medicare Advantage Special Needs Plans* (AARP Public Policy Institute, September 2009), <http://tinyurl.com/74cystl> (pdf, 716 KB).

53. *Ibid.*; and Melanie Bella and Lindsay Palmer, *Encouraging Integrated Care for Dual Eligibles* (Center for Health Care Strategies, July 2009), <http://tinyurl.com/ldzv8mf> (pdf, 169 KB).

54. Both beneficiaries and providers may be resistant to the idea of required enrollment in managed care plans because it might restrict beneficiaries' choice of providers or reduce payment rates or the volume of services provided.

55. See, for example, Patricia Neuman and others, "Dx for a Careful Approach to Moving Dual-Eligible Beneficiaries Into Managed Care Plans," *Health Affairs*, vol. 31, no. 6 (June 2012), pp. 1186–1194, <http://dx.doi.org/10.1377/hlthaff.2012.0160>.

56. See, for example, Harris Meyer, "The Coming Experiments in Integrating and Coordinating Care for 'Dual Eligibles,'" *Health Affairs*, vol. 31, no. 6 (June 2012), pp. 1151–1155, <http://dx.doi.org/10.1377/hlthaff.2012.0505>; Patricia Neuman and others, "Dx for a Careful Approach to Moving Dual-Eligible Beneficiaries Into Managed Care Plans," *Health Affairs*, vol. 31, no. 6 (June 2012), pp. 1186–1194, <http://dx.doi.org/10.1377/hlthaff.2012.0160>; and Paul Saucier and Wendy Fox-Grage, *Medicaid Managed Long-Term Care* (AARP Public Policy Institute, November 2005), http://assets.aarp.org/rgcenter/il/ib79_mmltc.pdf (191 KB).

51. Although Table 6 shows a total of almost 5 million full duals in the states that applied to test a capitation model, the demonstration proposals from all of the applicant states cover only 3 million full duals in all. That difference occurs because some states are proposing to target subsets of their full-dual population.

Table 6.

Demographic Characteristics of Full Dual-Eligible Beneficiaries, 2009, in States That Have Applied or Not Applied for CMS's Financial Alignment Demonstration

	States That Have Applied for CMS's Financial Alignment Demonstration, by Model of Alignment Proposed ^a		States That Have Not Applied
	Predominantly Capitation Model ^b	Predominantly Managed Fee-for-Service Model ^c	
Full Duals Under Age 65			
Number of beneficiaries (Millions)	1.7	0.3	0.8
Percentage with various characteristics			
Diagnosed with three or more chronic conditions	8	9	8
Institutionalized	4	4	4
Receiving any long-term services and supports	31	36	29
Diagnosed with a mental illness	37	39	36
Diagnosed with dementia	3	3	3
Average community medical risk score ^d	1.2	1.2	1.2
Full Duals Age 65 or Older			
Number of beneficiaries (Millions)	2.7	0.4	1.1
Percentage with various characteristics			
Diagnosed with three or more chronic conditions	24	27	29
Institutionalized	19	29	30
Receiving any long-term services and supports	51	65 *	56
Diagnosed with a mental illness	23	29	29
Diagnosed with dementia	20	25	26
Average community medical risk score ^d	1.7	1.8	1.9

Source: Congressional Budget Office.

Notes: Dual-eligible beneficiaries are people who are enrolled in Medicare and Medicaid at the same time and who are eligible to receive benefits from both programs. "Full duals" qualify for full benefits from both programs.

CMS = Centers for Medicare & Medicaid Services.

- a. For a list of applicant states, see Table 5. Three states (New York, Oklahoma, and Washington) proposed testing both the capitation model and the managed fee-for-service model in their demonstration projects. For the purposes of this table, those states are categorized by whichever model would be used for the larger population of beneficiaries.
- b. Capitation involves making a single payment, generally to a managed care plan, to cover all care that beneficiaries receive within a specified set of benefits. The capitation model in the demonstration projects will employ three-way contracts between CMS, a state, and participating health plans to cover the full range of Medicare and Medicaid benefits. CMS and the state will jointly set payment rates for the health plans at levels that are estimated to result in lower combined Medicare and Medicaid spending for the plans' enrollees than would occur under current law.
- c. Fee for service involves paying health care providers a fee for each covered service performed for beneficiaries. The managed fee-for-service model in the demonstration projects will require states to ensure that beneficiaries receive integrated access to all acute care and long-term care services covered by Medicare and Medicaid, building on the states' existing fee-for-service delivery systems.
- d. CMS calculates a risk score for each Medicare enrollee on the basis of his or her medical diagnoses and demographic characteristics. The scores are used to adjust Medicare's payments to managed care plans to reflect enrollees' expected costs for Parts A and B of Medicare.

[* Value corrected]

- Most managed care plans provide comprehensive acute and postacute care services. However, many of those plans lack experience in coordinating care and bearing financial risk for people who need LTSS or behavioral health services and in integrating such services with acute care.⁵⁷
- Historically, states have not had timely access to the Medicare data they need to coordinate the services that dual-eligible beneficiaries receive. In 2011, the National Association of Medicaid Directors urged that more efforts be made to minimize the operational barriers that states faced in getting Medicare data, standardize practices for obtaining those data, and highlight successful experiences by states in obtaining and using the data.⁵⁸ CMS's new Medicare-Medicaid Coordination Office (MMCO) is working to improve states' access to Medicare data for dual-eligible beneficiaries.⁵⁹
- Establishing an integrated managed care plan involves up-front costs, such as expenses to create new contracts with SNPs or to develop infrastructure and hire personnel for new PACE programs or other, similar initiatives.⁶⁰ (The Medicare Payment Advisory Commission recently reported that PACE programs have estimated start-up costs of \$2 million to \$3 million per site.)

Some of those challenges have been evident in the slower-than-expected pace at which CMS's financial alignment demonstration has gotten under way. Participants have

57. See Suzanne Gore and Alice Lind, *Developing an Integrated Care Program for Dual Eligibles Using Special Needs Plans* (Center for Health Care Strategies, January 2011), www.chcs.org/usr_doc/CHCS_SNP_Brief_Jan_2011.pdf (138 KB).

58. National Association of Medicaid Directors, *Advancing Medicare and Medicaid Integration: Policy and Operational Challenges for State Access to Medicare Data* (October 2011), <http://medicaidirectors.org/node/190>.

59. See Medicare-Medicaid Coordination Office, "Medicare Data for Dual Eligibles for States" (February 20, 2013), <http://go.usa.gov/bxj5>.

60. Barbara Coulter Edwards and others, *Integrating Medicare and Medicaid: State Experience With Dual Eligible Medicare Advantage Special Needs Plans* (AARP Public Policy Institute, September 2009), <http://tinyurl.com/74cystl> (pdf, 716 KB); and Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System* (June 2012), p. 75, www.medpac.gov/documents/Jun12_EntireReport.pdf (2 MB).

reported various obstacles to implementing their demonstration projects:

- Although creating the MMCO may have improved some coordination, operational partitions still exist between Medicare and Medicaid within CMS.
- States have continued to experience difficulties and delays in obtaining and analyzing Medicare data from CMS.
- Uncertainties remain about how shared-savings arrangements will function in both the capitated and fee-for-service models.
- States have wrestled with how to implement coordination and integration of care, especially during the transition to the new system.⁶¹
- States have struggled to educate potential enrollees in their demonstration projects about the new program. For example, to prepare for full implementation, CMS conducted field tests in Massachusetts of the first phases of the passive enrollment process. Those tests were largely unsuccessful. Beneficiaries reported that they were confused by the letters they received explaining the program, which raises questions about whether many full duals will be able to make an informed choice about how their care is delivered, as CMS's guidelines require.⁶²

Evaluating the success of the financial alignment demonstration projects will also be challenging. Effective evaluation is a critical component of any demonstration for Medicare or Medicaid, and evaluating the impact of the financial alignment demonstration projects on spending and quality of care may prove difficult, especially if evaluation is not built into the design. In many participating states, identifying an appropriate comparison population in the state will be hard because a large share

61. See Vernon K. Smith and others, *Medicaid Today; Preparing for Tomorrow—A Look at State Medicaid Program Spending, Enrollment, and Policy Trends* (Kaiser Family Foundation, October 2012), <http://tinyurl.com/cm82pq>; and Kathleen Gifford and others, *A Focus Group With Medicaid Directors: As FY 2012 Ends, Looking Toward FY 2013* (Kaiser Family Foundation, June 2012), <http://tinyurl.com/p3e2tg7>.

62. See John Reichard, "Bella Says Many States in Giant Duals Demo Wouldn't Join Until 2014," *CQ HealthBeat* (October 17, 2012).

of the dual-eligible population will be taking part in the demonstration. Moreover, if enrollment in the program is voluntary, or if beneficiaries are permitted to opt out, the people who participate may differ from the people who do not in important ways that affect their outcomes. Using other states as the basis for comparison also presents problems, given the wide range of initiatives targeting dual-eligible beneficiaries that both applicant and nonapplicant states are undertaking.

Individual states may aim to compare spending and health outcomes for dual-eligible beneficiaries before and after implementation of the demonstration projects. The findings from such comparisons may not indicate the effects of the projects, however, if other changes in the delivery of health care are occurring at the same time. Moreover, the findings may not translate to other states because of the different systems of care that exist among the states and the potential for other differences between applicant and nonapplicant states.

Potential Legislative Actions Targeting Dual-Eligible Beneficiaries and Their Impact on the Federal Budget

Given the complex and expensive health care needs of dual-eligible beneficiaries, federal lawmakers may opt to take further steps to identify and implement strategies intended to produce savings for the Medicare and Medicaid programs, improve the quality of care that dual-eligible beneficiaries receive, or both. Potential legislative actions could range from incremental changes in Medicare and Medicaid to broader structural reforms that would combine all benefits for full duals within a single new program or delivery system. However, if policy changes that affect dual-eligible beneficiaries are enacted before the current financial alignment demonstration projects are well under way, lawmakers may risk missing the chance to apply any lessons learned from those efforts.

Anticipating how legislative actions aimed at dual-eligible beneficiaries would be likely to affect the federal budget is difficult—in large part because considerable uncertainty exists about what spending for dual-eligible beneficiaries will be in coming years even without new legislation. For example, how many demonstration projects will be conducted under current law, how large will they be, and how will states and health plans implement specific

features of those projects once negotiations between CMS and states are finalized? Moreover, how might the lessons from the demonstration projects be applied to other beneficiaries and other states under current law? In particular, the Secretary of HHS and the states have considerable flexibility to experiment with other ways of delivering health care to full duals, and the Secretary has the authority to broadly expand any demonstration projects conducted by CMMI that, on the basis of evaluation, are not expected to compromise the quality of care, limit the provision of Medicare or Medicaid benefits, or increase spending.

Potential Legislative Changes

Incremental changes to existing programs might be intended to make it easier for more states to develop financial alignment and care coordination initiatives or to help states that have such initiatives build on them. In addition, federal lawmakers could encourage new initiatives by alleviating some of the impediments that may have kept states from participating in the financial alignment demonstration or from making other changes in their arrangements for dual-eligible beneficiaries. For example, legislation could give states funding to create the infrastructure necessary to restructure their systems for delivering health care to dual-eligible beneficiaries. Legislation could also extend the minimum period for phase one of the financial alignment demonstration, in case some states see three years as too short an approval period to justify making the considerable structural changes needed to improve the delivery of care for dual-eligible beneficiaries. In addition, if the Secretary of HHS does not use his or her authority in the future to expand particular components of CMMI initiatives that lawmakers consider promising, lawmakers could make those components a requirement for the Medicaid or Medicare program.

Alternatively, federal lawmakers could enact larger structural changes that would move full duals into a single, integrated delivery system that would provide all of the benefits for which they now qualify under Medicare and Medicaid. Having one payment system for the care provided to dual-eligible beneficiaries would eliminate conflicts between the financial incentives created by Medicare and Medicaid and would reduce the incentives for cost shifting that exist under the current, bifurcated system, which can cause full duals to receive inappropriate care.

Two broad approaches to creating a financially integrated system could be considered. One approach would be to continue to involve Medicare and Medicaid but to align the two programs' financial incentives by contracting with a third party—such as a managed care plan, accountable care organization, or Medicaid health home—to provide or coordinate care in exchange for a blended payment rate that covered services from both programs. Federal lawmakers could specify the amount of the blended payment rate in statute, or they could allow CMS to negotiate with the states to determine the blended payment rate for the set of services covered by the third party.

A second approach would be for federal lawmakers to give either Medicaid or Medicare sole financial responsibility for full duals. Several ways of doing that have been proposed in the past:⁶³

- One alternative would be for the federal government to give states a block grant to provide all care for full duals. The block grant could be designed to convert the federal share of Medicaid and Medicare payments for full duals into a single payment to each state, as earlier legislation did with funding for welfare. The size of the block grant could be adjusted annually for inflation using various economic indexes. That alternative would make federal spending on dual-eligible beneficiaries more predictable. It would also eliminate the federal subsidy for each additional dollar that states spend on care for those beneficiaries, thus giving states greater incentive to find more cost-effective ways to care for them. However, the block grant might shift some of the cost burden and financial risk to states, which could prompt states to cut optional Medicaid benefits or other state-funded programs to pay for the cost of providing care to dual-eligible beneficiaries.
- Another alternative would be to construct a “swap” that would shift responsibility for a portion of the costs of Medicaid, education, or other programs to the

states in exchange for having Medicare take over all responsibility for full duals. That alternative might include creating a single set of federal eligibility criteria for full duals, in contrast to the existing variation in states' eligibility requirements for Medicaid. That approach would also require the Congress or CMS to set payment rates for Medicare for services that the program currently does not cover or covers to only a limited degree, such as long-term care in nursing facilities and a range of home- and community-based services. It is unclear whether making the federal government fully responsible for full duals would reduce overall spending for their care relative to current levels. On average, Medicare pays higher rates to physicians for acute care services than Medicaid does, so it is possible that new Medicare payment rates for services that the program does not cover now would be higher than the rates that Medicaid pays for those services.⁶⁴

In addition, because state Medicaid programs vary widely in how they set eligibility criteria for long-term care and in the tools they use to assess whether people meet those criteria, an important policy question would be whether such variation should continue or whether a single national eligibility standard and a common assessment tool should apply in all states. Allowing the variation to continue would raise fairness issues among the states, but adopting a uniform standard and common assessment tool could create complex transition issues because some beneficiaries already receiving long-term care services through Medicaid might not meet the new criteria.

Although the various approaches described above would work expressly to align financing for dual-eligible beneficiaries, they would not necessarily improve how medical care for those beneficiaries is managed or coordinated. Other explicit care management policies or initiatives might be required to achieve that goal.

Possible Budgetary Effects of Legislative Changes

To estimate how a proposed change in law would alter federal spending, analysts must first estimate the path that spending would be likely to take under current law. That task, which is often challenging, is especially difficult now with spending for dual-eligible beneficiaries

63. See Medicare Payment Advisory Commission, *Report to the Congress: Aligning Incentives in Medicare* (June 2010), Chapter 5, p. 142, www.medpac.gov/chapters/Jun10_Ch05.pdf (485 KB); Brian Bruen and John Holahan, *Shifting the Cost of Dual Eligibles: Implications for States and the Federal Government* (Kaiser Family Foundation, November 2003), <http://tinyurl.com/o9x8jzz>; and John Holahan, Dawn M. Miller, and David Rousseau, *Rethinking Medicaid's Financing Role for Medicare Enrollees*, Publication 7862 (Kaiser Family Foundation, February 2009), <http://tinyurl.com/plt6ub6>.

64. See Stephen Zuckerman and Dana Goin, *How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence From a 2012 Survey of Medicaid Physician Fees* (Kaiser Family Foundation, December 2012), <http://tinyurl.com/qbjx62w>.

because of the rapid changes that are going on in many states. In particular, with the first financial alignment demonstration projects not yet launched and the features of many others still being developed, it is difficult to project the budgetary effects of new proposals relative to, and in the midst of, that shifting environment. As the demonstration projects begin and progress, further information about them will allow for improved analysis.

Nevertheless, the fact that the Secretary of HHS has the ability to make broad changes at his or her discretion will continue to be a significant source of uncertainty, because the Secretary may or may not choose to expand demonstration projects within or among states. In addition, estimating the federal budgetary effects of the demonstration projects with any degree of precision would require data on their spending—including for care management fees and other costs beyond the provision of medical services—which will not be available for some time, as well as reasonable estimates of what spending for the affected population would have been without the demonstration.

Despite the many challenges of predicting the budgetary impact of new proposals aimed at dual-eligible beneficiaries, savings might be achieved by combining care coordination and integration of financing with cuts to Medicare's, Medicaid's, or both programs' payments for dual-eligible beneficiaries relative to the amounts paid for their care under current law. That is, potential federal savings from policies that would alter payment rates for health care providers would depend importantly on the difference between the federal payments made to the entity in charge of managing care for dual-eligible beneficiaries and projected federal payments for the same services under current law. Beyond that difference in payments, whether additional federal savings would occur would depend on how payments were structured. If managing entities received a capitated rate, they might be able to operate efficiently and reduce spending below that rate—but such efficiencies would not translate into further savings for the federal budget unless contracts or the rate-setting process allowed the government to recoup some of those additional savings over time. In the case of block grants to the states, the savings generated from such grants would depend largely on how much smaller the block grants were than current-law payments to the states for the affected population.

The federal savings that could be achieved through new proposals for dual-eligible beneficiaries would depend on

numerous other factors as well. For example, a number of programs have tried to reduce Medicare spending by providing incentives to coordinate care; although many have succeeded in reducing hospitalizations, the resulting savings have generally been too small to offset the cost of the coordination incentives.⁶⁵ More recent evidence, however, suggests that savings from coordinating care may be greater for the dual-eligible population.⁶⁶ Potential savings from initiatives to better coordinate care could also be affected if high-cost or complex services, such as LTSS and behavioral health, were carved out of new programs. Such carve-outs would limit the ability of managing entities to fully coordinate the care of higher-cost beneficiaries and would reduce the alignment of incentives among all providers.

Potential savings would also be affected by enrollment rules. For example, if enrollment in a financial alignment or coordinated care initiative was voluntary, the potential for savings would be more limited than if enrollment was required. Experience with voluntary enrollment in managed care suggests that healthier beneficiaries might be more likely than others to choose a voluntary managed care plan (or to remain in a plan in which they had been automatically enrolled), leaving higher-cost beneficiaries in a traditional FFS environment. The behavior of providers could exacerbate that problem if providers had an incentive to encourage high-cost users to choose FFS because of differences in payment rates or because the providers had been excluded from the managed care network.

The net budgetary impact of a financial alignment or coordinated care initiative would also depend on any initial investments required to redesign the health care delivery system for the full-dual population. In addition, any spending for outreach to providers and other stakeholders might limit an initiative's potential for savings, particularly in the short run.

65. See Congressional Budget Office, *Lessons From Medicare's Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment* (January 2012), www.cbo.gov/publication/42860.

66. See Carrie H. Colla and others, "Spending Differences Associated With the Medicare Physician Group Practice Demonstration," *Journal of the American Medical Association*, vol. 308, no. 10 (September 2012), pp. 1015–1023, <http://dx.doi.org/10.1001/2012.jama.10812>.



Appendix: Data Used in This Analysis

The Congressional Budget Office (CBO) compiled information about dual-eligible beneficiaries from multiple sources for this analysis. The primary underlying data sets are administrative data from the Medicare and Medicaid programs that detail beneficiaries' use of services and the programs' payments to health care providers. CBO merged those data sets to identify beneficiaries who were enrolled in both programs. Because Medicare's administrative data do not cover payments to private health care plans, CBO combined information from several of Medicare's other files of administrative data to estimate payments to Part C (Medicare Advantage) and Part D (prescription drug) plans—and thus to calculate total spending per beneficiary by Medicare or Medicaid. In addition, CBO used those data to identify the prevalence of various chronic conditions among dual-eligible beneficiaries. CBO chose to focus on 2009 because that was the most recent year for which all of the relevant sources of data were available when the analysis began.

Claims-Based Administrative Files

The Beneficiary Annual Summary File (BASf) contains aggregated beneficiary-level data for everyone who receives Medicare benefits. Those data include information about beneficiaries' demographic characteristics, the number of months they have been enrolled in Parts A and B of Medicare and in Medicare Advantage, and their diagnoses of chronic conditions. The BASf also contains data about beneficiaries' use of services and various parties' spending for those services, but only for claims processed by the Centers for Medicare & Medicaid Services (CMS)—that is, claims covered by fee-for-service (FFS) Medicare for benefits under Parts A and B of the program.¹ Payments to providers are reported separately by the type of service used (such as inpatient hospital services, outpatient hospital services, and

physicians' services). Medicare's payments and beneficiaries' cost-sharing responsibilities are also included. (For most dual-eligible beneficiaries, those cost-sharing responsibilities are covered by Medicaid rather than by the beneficiary.)²

The Medicare Part D Prescription Drug Event file contains detailed information about each prescription filled by someone enrolled in a Part D plan (whether an independent Part D plan or a Medicare Advantage drug plan). Spending on filled prescriptions is broken down by payment component (ingredient cost, dispensing fee, or sales tax), by type of payer (plan, low-income cost-sharing subsidy, beneficiary, or third-party payer), and by whether a beneficiary is in the catastrophic phase of the Part D benefit (when the person's out-of-pocket spending for prescription drugs has exceeded the so-called catastrophic threshold, meaning that for the rest of the year, the beneficiary is responsible for only 5 percent of his or her drug costs). The associated denominator file (which provides demographic and enrollment data) also includes information about the number of months that someone was enrolled in Part D during a given year.

The Medicaid Statistical Information System (MSIS) file contains detailed information about payments to providers for all Medicaid-covered services and about enrollment in managed care plans. MSIS data include cost-sharing amounts paid to providers for Medicare-covered services but do not include payments of Medicare

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1. CMS also processes a small subset of claims covered by managed care organizations.
 2. State Medicaid programs are required to cover only the amount of cost sharing that will bring payments up to Medicaid's payment rates rather than up to Medicare's payment rates, which are generally higher.

premiums or disproportionate-share payments to hospitals. Unlike the BASF data, the MSIS data include payments to managed care plans. (Payments to providers *by* managed care plans are excluded, however.) The MSIS data also include information about whether someone is a full or partial dual-eligible beneficiary.

The two Medicare data sets report information by calendar years, whereas MSIS data are reported on a fiscal year basis, so there is some mismatch in timing between the matched Medicare and Medicaid spending. However, both data sources contain a full year of data and thus should still accurately represent annual spending patterns.

CBO receives those administrative files from CMS and Acumen, a company that processes claims for CMS. Versions of some of the files may be publicly available through CMS.

Merging Claims-Based Files for Medicare and Medicaid

Administrative data for Medicare and Medicaid use different identifiers to uniquely (and anonymously) identify beneficiaries; that difference creates a complication in matching those data for beneficiaries enrolled in both programs. CBO acquired a crosswalk from Acumen that matches the beneficiary identifiers from the Medicare and Medicaid data sets for each person who received services from both programs. The crosswalk also includes a beneficiary's state of residence.

Dual-eligible beneficiaries were identified by whether a person showed up in both programs' data sets. Matches were counted only if the person's sex was the same in both records and if the dates of birth listed in both places were within 31 days of each other. If a date of birth was invalid (missing or chronologically impossible) in one of the two data sets, matches were done by age and were counted if ages matched within one year. About 0.25 percent of matches identified through the crosswalk failed to match on sex, and 1.5 percent failed to match on date of birth or age. Thus, a total of 1.8 percent of the matched observations were dropped for failing to meet one or both criteria.

Of the observations that remained, roughly 1.5 percent of the observations in the Medicare data matched more than one observation in the Medicaid data. If the demographic

characteristics matched, CBO assumed that the multiple Medicaid observations represented the same person and aggregated them. Multiple Medicaid observations for the same person may occur when an enrollee moves and applies for Medicaid coverage in his or her new location.

Determining Medicare's Payments to Plans

Administrative data for Medicare do not include the program's payments to Medicare Advantage plans or Part D plans. CBO estimated those payments using data from several sources.

Payments to Medicare Advantage Plans

In most cases, Medicare Advantage plans are paid using a formula that is based on three factors: a benchmark amount set at the county or regional level, the bid that a plan submitted to CMS for providing standard Medicare benefits to the average beneficiary (one with a risk score of 1.0), and the risk score for a given individual. If a plan's bid is below the applicable benchmark, CMS pays a share of the risk-adjusted difference to the plan as a rebate to use for supplemental benefits or for reducing premiums.³ If a plan's bid is above the benchmark, beneficiaries pay the difference between the bid and the benchmark, and CMS pays the plan the risk-adjusted bid minus the beneficiary payment.

CMS pays Medicare Advantage plans according to their total enrollment, using the average risk score for their enrollees. However, to calculate spending figures per beneficiary, CBO estimated the payments made to Medicare Advantage plans on behalf of each beneficiary each month the beneficiary was enrolled, using the following formulas:

- If the plan's submitted bid was no higher than the benchmark: Payment per enrolled month = $[\text{Bid} * \text{RiskScore}] + [0.75 * \text{RiskScore} * (\text{Benchmark} - \text{Bid})]$
- If the plan's submitted bid was higher than the benchmark: Payment per enrolled month = $(\text{Bid} * \text{RiskScore}) - (\text{Bid} - \text{Benchmark})$

3. The Affordable Care Act (ACA) changed the Medicare Advantage benchmarks and introduced a quality-related bonus payment. Neither change applies here because these data are from 2009, before the ACA was implemented.

That estimating method could not be used in three cases: for the Program of All-Inclusive Care for the Elderly (PACE), for cost plans, and for payments on behalf of beneficiaries with end-stage renal disease (ESRD). In 2009, PACE programs did not submit bids to CMS, so they were paid the risk-adjusted benchmark. Those payments also incorporated a “frailty adjuster,” which depended on the number of limitations on activities of daily living that a beneficiary had, but CBO does not have access to information about that adjuster. Thus, the estimates of payments to PACE programs used in this analysis are likely to underestimate actual payments to some extent.

Cost plans are a type of Medicare Advantage plan that are paid on the basis of claims for services provided rather than receiving a capitated payment. The estimates of per capita payments to cost plans derived from Medicare’s administrative data suggest that a substantial share of those claims are not reported. Thus, to approximate payments to cost plans, CBO started with the formula for calculating payments to typical Medicare Advantage plans and modified it to account for the relative difference between average per capita payments to cost plans and average per capita payments to typical Medicare Advantage plans. Of the roughly 20 percent of dual-eligible beneficiaries enrolled in Medicare Advantage in 2009, fewer than 2 percent were enrolled in cost plans, and such plans typically do not cover an enrollee’s entire use of services. (The remaining claims for those enrollees are covered by traditional fee-for-service Medicare.)

For Medicare Advantage enrollees with end-stage renal disease, the county or regional benchmark is replaced with an ESRD-specific benchmark. Plans are paid that benchmark for each month that a beneficiary with ESRD is enrolled. The benchmark is not adjusted further for risk because it is constructed to include the expected costs of someone with ESRD.⁴

CBO used four sets of data to estimate payments to Medicare Advantage plans:

- *Intermediate denominator file.* This file, which is not publicly available, includes monthly data on enrollment in all parts of Medicare. It also identifies which

Medicare Advantage or Part D plan a beneficiary is enrolled in, if applicable.

- *Plan-submitted bid file.* This file, which is not publicly available, lists the bids that Medicare Advantage and Part D plans submit to CMS and related information. For beneficiaries who are listed as being enrolled in Medicare Advantage but who do not match plan-specific bid information, CBO calculated a county-level enrollment-weighted average bid.
- *County and regional benchmarks.* These files are publicly available on CMS’s website.⁵ CBO matched bids from regional preferred provider organizations to regional benchmarks and matched bids from all other Medicare Advantage plans to county benchmarks.
- *Risk-adjustment data.* This file, which is not publicly available, contains the medical and prescription drug risk scores that CMS calculates for each person enrolled in Medicare, regardless of Medicare Advantage or Part D enrollment. The data set also contains the underlying components used to construct those risk scores, such as age group, sex, disability status, and chronic conditions (as identified using diagnostic records from the previous year). New enrollees are assigned a risk score on the basis of their demographic characteristics alone, because diagnostic records are not available for them. Institutionalized beneficiaries are assigned a medical risk score that is adjusted for the fact that they receive some care in a nursing facility. Because the risk-adjustment model uses older data, CMS calculates a normalization factor each year to ensure that the average assigned risk score (for new enrollees, for the community Hierarchical Condition Category model, and for the institutional Hierarchical Condition Category model) for fee-for-service beneficiaries equals 1.0 in each year. The normalization factor for medical risk scores was 1.030 in 2009. CBO normalized the assigned medical risk scores using that factor.

Payments to Medicare Part D Plans

Medicare’s payments to prescription drug plans are all based on the same formula: The plan-submitted bid is multiplied by a risk score and a frailty adjuster, as

4. Medicare beneficiaries with ESRD are typically not enrolled in Medicare Advantage plans, unless they enrolled in such a plan before being diagnosed with ESRD.

5. See Centers for Medicare & Medicaid Services, “Ratebooks & Supporting Data” (April 25, 2012), <http://go.usa.gov/bx8W>.

applicable. The frailty adjuster equals 1.21 for institutionalized beneficiaries under the age of 65; it equals 1.08 for elderly institutionalized beneficiaries and for people enrolled in the low-income subsidy program who are not institutionalized. Dual-eligible beneficiaries are automatically enrolled in the low-income subsidy program and receive a full premium subsidy if their plan's bid is below a certain benchmark. Because the majority of dual-eligible beneficiaries pay no premium, or a very small premium, for Part D, CBO makes the simplifying assumption that CMS pays the full Part D premium for those beneficiaries.

Payments to plans for nondual Medicare beneficiaries who are not enrolled in the low-income subsidy program are reduced by the sum of the Part D premium (\$30.36 in 2009) and the difference between the chosen plan's bid and the national average bid. CBO assumes that CMS pays the full Part D premium for nondual Medicare beneficiaries who receive full premium assistance under the low-income subsidy program.

To estimate Medicare's payments to Part D plans, CBO used the intermediate denominator file, the plan-submitted bid file for Part D, and the risk-adjustment data described above. In the case of the bid file, CBO calculated a state-level enrollment-weighted average bid to assign to beneficiaries who were listed as being enrolled in Medicare Part D but who did not match plan-specific bid information.⁶ In the case of the risk-adjustment data, CMS calculates a normalization factor for prescription drug risk scores (as it does for Medicare Advantage risk scores) to bring the average score to 1.0. For 2009, the normalization factor for prescription drug risk scores was 1.085, and CBO adjusted those risk scores accordingly.

Calculating Total Spending and Spending by Type of Service

In this analysis, CBO reports three program-based spending totals: for Parts A and B of Medicare, for Part D of Medicare, and for Medicaid. The first total is the sum of Medicare's spending for Hospital Insurance and Medical Insurance (and payments to Medicare Advantage plans, as applicable). The second is the sum of Medicare's payments to prescription drug plans, low-income cost

sharing for prescription drugs (part of the low-income subsidy benefit in Part D), and 80 percent of spending in the catastrophic phase of the Part D benefit (which is included because the federal government covers 80 percent of catastrophic spending as part of its reinsurance to plans). The third total is the sum of all Medicaid spending by service type, including payments to plans, in the Medicaid Statistical Information System file. Types of services (as shown in Table 3 on page 10) are categorized as follows:⁷

- Acute care
 - Inpatient care
 - Ambulatory care
 - In Medicare, outpatient and physicians' services
 - In Medicaid, services provided by physicians, clinics, nurse midwives, nurse practitioners, and other practitioners (such as chiropractors, podiatrists, psychologists, and optometrists), as well as outpatient hospital services
 - Prescription drugs
 - Other acute care
 - In Medicare, hospice services, purchases of durable medical equipment, and payments to Medicare Advantage plans
 - In Medicaid, hospice services, transportation, therapy (speech/language, occupational, and physical), targeted case management, services provided by religious nonmedical health care institutions, rehabilitation, private-duty nursing, primary care case management, prepaid health plans, health maintenance organizations, dental care, laboratory work, abortion services, and other services (such as prosthetics and eyeglasses)
- Postacute care
 - Skilled nursing facility care
 - Home health care

6. The choice of a county-level or state-level average is related to plans' typical service areas, which are county level for Medicare Advantage and mostly state level for Part D.

7. CBO followed the categorizations designated in Teresa A. Coughlin, Timothy Waidmann, and Lokendra Phadera, *The Diversity of Dual Eligible Beneficiaries: An Examination of Services and Spending for People Eligible for Both Medicaid and Medicare* (Kaiser Family Foundation, April 2012), www.kff.org/medicaid/7895.cfm.

■ Long-term care

- Institutional care (Medicaid's payments to nursing facilities, to intermediate care facilities for people with mental retardation, and to institutional mental health facilities)
- Community-based long-term care (Medicaid's payments for personal care and for home- and community-based services)

Identifying Chronic Conditions

Two data sources contain information about the prevalence of chronic conditions among Medicare beneficiaries: The Beneficiary Annual Summary File reports conditions from the CMS Chronic Conditions Data Warehouse (CCW), and the risk-adjustment files report conditions that are included in calculating risk scores. The CCW is one of the standard sources of data about the chronic conditions of Medicaid and Medicare beneficiaries, but it is constructed only from fee-for-service claims and therefore is reliable only for beneficiaries who were in fee-for-service Medicare throughout the period covered by the data.

CMS created the CCW and the risk-adjustment models for different purposes and thus had different motivations for selecting chronic conditions for the two projects. As a result, the two data sources contain different, but partially overlapping, lists of conditions. In 2009, the CCW tracked 20 chronic conditions so that researchers could follow beneficiaries with certain life-altering medical conditions. The risk-adjustment models are intended to identify which beneficiaries are expected to have higher or lower medical and prescription drug costs so that payments to plans can be adjusted appropriately. Thus, the models include a much larger number of conditions that have been found to affect the cost of medical services (70 conditions) or the cost of prescription drugs (84 conditions).⁸

8. Those numbers of conditions differ from the ones in Box 2 on page 12 because they are for the 2009 versions of the models, whereas Box 2 reports values for the 2013 versions of the models.

Another difference between the two sources is the look-back period (the number of years of diagnoses used to determine whether a beneficiary has a condition). The look-back period in the CCW ranges from one year to three years, depending on the condition. The risk-adjustment models include diagnoses only from the previous year. Both sources rely on the diagnostic information listed in the claims for payment that physicians file with CMS, Medicare Advantage plans, or Part D plans.

CBO used the 20 conditions listed in the CCW as criteria for selecting conditions from the risk-adjustment models (see Table A-1). For three of the CCW conditions, CBO was unable to find matching risk-adjustment conditions. In several other cases, the related risk-adjustment conditions overlap imperfectly with the CCW conditions. In many cases, a condition is defined more narrowly for the risk-adjustment models than for the CCW. That difference is also apparent when comparing the prevalence of chronic conditions in the two data sets. Among fee-for-service beneficiaries for whom chronic conditions are listed in both data sets, the variables used in the risk-adjustment models identify more beneficiaries with no chronic conditions and fewer beneficiaries with three or more chronic conditions than the CCW variables do. The same is true when looking only at conditions that are identified in both data sets. Thus, the risk-adjustment data for that set of chronic conditions paint a healthier picture of dual-eligible beneficiaries (and indeed of all Medicare beneficiaries) than the CCW data do (see Table A-2).

The two sources produce similar conclusions, however, when comparing groups of beneficiaries. For example, both data sets show that dual-eligible beneficiaries are likely to have a greater number of chronic conditions than other Medicare beneficiaries and that full duals have a greater number of chronic conditions than partial duals. Likewise, both sources of data indicate that institutionalized Medicare beneficiaries have more chronic conditions than noninstitutionalized beneficiaries and that elderly Medicare beneficiaries have more chronic conditions than nonelderly beneficiaries.

Table A-1.**Matching of Chronic Conditions Reported in Two Data Sets, 2009**

Condition Reported in the CCW	Look-Back Period in the CCW ^a	Matching Condition Reported in the Risk-Adjustment Files
Acute myocardial infarction	1 year	MA: acute myocardial infarction; Rx: none
Alzheimer's disease and related disorders or senile dementia ^b	3 years	MA: none; Rx: dementia with depression or behavioral disturbance, dementia/cerebral degeneration
Atrial fibrillation	1 year	No match
Cataract	1 year	No match
Chronic kidney disease	2 years	No match
Chronic obstructive pulmonary disease	1 year	MA: chronic obstructive pulmonary disease; Rx: none
Depression	1 year	MA: major depressive, bipolar, and paranoid disorders; Rx: none
Diabetes	2 years	MA: diabetes with or without complications; ^c Rx: diabetes with or without complications
Glaucoma	1 year	MA: none; Rx: open-angle glaucoma, glaucoma and keratoconus
Heart failure	2 years	MA: congestive heart failure; Rx: congestive heart failure
Hip/pelvic fracture	1 year	MA: hip fracture/dislocation; Rx: pelvic fracture
Ischemic heart disease	2 years	MA: acute myocardial infarction, unstable angina and other acute ischemic heart disease, angina pectoris/old myocardial infarction; Rx: none
Osteoporosis	1 year	MA: none; Rx: osteoporosis and vertebral fractures
Rheumatoid arthritis/osteoarthritis	2 years	MA: rheumatoid arthritis and inflammatory connective tissue disease; Rx: rheumatoid arthritis and other inflammatory polyarthropathy
Stroke/transient ischemic attack	1 year	MA: ischemic or unspecified stroke; RX: none
Colorectal cancer, endometrial cancer, female breast cancer, lung cancer, prostate cancer	1 year	MA: metastatic cancer and acute leukemia; lung, upper digestive tract, and other severe cancers; lymphatic, head and neck, brain, and other major cancers; breast, prostate, colorectal, and other cancers and tumors; Rx: acute myeloid leukemia; metastatic cancer, acute leukemia, and severe cancers; lung, upper digestive tract, and other severe cancers

Source: Congressional Budget Office.

Note: CCW = Centers for Medicare & Medicaid Services' Chronic Conditions Data Warehouse; MA = Medicare Advantage risk-adjustment model (CMS-HCC); Rx = prescription drug risk-adjustment model (CMS-RxHCC).

- The look-back period is the number of years of diagnoses used to determine whether someone has a chronic condition.
- Although the CCW also lists Alzheimer's disease separately, CBO does not count it separately as a chronic condition for the purposes of counting CCW conditions because it is a subset of "Alzheimer's disease and related disorders or senile dementia."
- Listed complications are renal or peripheral circulatory manifestation, neurologic or other specified manifestation, acute complications, and ophthalmologic or unspecified manifestation.

Table A-2.

Comparison of the Number of Chronic Conditions Among Medicare Beneficiaries in Two Data Sets, 2009

(Percentage of beneficiaries)

	Number of Chronic Conditions as Reported in the Risk-Adjustment Files					Total
	0	1-2	3-4	5-6	More than 6	
Number of Chronic Conditions as Reported in the CCW						
0	82	18	1	*	*	100
1-2	37	57	5	*	*	100
3-4	14	63	21	2	*	100
5-6	7	46	38	8	1	100
More than 6	4	30	44	19	3	100
Number of Chronic Conditions as Reported in the CCW, Including Only Conditions Also Reported in the Risk-Adjustment Files						
0	79	20	1	*	*	100
1-2	29	63	7	1	*	100
3-4	10	57	29	4	*	100
5-6	5	37	43	14	1	100
More than 6	3	24	43	25	5	100

Source: Congressional Budget Office.

Note: CCW = Centers for Medicare & Medicaid Services' Chronic Conditions Data Warehouse; * = between zero and 0.5 percent.

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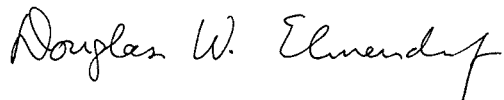
About This Document

This Congressional Budget Office (CBO) report was prepared at the request of the Chairman of the Senate Committee on Finance. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

The analysis was prepared by Tamara Hayford of CBO's Health, Retirement, and Long-Term Analysis Division—in close collaboration with Andrea Noda of CBO's Budget Analysis Division—with guidance from Linda Bilheimer and Jean Hearne. Jessica Banthin, Thomas Bradley, Melinda Buntin, Sheila Campbell, Philip Ellis, Holly Harvey, Paul Jacobs, Michael Levine, Paul Masi, Gordon Mermin, Jamease Miles, Lyle Nelson, and Lara Robillard provided helpful comments.

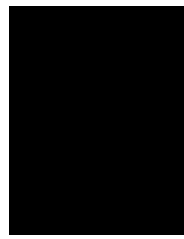
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Douglas W. Elmendorf
Director

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Glossary

accountable care organizations: Groups of doctors, hospitals, and other health care providers who join together to provide coordinated care to a set of patients and who agree to be held accountable for the quality and total cost of those patients' care. The Centers for Medicare & Medicaid Services is encouraging the development of accountable care organizations by offering to share savings with those groups if they can demonstrate that they have met certain quality standards and savings benchmarks for their Medicare patients.

acute care: Medical care provided by physicians' offices, short-term acute care hospitals, and outpatient care facilities. Services such as prescription drugs and dental care are also considered to be acute care.

aged, blind, or disabled (ABD) Medicaid beneficiaries: People who are eligible for and receive Medicaid benefits because of age, blindness, or disability in addition to the amount of their income and assets. The dual-eligible population is a subset of those beneficiaries.

behavioral health care: Treatment of mental health and substance abuse problems.

capitated payment: A single payment, made on a per-enrollee basis, that covers all care within a specified set of benefits. Medicare and Medicaid make capitated payments to managed care organizations, which then pay health care providers for a specific set of benefits for people enrolled in a managed care plan. The recipient of a capitated payment keeps the difference between its costs and the amount of the payment if costs are below the payment, but it is responsible for paying any costs that exceed the capitated payment.

cost plan: A type of Medicare Advantage plan in which payments to plans are based on submitted claims rather than being capitated. Fewer than 2 percent of dual-eligible beneficiaries enrolled in a Medicare Advantage plan are enrolled in a cost plan. Such plans typically do

not cover all of an enrollee's use of services; the remaining claims for those enrollees are covered by traditional fee-for-service Medicare.

dual-eligible beneficiaries: People who are jointly enrolled in Medicare and Medicaid and who are eligible to receive benefits from both programs. All dual-eligible beneficiaries qualify for full Medicare benefits, which cover their acute and postacute care. Dual-eligible beneficiaries vary, however, in the amount of Medicaid benefits for which they qualify. The dual-eligible population can be divided into "full duals" and "partial duals" on the basis of the Medicaid benefits that people are eligible to receive. At a minimum, all dual-eligible beneficiaries qualify to have the Medicaid program pay their premiums for Part B of Medicare (and for Part A, if applicable).

fee for service (FFS): A payment system in which a health care program or plan pays providers a fee for each covered service performed for its enrollees.

full duals: Dual-eligible beneficiaries who qualify for full benefits from Medicaid as well as from Medicare. Thus, Medicaid pays for their premiums for Part B of Medicare (and for Part A, if applicable) and covers various health care services that Medicare does not cover, such as most types of long-term services and supports (as well as dental care and other services in some states). In addition, some states' Medicaid programs cover the entire cost-sharing amounts that full duals incur under Medicare, whereas other states cover only a portion of those amounts.

health home: A type of medical home that serves Medicaid beneficiaries who have a particular set of chronic conditions. Health homes are intended to address those beneficiaries' needs for behavioral and physical health care as well as for institutional or community-based long-term care. The Affordable Care Act created an optional program in which states can receive a 90 percent federal matching rate for up to two years for providing this type of service.

long-term services and supports (LTSS): A category that encompasses a variety of supportive services provided to people who have limits on their ability to perform daily activities, such as bathing or dressing. LTSS typically excludes medical services that are needed to manage underlying health conditions. LTSS can be provided in nursing homes or other institutions, in people's homes, or in community-based settings (such as adult day care centers). Medicaid is the primary government payer for most of those types of services. The exceptions are skilled nursing facility services, hospice care, and home health care services, which are provided by Medicare in some circumstances.

managed FFS: A model in which providers are paid on a fee-for-service basis while beneficiaries are enrolled in care management programs designed to improve the quality of, and promote the appropriate use of, health care services.

managed LTSS: Long-term services and supports provided to Medicaid beneficiaries through managed care programs. The number of state Medicaid programs offering managed LTSS is growing rapidly.

medical home: A model for delivering health care—increasingly being used by state Medicaid programs—in which a team of health care professionals, led by a primary care provider, coordinates the care given to an individual or family.

Medicare Advantage: Medicare's managed care program, known formally as Medicare Part C. Most Medicare Advantage plans receive a capitated payment from Medicare in exchange for providing beneficiaries with all of the services covered by Parts A and B of Medicare. (A small number of plans, called cost plans, are paid on a claim-by-claim basis rather than with a capitated payment and do not necessarily cover all of those services.) Roughly 20 percent of dual-eligible beneficiaries are enrolled in Medicare Advantage plans.

nondual: A term used to describe Medicare beneficiaries who are not enrolled in Medicaid or Medicaid beneficiaries who are not enrolled in Medicare.

partial duals: Dual-eligible beneficiaries who qualify to have Medicaid pay some of the expenses they incur under Medicare. For all partial duals, Medicaid pays the

premiums for Part B of Medicare (and for Part A, if applicable). For some partial duals (depending on the state they live in and their income and assets), Medicaid also pays part or all of the cost-sharing amounts they owe under Medicare.

Parts A, B, C, and D: The Medicare program has three components: Hospital Insurance (Part A), Medical Insurance (Part B), and prescription drug coverage (Part D). Medicare Part C (known as Medicare Advantage) specifies the rules under which private health care plans can assume responsibility for, and be compensated for, providing benefits covered under Parts A, B, and D.

postacute care: Recuperation and rehabilitation services provided to patients recovering after a stay in a hospital for acute care. Postacute care is provided by skilled nursing facilities, home health agencies, and inpatient rehabilitation facilities, among others.

Program of All-Inclusive Care for the Elderly (PACE): A health care program that receives capitated payments in exchange for offering specialized services to Medicare and Medicaid beneficiaries who are age 55 or older and who need the degree of care usually provided in nursing facilities. PACE provides beneficiaries with community-based long-term services and supports that are intended to help them remain outside institutions. Notably, PACE programs may use their Medicare and Medicaid payments for any services that would enable a beneficiary to continue to live at home, including physical improvements to make the home more accessible. In addition, PACE programs have their own facilities—which provide services such as adult day care and visits by physicians—and offer transportation between a beneficiary's home and those facilities.

risk-based managed care: A system in which a health care program contracts with health plans, most of which are privately run, to provide a set of covered benefits for a fixed amount per beneficiary. Those amounts may be adjusted to reflect the health risks of beneficiaries.

special-needs plan (SNP): A type of Medicare Advantage plan that is designed to provide targeted services to Medicare beneficiaries who are in institutions, are dual-eligible beneficiaries, or have a severe or disabling chronic condition.