Elevance Health | Public Policy Institute

Managed Care Models Improve Outcomes for Partial Dual Eligible Individuals

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Contents

Key Takeaways

- Individuals who are eligible for partial dual status experience complex health-related social and medical needs, and could benefit from managed care, such as Dual Eligible Special Needs Plans.
- This analysis shows that managed care results in higher primary care utilization and reduced rates of inpatient hospitalization, readmissions, and skilled nursing stays as compared to Traditional Medicare.
- Partial dual eligible individuals should be provided the option to pick a managed care plan that matches their individual goals and preferences.

Overview

Previous research has found that partial dual eligible individuals, who are eligible for Medicare as well as Medicaid assistance in paying for certain Medicare out-of-pocket costs, have significant medical and functional needs that are similar to those of the full dual eligible population.[1]

For example, partial dual eligible individuals are more likely to experience functional frailty and cognitive impairment as compared to non-dually eligible individuals.[2] Because their healthcare needs are generally more complex than those of the non-dually eligible Medicare population, partial dual eligible individuals could benefit from plans that are tailored to their unique needs, such as Dual Eligible Special Needs Plans (D-SNPs). Further, over half of partial dual eligible individuals experience "churn" in their Medicaid status, potentially causing fragmentation of care as they gain or lose access to benefits, signaling the need for higher intensity care management.[3]

Over 18 percent of all Medicare enrollees in 2020 qualified for some level of additional financial assistance.

The purpose of this analysis is to compare outcomes for partial dual eligible individuals enrolled in managed care plans, specifically D-SNPs or other Medicare Advantage (MA) plans, and those enrolled in Traditional Medicare (TM) (often referred to as Medicare Fee-For-Service).

To accomplish this goal, the Elevance Health Public Policy Institute (PPI) engaged Health Management Associates (HMA) and Berkeley Research Group (BRG) to examine Medicare utilization data for Medicare enrollees who are partial dual eligible individuals. HMA and BRG conducted policy and literature reviews to examine prior evidence and recommendations regarding the partial dual eligible population, as well as performed data analyses on Medicare fee-for-service claims data and MA encounter data from 2017-2019.

Background

Medicare beneficiaries with low incomes are potentially eligible for two separate but overlapping benefit programs.

First, there are the four categories of eligibility under the Medicare Savings Programs (MSP).[4] There are standard levels of income and assets that the Centers for Medicare & Medicaid Services (CMS) sets for each of these four categories of programs, although as of 2022 seven states set more generous income eligibility thresholds and fourteen states either raised or eliminated the asset threshold.[5]

- **The Qualified Medicare Beneficiary (QMB) program** covers all Medicare Part A&B premiums, deductibles, and coinsurance or copayments for Medicare-allowed services. Eligibility in 2022 is generally restricted to individuals with income at or below $1,153 per month and assets at or below $8,400.
- **The Specified Low-Income Beneficiary (SLMB) program** covers Medicare Part B premiums. Eligibility in 2022 is generally restricted to individuals with income at or below $1,379 per month and assets at or below $8,400.

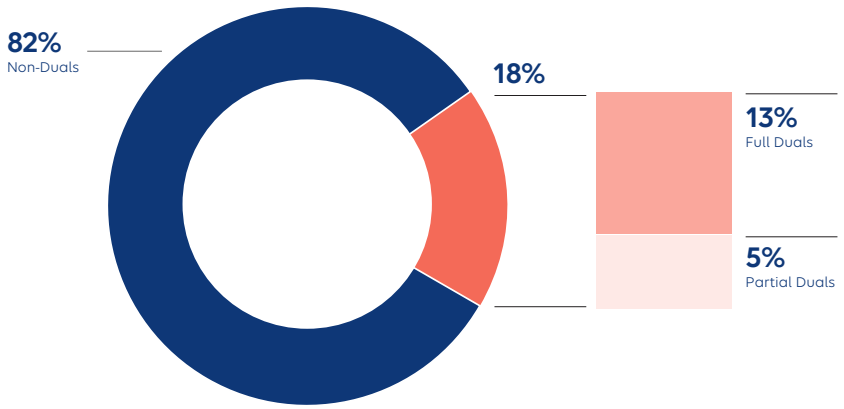
- **The Qualifying Individual (QI) program** also covers Medicare Part B premiums and is administered by states on a first come, first served basis. Eligibility in 2022 is generally restricted to individuals with income at or below $1,549 per month and assets at or below $8,400.
- **The Qualified Disabled Working Individual (QDWI) program** covers Medicare Part A premiums. Eligibility is generally restricted to individuals with a disability who are working and do not qualify for premium-free Part A care. In addition, eligibility in 2022 is restricted to individuals with income at or below $4,615 per month and assets at or below $4,000.[6]

Second, Medicare beneficiaries with low incomes may qualify for the full set of state-covered Medicaid services, including benefits such as long-term care services, non-emergency medical transportation, or vision care. Similar to the MSPs, CMS generally requires states to offer Medicaid coverage to Medicare beneficiaries with income at or below $838 per month in 2022, although nineteen states have higher income thresholds. The Appendix displays each state's Medicaid & MSP income requirements as of 2022.

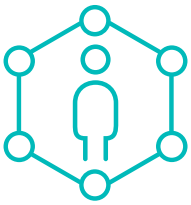
A Medicare beneficiary who qualifies for one of the MSPs only and does not qualify for state-covered Medicaid services, is known as a "partial dual eligible" enrollee. Medicare beneficiaries who qualify for the full set of Medicaid benefits are known as "full dual eligible" enrollees. They may also separately qualify for support through the MSPs (e.g., QMB-plus and SLMB-plus). As of 2020, there were 8 million full dual eligible Medicare enrollees and 3.3 million partial dual eligible Medicare enrollees. Combined, over 18 percent of all Medicare enrollees in 2020 qualified for some level of additional financial assistance. (Figure 1)

Prior research has found that partial dual eligible individuals are more similar to full dual eligible individuals than non-dual individuals, along multiple factors such as food insecurity, housing situation, functional frailty, and cognitive impairment.[7] In addition, Medicare enrollees who are partial dual eligible experience high rates of Medicaid coverage "churn", with 56 percent experiencing a change in Medicaid status over a 30-month period.[8]

Figure 1
Proportion of Medicare Beneficiaries Who Qualify for Medicaid Benefits



Source: Centers for Medicare & Medicaid Services, Chronic Conditions Data Warehouse (2020).
N = 65.9 million Medicare beneficiaries.



Partial dual eligible individuals are more similar to full dual eligible individuals than non-dual individuals.

Medicare Advantage & Dual Eligible Special Needs Plans

All Medicare beneficiaries who are enrolled in both Medicare Parts A & B are eligible to enroll in a MA plan. MA plans are required to pay for Medicare-covered services, as well as set a maximum out-of-pocket threshold for enrollees. Most MA plans reduce the standard Medicare coinsurance amounts, limiting the out-of-pocket costs that an enrollee must pay for each service. Many MA plans also cover additional services at limited or no extra cost to the enrollee, including vision, dental, hearing, fitness, and other services to address health-related social needs. In general, MA plans must offer a uniform set of benefits to all enrollees, with some modifications allowed for enrollees with certain chronic conditions. As of June 2022, 46 percent of all Medicare beneficiaries were enrolled in a MA plan.[9]

Some MA plans are created to specifically meet the needs of Medicare beneficiaries with low incomes. These plans, called D-SNPs, are required to have a State Medicaid Agency Contract (SMAC). D-SNPs often adjust the health plan benefit design to reflect the diverse care and service needs for these individuals, as well as state-specific requirements. All D-SNPs are required to have an approved Model of Care (MOC) that ensures the plan has a care management strategy that covers, at a minimum, quality, care management, and care coordination processes. As of June 2022, 4.3 million Medicare beneficiaries were enrolled in a D-SNP, representing 15 percent of total MA enrollment.[10]

The SMAC is the agreement between the D-SNP and the state regarding the types of Medicare and Medicaid services that the plan will cover, the cost-sharing protections offered by the plan, and the type of dual eligible individuals that the plan is allowed to enroll. States can dictate the types of dual eligible individuals who are eligible for D-SNPs; as of 2022, thirty-six states allow both full dual eligible and partial dual eligible individuals to enroll in D-SNPs.[11] Importantly, some of these states allow partial dual eligible individuals to enroll in some, but not all, D-SNPs. In addition, some states only allow partial dual eligible individuals who qualify for the QMB and/or SLMB programs to enroll in D-SNPs.

Methodology

This analysis sought to explore utilization differences for partial dual eligible Medicare enrollees between D-SNPs, standard MA plans, and TM.

BRG and HMA used the 100 percent Research Identifiable Files accessed through a data use agreement with CMS between 2012 and 2019, which contains Medicare-paid services received by all beneficiaries, including the TM fee-for-service claims files and the MA encounter data set. They limited the analysis to individuals eligible for the QMB, SLMB, or QI programs, and excluded any individual in a month where they qualified for full Medicaid benefits.

BRG and HMA assigned each individual in the analysis to a specific type of coverage, using the Master Beneficiary Summary File (MBSF) and the relevant year's MA Plan Landscape file.

They chose to require a minimum of seven months of coverage in each year between 2017 and 2019 for a particular enrollment type for assignment to ensure the claims data primarily reflected the utilization associated with one specific type of coverage. They also excluded individuals who had at least 100 days of residence in a nursing home, given the unique characteristics and needs of the long-term institutionalized population.

Given the variability in SMAC permissions for partial dual eligible enrollment in D-SNPs, BRG and HMA limited the analysis to 23 states that had at least 22,000 member months of partial dual eligible enrollment in D-SNPs in 2019.[12] In addition, prior evidence on medical price and insurance elasticity has demonstrated utilization of healthcare is affected by out-of-pocket costs.[13] With the significant differences in both Medicaid and MSP eligibility seen across states, the primary analysis focuses on ratios of utilization between coverage types within each state.

The analyses also compared partial dual eligible individuals in the QMB program separately from individuals in the SLMB or QI program, since out-of-pocket costs are covered for QMB enrollees but not SLMB or QI enrollees. BRG and HMA did not include partial dual eligible individuals in the QDWI program due to small enrollment numbers.

BRG and HMA calculated five distinct utilization metrics to compare across the coverage types. All metrics were calculated as events per 1,000 enrollees per year.

1. Primary Care Provider (PCP) Visits: The number of evaluation & management (E&M) visits billed by a primary care provider, including physicians with specialties of internal medicine, family practice, geriatrics, or general practice. PCP visits include visits to Federally Qualified Health Centers (FQHC).

2. Acute Inpatient Hospitalizations: The number of stays at an acute inpatient hospital, not including stays that occurred within 30 days of a discharge from an earlier acute inpatient stay.

3. 30-Day All Cause Readmissions: The number of stays for patients readmitted to an acute inpatient hospital within 30 days of discharge from an earlier acute inpatient stay.

4. Emergency Department (ED) Visits: The number of times a patient visited an emergency department for any reason that did not result in an acute inpatient admission.

5. Skilled Nursing Facility (SNF) Admissions: The number of admissions to a SNF for post-acute care after an acute inpatient hospitalization discharge.

Finally, to account for variation in utilization from risk, BRG and HMA used the most recent CMS Hierarchical Condition Category (HCC) model to calculate a risk score for each enrollee. The CMS-HCC model uses health status or diagnosis and demographic characteristics to predict healthcare expenditures.[14] They followed the same process used by CMS for MA risk scores, using diagnoses from the prior year to determine the subsequent year HCC score for each individual in the analysis. They then applied the risk scores to each of the utilization metrics.

Findings

The study population included 8.2 million partial dual eligible enrollees across all three years, including 4.2 million QMB enrollees and 4.0 million SLMB/QI enrollees. Of the QMB population, 50 percent were in the TM program, 29 percent were in a D-SNP, and 21 percent were in a standard MA plan. Of the SLMB/QI population, 44 percent were in the TM program, 11 percent were in a D-SNP, and 46 percent were in a standard MA plan. The TM enrollees tended to be younger than D-SNP or MA enrollees and had a higher overall mortality rate. In addition, TM enrollees had a lower risk score than D-SNP or MA enrollees. Other demographic characteristics were similar across the various coverage types.

Table 1
Non-Institutionalized Partial Dual Eligible Medicare Enrollees, 2019

	QMB			SLMB/QI		
	D-SNP	**MA**	**TM**	**D-SNP**	**MA**	**TM**
Total	476,693	348,411	887,931	165,647	805,172	853,319
Male	37%	36%	41%	42%	39%	46%
Female	63%	64%	59%	58%	61%	54%
Age <65	36%	30%	45%	35%	31%	42%
Age 65-74	40%	42%	34%	39%	39%	34%
Age 75-84	19%	21%	15%	20%	23%	17%
Age 85+	5%	7%	6%	6%	8%	7%
Initial Eligibility for Medicare: Age-In	46%	57%	42%	42%	48%	40%
Initial Eligibility for Medicare: Disability and/or ESRD	54%	43%	58%	58%	52%	60%
Deceased in 2019	1%	1%	5%	1%	1%	5%

Source: BRG analysis of 100% Medicare beneficiaries among states in the sample, based on data use agreement with CMS.
Note: QMB = Qualified Medicare Beneficiary; SLMB = Specified Low-Income Medicare Beneficiary; QI = Qualifying Individual; ESRD = End-Stage Renal Disease.

Risk Adjusted Healthcare Utilization

In general, the risk adjusted utilization patterns for partial dual eligible individuals in D-SNPs were notably different compared to individuals in TM, and comparable to individuals in standard MA plans.

- **PCP Visits:** Partial dual eligible individuals in D-SNPs averaged twice as many visits to PCPs compared to partial dual eligible individuals in TM and had a slightly higher visit rate compared to partial dual eligible individuals in standard MA. Prior evidence has found that primary care is associated with better health outcomes.[15]
- **Acute Inpatient Hospitalizations:** Partial dual eligible individuals in D-SNPs had 20-25 percent lower rates of inpatient hospital stays compared to partial dual eligible individuals in TM, and similar rates compared to partial dual eligible individuals in standard MA. The lower inpatient hospitalization rates may reflect efforts by MA plans to provide focused care management activities for higher-risk individuals.
- **30-Day All Cause Readmissions:** Partial dual eligible individuals in D-SNPs had 30-40 percent lower rates of all cause inpatient readmissions compared to partial dual eligible individuals in TM, and slightly lower rates compared to partial dual eligible individuals in standard MA. The lower readmission rates suggest that D-SNPs may be highly focused on ensuring their enrollees transition back home after a hospitalization. D-SNPs offer supplemental benefits to enrollees, such as medically tailored home delivered meals, which can reduce admissions and readmissions.[16]
- **Emergency Department Visits:** Partial dual eligible individuals in D-SNPs had 5-10 percent lower rates of ED visits compared to partial dual eligible individuals in TM, and 10-20 percent higher rates compared to partial dual eligible individuals in standard MA. Health plans often focus efforts on eliminating avoidable ED visits via care management programs, which would help explain the strong performance by D-SNPs and standard MA plans versus TM on this measure. The benefit design of D-SNPs often requires low or zero copayment for ED visits, which might drive the higher utilization in this plan type as compared to MA.
- **Skilled Nursing Facility Admissions:** Partial dual eligible individuals in D-SNPs had 20-25 percent lower rates of SNF admissions compared to partial dual eligible individuals in TM, and slightly lower rates compared to partial dual eligible individuals in standard MA. When comparing D-SNPs to MA, those who qualify for the QMB program have lower rates of SNF visits but SLMB/QI individuals have the same rates of SNF visits. Some of this variation can be explained by the lower rates on acute inpatient stays, as most individuals do not qualify for a SNF stay without an inpatient stay. However, care management programs that ensure an appropriate transition to the home by the D-SNP may also contribute to these results.

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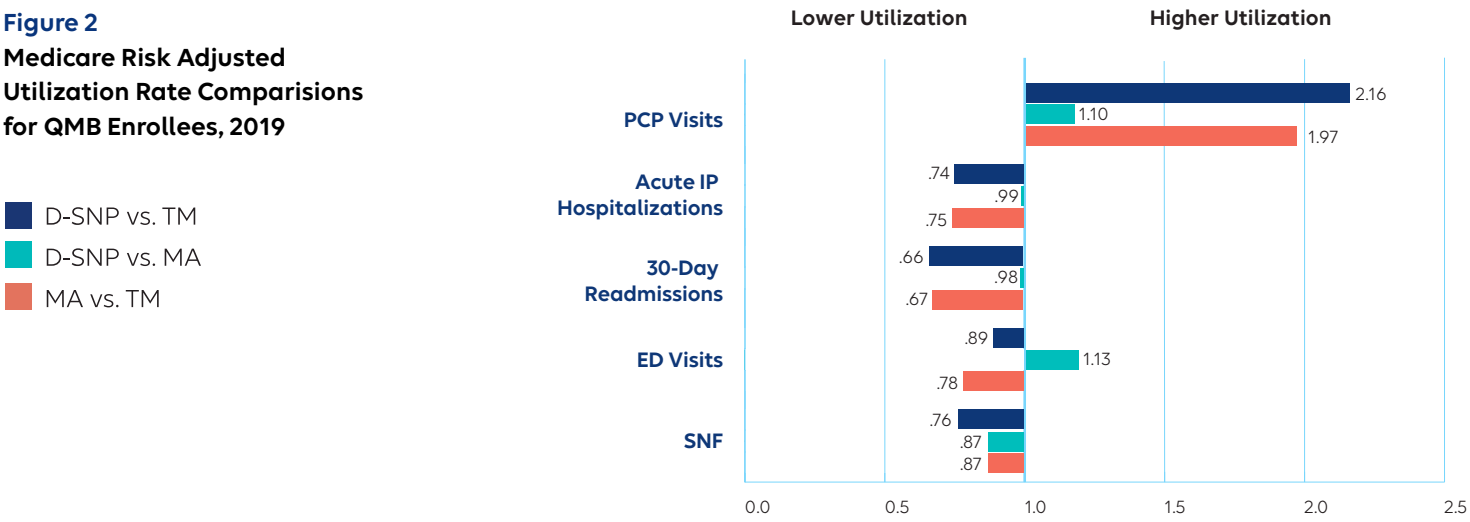
Partial dual eligible individuals had twice as many PCP visits in D-SNPs than in TM.

Figure 2

Medicare Risk Adjusted Utilization Rate Comparisions for QMB Enrollees, 2019

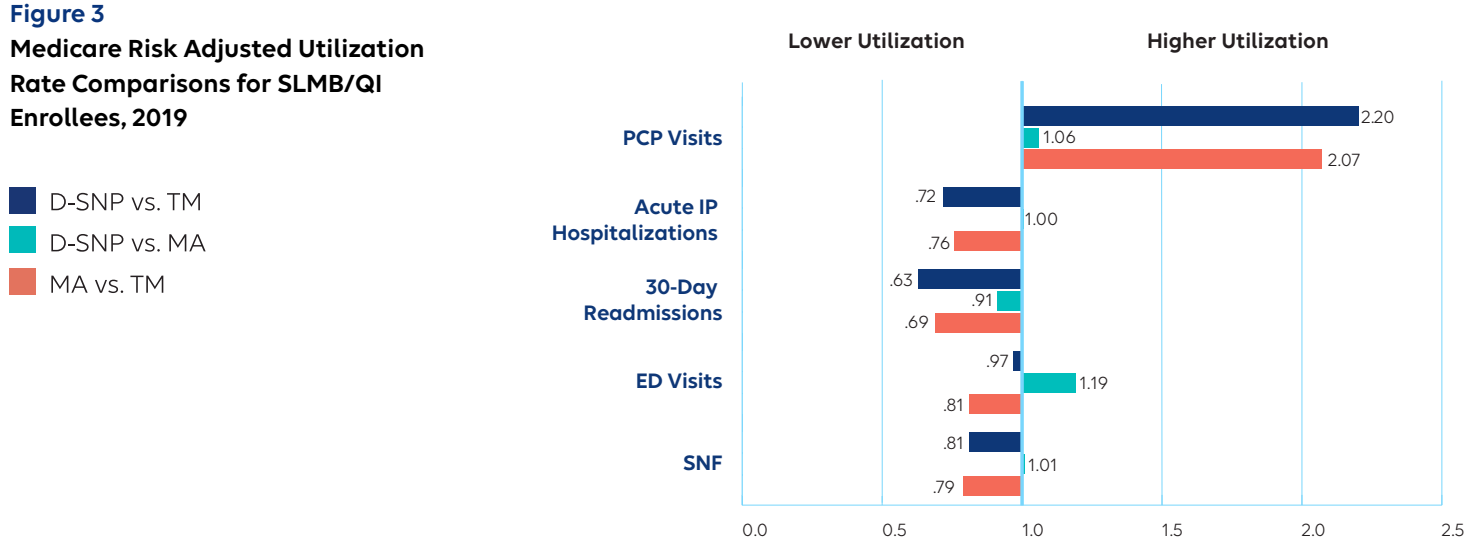


Source: BRG analysis of 100% 2019 Master Beneficiary Summary, Long Term Care Minimum Data Set, Medicare TM Claims, Medicare Advantage Encounter Files, based on data use agreement with CMS.

Note: For an example of how the ratios in this table should be interpreted, the D-SNP to TM ratio for QMBs with respect to PCP visits shows that QMB partial dual enrollees in D-SNPs had more than twice (2.16 times) as many PCP visits as QMB partial dual enrollees in TM.
QMB = Qualified Medicare Beneficiary; PCP = Primary Care Provider; IP = Inpatient; ED = Emergency Department; SNF = Skilled Nursing Facility; D-SNP = Dual Eligible Special Needs Plan; TM = Traditional Medicare; MA = Medicare Advantage.

Figure 3

Medicare Risk Adjusted Utilization Rate Comparisons for SLMB/QI Enrollees, 2019



Source: BRG analysis of 100% 2019 Master Beneficiary Summary, Long Term Care Minimum Data Set, Medicare TM Claims, Medicare Advantage Encounter Files, based on data use agreement with CMS.

Note: For an example of how the ratios in this table should be interpreted, the D-SNP to TM ratio for SLMB/QI with respect to PCP visits shows that SLMB/QI partial dual enrollees in D-SNPs had more than twice (2.20 times) as many PCP visits as SLMB/QI partial duals enrollees in TM.
SLMB/QI= Specified Low-Income Medicare Beneficiary/Qualified Individual Program; PCP = Primary Care Provider; IP = Inpatient; ED = Emergency Department; SNF = Skilled Nursing Facility; D-SNP = Dual Eligible Special Needs Plan; TM = Traditional Medicare; MA = Medicare Advantage.

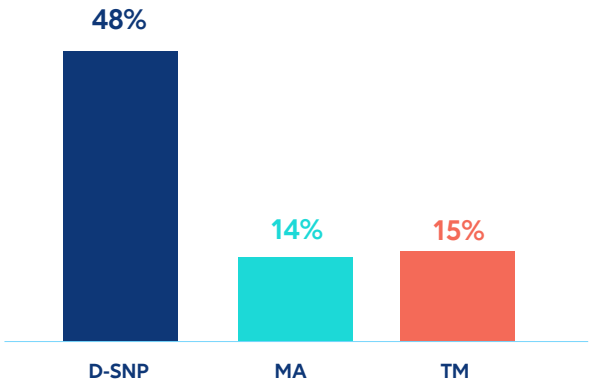
Transitions to Full Dual Status

To understand how D-SNPs impact state and federal level healthcare spending and support enrollee needs, this analysis examined how many months it took for partial dual eligible enrollees to transition to being fully dual eligible across D-SNP, MA, and TM plans. Across the analysis sample, on average, partial dual eligible individuals enrolled in D-SNPs take longer to transition to full dual status. On average, enrollees in D-SNPs have about a 40 percent longer transition time to full dual status as compared to partial dual enrollees in TM. The longer transition time could indicate that D-SNPs are coordinating and supporting enrollees' care needs, slowing their progression to full dual status.

Looking at the overall proportion of partial dual enrollees who transition to full dual status, a higher share of partial dual enrollees in D-SNPs transitioned to full dual status as compared to those in MA or TM from 2012-2019. Among D-SNP enrollees who first became eligible for partial dual status in 2012, 48 percent transitioned to full dual status by 2019. In comparison, 14 and 15 percent of partial dual enrollees in MA and TM, respectively, became fully dual eligible in the same timeframe. (Figure 4)

When partial dual enrollees transition to full dual status, they have the option to select a D-SNP, even if they weren't enrolled in one previously. Allowing partial dual eligible individuals to enroll in D-SNPs before gaining full dual eligibility, or to remain in D-SNPs as they "churn" between partial and full dual eligibility, could support continuity of care in this population.

Figure 4
Share of Partial Duals by Enrollment Type in 2012 Who Transitioned to Full Dual Status by 2019



Source: BRG analysis of 100% Medicare beneficiaries of 2019 Master Beneficiary Summary File, based on data use agreement with CMS.

D-SNP = Dual Eligible Special Needs Plan; MA = Medicare Advantage; TM = Traditional Medicare

Discussion

Care coordination and other tailored benefits are critical components for managing partial duals' health-related social and medical needs.

Prior research has demonstrated that Medicare beneficiaries with low incomes more frequently experience fragmented care and poor health outcomes.[17] Part of this problem stems from lack of access to primary care providers, with research demonstrating that one-third of counties with the highest density of low-income Medicare enrollees had PCP shortages.[18] Other studies have demonstrated that providing care coordination services and greater PCP access can help lower healthcare spending.[19] Most MA plans offer some level of care coordination, while D-SNPs have a formal MOC in place to ensure enrollees have focused care coordination and care management processes.

Our analysis suggests that these formal processes offered by D-SNPs increase access to and utilization of PCP care. The higher PCP access and utilization, coupled with the D-SNP MOC, may lead to the observed lower inpatient hospitalizations, readmissions, and SNF visits. Unexpectedly, the higher intensity care coordination of D-SNPs does not appear to be reducing ED visits compared to standard MA plans, although D-SNP enrollees do have fewer ED visits than the unmanaged TM population. This could be explained in part by the benefit design offered in D-SNPs, as the low or no cost copayments for ED visits could contribute to the higher utilization of the ED. Nevertheless, managed care products overall outperformed TM, likely due to their care management services, curated networks, and supplemental benefit offerings.

Evidence has shown that Medicare enrollees with low incomes who cycle in and out of Medicaid eligibility may face disruptions in care, which in turn can lead to poor health outcomes and increased costs for Medicare and the states.[20] Given the high rates of Medicaid eligibility churn experienced by individuals who are partially dual eligible, these results suggest managed care plans could help increase the probability of improved outcomes. Some states allow or require eligibility "deeming" periods for individuals enrolled in D-SNPs, which allows individuals who lose their Medicaid eligibility, but are expected to regain it, to stay enrolled in their plans for up to six months.

Further, permitting or even encouraging partial dual eligible individuals to enroll in D-SNPs at the outset would allow enrollees to remain in their same coordinated and tailored plan when they transition to full dual status. The higher rates of partial dual individuals transitioning to full dual status in D-SNPs as compared to TM could indicate that D-SNPs are proactively connecting individuals to resources as their financial and medical situations evolve, including ensuring they enroll in full Medicaid benefits as applicable.

Conclusion

Individuals who are partially dual eligible account for 18 percent of all people eligible for Medicare yet they are limited in their plan choices in some states. This analysis illustrates that D-SNPs show promising trends in promoting access to and utilization of PCP care, which in turn is leading to lower rates of inpatient hospitalizations, readmissions, and SNF visits. D-SNPs are also associated with less ED use as compared to TM.

Overall, managed care plans outperformed TM on all utilization measures examined in this analysis, underscoring how care coordination and other tailored benefits are critical components for managing partial duals' health-related social and medical needs. Despite this, partial dual eligible individuals do not have the opportunity to enroll in D-SNPs in all states. Partial dual eligible individuals should be provided the option to pick a managed care plan that matches their individual goals and preferences, whether that be a D-SNP or another type of MA plan, both of which drive positive health outcomes.

The Elevance Health Public Policy Institute gratefully acknowledges the support of Health Management Associates and Berkeley Research Group in the research and writing of this paper.

Appendix:
State Medicaid & MSP Eligibility Requirements

State	Income Limit as Percent of 2022 Federal Poverty Level (FPL)					
	Medicaid	QMB	SLMB	QI	Asset Limit[1]	Included in Analysis
Alabama	74%	102%	122%	137%	Yes	Yes
Alaska	100%	102%	122%	137%	No	No
Arizona	100%	102%	122%	137%	Yes	Yes
Arkansas	80%	102%	122%	137%	No	Yes
California	100%	102%	122%	137%	No	Yes
Colorado	74%	102%	122%	137%	No	Yes
Connecticut	60%	211%	231%	246%	Yes	Yes
Delaware	74%	102%	122%	137%	Yes	No
District of Columbia	100%	300%	300%	300%	Yes	No
Florida	88%	102%	122%	137%	No	Yes
Georgia	74%	102%	122%	137%	No	Yes
Hawaii	100%	117%	140%	157%	No	No
Idaho	77%	102%	122%	137%	No	No
Illinois	100%	102%	122%	137%	No	No
Indiana	100%	150%	170%	185%	No	Yes
Iowa	74%	102%	122%	137%	No	No
Kansas	74%	102%	122%	137%	No	No
Kentucky	74%	102%	122%	137%	No	Yes
Louisiana	74%	102%	122%	137%	Yes	Yes
Maine	100%	150%	170%	185%	Yes	No
Maryland	74%	102%	122%	137%	No	No
Massachusetts	100%	130%	150%	165%	Yes	No
Michigan	100%	102%	122%	137%	No	Yes
Minnesota	100%	102%	122%	137%	Yes	No
Mississippi	74%	104%	124%	139%	Yes	Yes
Missouri	85%	102%	122%	137%	No	Yes

Appendix:
State Medicaid & MSP Eligibility Requirements (cont.)

State	Income Limit as Percent of 2022 Federal Poverty Level (FPL)					
	Medicaid	QMB	SLMB	QI	Asset Limit[1]	Included in Analysis
Montana	74%	102%	122%	137%	No	No
Nebraska	100%	102%	122%	137%	No	No
Nevada	74%	102%	122%	137%	No	No
New Hampshire	75%	102%	122%	137%	No	No
New Jersey	100%	102%	122%	137%	No	No
New Mexico	74%	102%	122%	137%	Yes	Yes
New York	82%	102%	122%	137%	Yes	Yes
North Carolina	100%	102%	122%	137%	No	Yes
North Dakota	83%	102%	122%	137%	No	No
Ohio	74%	102%	122%	137%	No	Yes
Oklahoma	100%	102%	122%	137%	No	No
Oregon	74%	102%	122%	137%	Yes	No
Pennsylvania	100%	102%	122%	137%	No	Yes
Rhode Island	100%	102%	122%	137%	No	No
South Carolina	100%	102%	122%	137%	No	No
South Dakota	74%	102%	122%	137%	No	No
Tennessee	74%	102%	122%	137%	No	Yes
Texas	74%	102%	122%	137%	No	Yes
Utah	100%	102%	122%	137%	No	No
Vermont	74%	102%	122%	137%	Yes	No
Virginia	80%	102%	122%	137%	No	No
Washington	74%	102%	122%	137%	No	Yes
West Virginia	74%	102%	122%	137%	No	No
Wisconsin	100%	102%	122%	137%	No	Yes
Wyoming	74%	102%	122%	137%	No	No

[1]Refers to increase or the elimination of asset limits.

Source: Kaiser Family Foundation. (2022). Eligibility for Medicare Savings Programs. Retrieved March 6, 2023, from https://www.kff.org/state-category/medicare/medicare-savings-programs/.

MSP = Medicare Savings Program; QMB = Qualified Medicare Beneficiary; SLMB = Specified Low-Income Medicare Beneficiary; QI = Qualified Individual

Endnotes

[1]ATI Advisory. (2021, June). Advancing the Policy Environment to Address the Unique Needs of Partial Dual Eligible Beneficiaries. Retrieved December 12, 2022, from https://www.elevancehealth.com/content/dam/elevance-health/articles/ppi_assets/47/47_report.pdf.

[2]Ibid.

[3]Ibid.

[4]In 2021, the 21st Century Cures Act allowed Medicare beneficiaries with end-stage renal disease (ESRD) to enroll in MA. Prior to 2021, Medicare beneficiaries with ESRD were able to enroll in MA only in limited circumstances.

[5]Centers for Medicare & Medicaid Services. (n.d.). Medicaid & CHIP How-To Information. Retrieved January 11, 2023, from https://www.medicaid.gov/about-us/beneficiary-resources/index.html#WI.

[6]Given the small size of the QDWI population, we excluded them from the research.

[7]ATI Advisory. (2021, June).

[8]Ibid.

[9]Centers for Medicare & Medicaid Services. (2022, June). MA State/County Penetration Data File. Retrieved December 12, 2022, from https://www.cms.gov/research-statistics-data-and-systemsstatistics-trends-and-reportsmcradvpartdenroldatama-state-county/ma-statecounty-penetration-2022-06.

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[12]See Appendix for a listing of the 23 states included in the analysis.

[13]Centers for Medicare & Medicaid Services. (2019, June). The Long-Term Projection for Medicare and Aggregate National Health Expenditures. Retrieved December 12, 2022, from https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/102xx/doc10297/chapter2.5.1.shtml#:~:text=CBO%20projects%20that%20without%20significant,to%2015%20percent%20by%202080.

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