Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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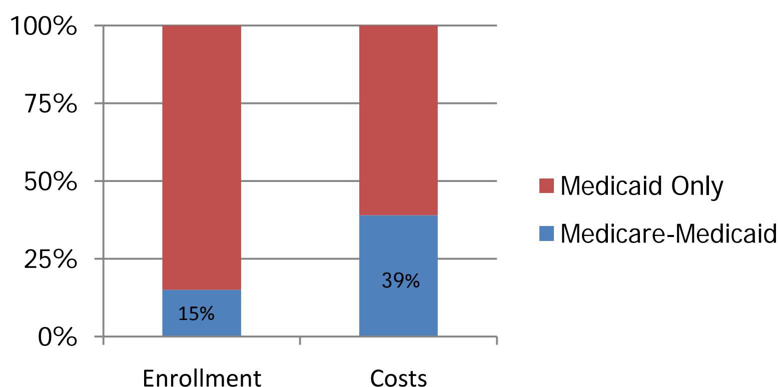
MEDICARE-MEDICAID COORDINATION OFFICE
FACT SHEET – August 2011

PEOPLE ENROLLED IN MEDICARE AND MEDICAID

In 2008, there were 9.2 million individuals eligible for both the Medicare and Medicaid programs.[1] Medicare-Medicaid enrollees, "dual eligibles," are among the most chronically ill and costly individuals enrolled in both the Medicare and Medicaid programs, with many having multiple chronic conditions and/or long-term care needs. More than half of Medicare-Medicaid enrollees have incomes below the poverty line[2] compared with 8 percent of other Medicare beneficiaries.[3] Forty-three percent of Medicare-Medicaid enrollees have at least one mental or cognitive impairment,[4] while 60 percent have multiple chronic conditions.[1] Nineteen percent live in institutional settings compared to only 3 percent of Medicare beneficiaries who are not also eligible for Medicaid.[5] This group must navigate two separate programs: Medicare for coverage of basic acute health care services and drugs, and Medicaid for coverage of long-term care supports and services, and help with Medicare premiums and cost-sharing.

Medicare-Medicaid enrollees account for a disproportionately large share of expenditures in both the Medicare and Medicaid programs: accounting for 16 percent of Medicare enrollees, yet 27 percent of Medicare spending in 2006.[5] In Medicaid, they comprised only 15 percent of enrollees but represented 39 percent of Medicaid spending in 2007.[6]

Share of Medicaid Enrollment and Costs Associated with Medicare-Medicaid Enrollees



Medicare-Medicaid enrollees account for approximately $120 billion in Federal and State spending – about twice as much as Medicaid spent on the 29 million children it covered. States alone spent over $50 billion in 2007 to support the uncovered health and long-term care costs of people enrolled in Medicare. The Medicaid spending on Medicare-Medicaid enrollees was $15,459 in 2007, over six times higher than the comparable cost of a non-disabled adult covered by Medicaid ($2,541). This

[1] *Id*, at 1.

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spending mostly reflects the significant costs of a population with low income and high health care needs; however, there is opportunity for savings through improved care coordination, simplification, and the alignment of Medicare and Medicaid rules.

MEDICARE-MEDICAID COORDINATION OFFICE. Created by the Affordable Care Act, the new Federal Coordinated Health Care Office (the Medicare-Medicaid Coordination Office) works to improve coordination between the Federal government and States for Medicare-Medicaid enrollees in order to ensure full access to covered services in both programs and high quality care. The Office is moving forward on improving access, coordination, and cost of care with a focus in three major areas: Program Alignment, Data and Analytics, and Models and Demonstrations. To date, the Medicare-Medicaid Coordination Office has:

- Selected 15 States to receive contracts for up to $1 million each to design new integrated care models for people enrolled in Medicare and Medicaid. The 15 States are California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin.
- Initiated the process of creating a technical assistance center to help all States better meet the needs of these complex, high-cost beneficiaries.
- Launched the Initiative to Align the Medicare and Medicaid Programs. The goal of this initiative is eliminate unnecessary and inefficient conflicts in the regulatory, statutory, and policy requirements of the two programs, where feasible.
- Announced the availability of more timely Medicare Parts A, B, and D claims data for States to help them improve their care coordination for low-income seniors and people with disabilities who are enrolled in Medicare and Medicaid.
- Developed a new demonstration program to test financial models designed to help States improve quality and share in the lower costs that result from better coordinating care. These models provide States with two new pathways to support integration for Medicare-Medicaid enrollees and provide opportunities to achieve savings as a result of improvements in care delivery.
- Announced a new demonstration that will focus on reducing preventable inpatient hospitalizations among residents of nursing facilities by providing these individuals with the treatment they need without having to unnecessarily go to a hospital.

QUESTIONS? FEEDBACK? EMAIL US: MEDICAREMEDICAIDCOORDINATION@CMS.HHS.GOV

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[1] Data based on the Centers for Medicare &Medicaid Services (CMS) Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office for Research, Development and Information, July 2010.
[2] In 2011, poverty is defined as $10,890 for an individual and $14,710 for married couples. Federal Register Notice, Vol. 76, No.13 Thursday, January 20, 2011. *Available* at: http://aspe.hhs.gov/poverty/11fedreg.pdf
[3] Medicare Payment Advisory Commission, Aligning Incentives in Medicare (June 2010), Coordinating the Care of Dual-Eligible Beneficiaries Chapter 5, 132. *Available* at: http://medpac.gov/documents/Jun10_EntireReport.pdf
[4] Chronic Disease and Co-Morbidity among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. Kaiser Commission on Medicaid and the Uninsured, 1. Kaiser Family Foundation. July 2010. *Available* at: http://www.kff.org/medicaid/upload/8081.pdf
[5] The Medicare Payment Advisory Committee (MedPAC), A Data Book: Healthcare spending and the Medicare program, June 2010. *Available at*: http://www.medpac.gov/documents/Jun10_EntireReport.pdf .
[6] Kaiser Family Foundation, The Role of Medicare for the People Dually Eligible for Medicare and Medicaid. January 2011. *Available at*: http://www.kff.org/medicare/upload/8138.pdf .