

A Profile of Medicare-Medicaid Dual Beneficiaries

June 2022

Acknowledgment

Supported by Arnold Ventures. For more information visit

<https://www.arnoldventures.org/work/complex-care>

ABOUT THIS CHARTBOOK



Purpose

Quantify and describe the demographics, needs, experiences, and health plan options of Medicare beneficiaries who are dually eligible for Medicaid (dual beneficiaries), highlighting unique characteristics for policymakers to consider in policy reform



Data sources

2019 Medicare Current Beneficiary Survey (MCBS)
2020 MCBS COVID Supplement
2021 Master Beneficiary Summary File (MBSF)
2022 March CMS Enrollment files

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Executive Summary

Individuals with both Medicare and Medicaid coverage (“dual beneficiaries”) comprise a medically, functionally, and socially complex population often forced to navigate two uncoordinated systems. As a result, these individuals tend to experience poor health outcomes and barriers to access, resulting in high spending across both the Medicaid and Medicare programs.



Demographics

Dual beneficiaries are more likely to be Black or Hispanic, low income, under age 65, and unmarried than are Medicare-only beneficiaries. Integrated culturally competent approaches are critical for advancing equitable health outcomes.



Social Determinants of Health (SDOH)

Dual beneficiaries experience a wide variety of social needs ranging from high rates of food insecurity and limited English proficiency to low rates of computer ownership and high school graduation compared to Medicare-only beneficiaries.



Delivery System Access

Half of all dual beneficiaries (and one quarter of rural dual beneficiaries) have access to a meaningfully integrated health plan product, though only seven percent are enrolled in one. Integrated plan options should be available for all dual beneficiaries.



Living Environment & Caregiving

Dual beneficiaries living in the community are more likely to live alone and in a rented home. Dual beneficiaries disproportionately rely on non-spouse female relatives for caregiving support.



Health Status

Dual beneficiaries experience higher rates of physical and behavioral health conditions, functional challenges, and cognitive needs.



Utilization & Spending

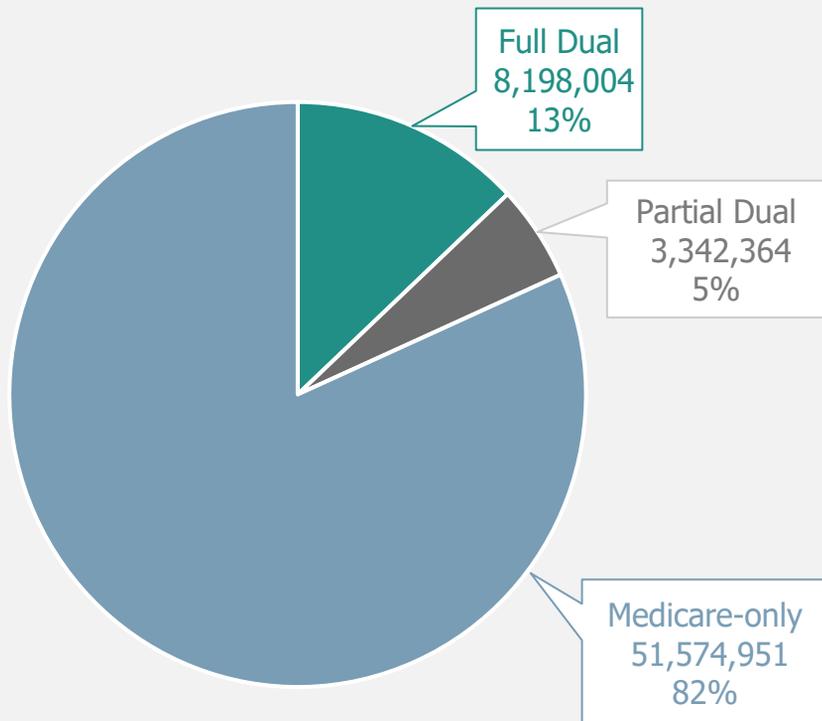
Dual beneficiaries use the emergency department, hospital, and home health at high rates, driving Medicare costs up. Utilization varies by race and ethnicity, age, and disability.

Background Information on Dual Eligibility

All dual beneficiaries receive some level of extra help with Medicare costs from their state Medicaid program, depending on the individual's income and asset levels.

- **Full Dual Beneficiary:** Beneficiary is eligible for full Medicaid benefits in their state. Referred to as "Full Dual" in figures in this Chartbook.
- **Partial Dual Beneficiary:** Beneficiary receives Medicare financial support from their state but no other Medicaid benefits. Referred to as "Partial Dual" in figures in this Chartbook.
- **Medicare-only Beneficiary:** Does not qualify for any form of Medicaid benefits. Referred to as "Medicare-only" in figures in this Chartbook.

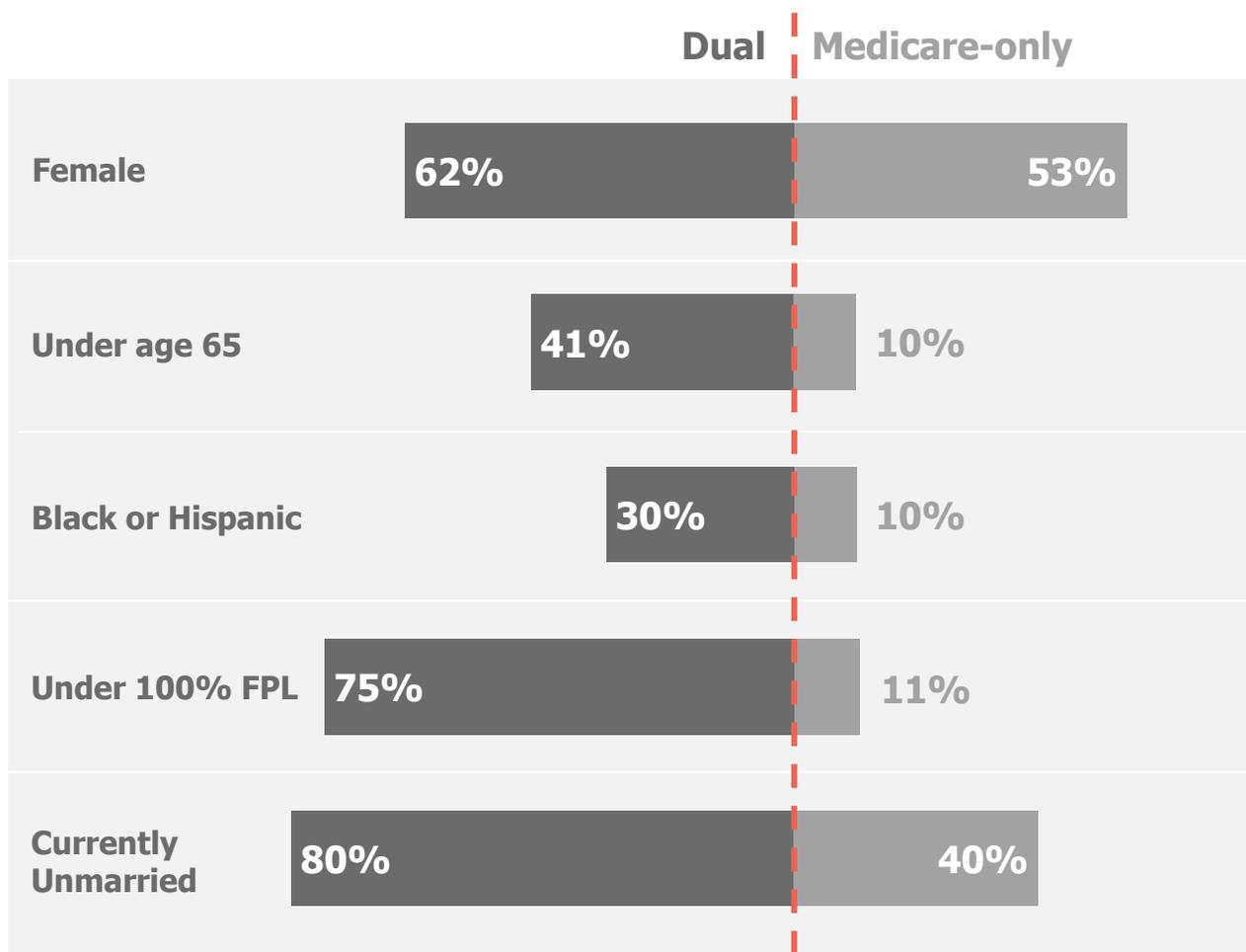
Of the 63.1 million Medicare Beneficiaries, 11.5 million (18%) are Dually Eligible for Medicare and Medicaid



Demographics

Key Takeaways

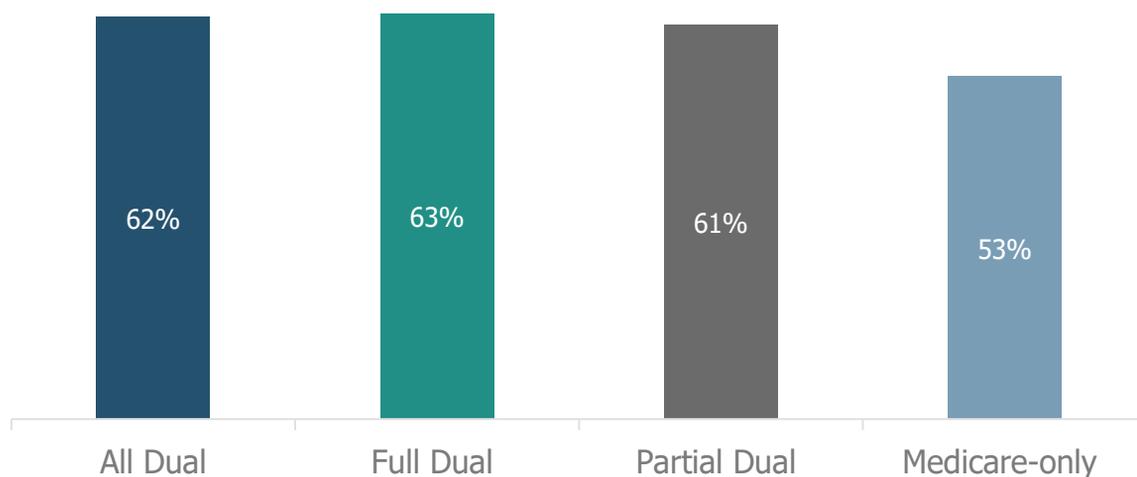
Of 64.2 million Medicare beneficiaries,¹ nearly 12 million are dual beneficiaries enrolled in both Medicare and Medicaid. Seven out of ten dual beneficiaries are eligible for full Medicaid benefits, while the remaining three out of ten receive partial benefits. Dual beneficiaries are demographically distinct from the broader Medicare population. Compared to Medicare-only beneficiaries, dual beneficiaries are more likely to be:



As detailed in each section that follows, these unique demographic characteristics demonstrate a strong need for culturally competent and holistic models that expand beyond medical needs.

Dual Beneficiaries Are More Likely to Identify as Female Than Medicare-Only Beneficiaries

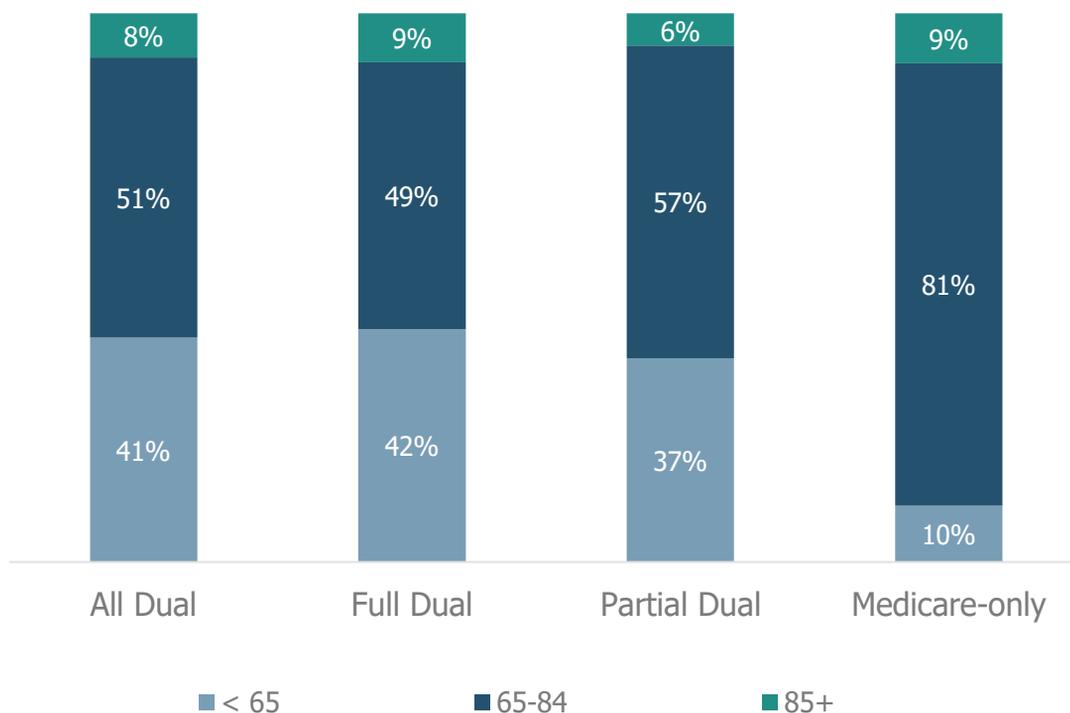
Percent of Medicare Beneficiaries that Identify as Female by Dual Status



- A greater proportion of dual beneficiaries identify as female compared to Medicare-only beneficiaries. Older women and women with disabilities have specific healthcare needs that should be considered when designing programs for dual beneficiaries.
- Compared to older men, older women are more likely to have arthritis, osteoporosis, high blood pressure, and cognitive impairment. Furthermore, female dual beneficiaries may face greater financial insecurity than their male counterparts due to receiving less Social Security income as a result of working lower-paying jobs or reducing time in the workforce to care for others.¹
- Women with disabilities are more likely to experience frequent mental distress than men with disabilities and are more likely to experience disparities in healthcare access compared to women without disabilities.

Dual Beneficiaries Are More Likely to be Under Age 65 Than Medicare-Only Beneficiaries

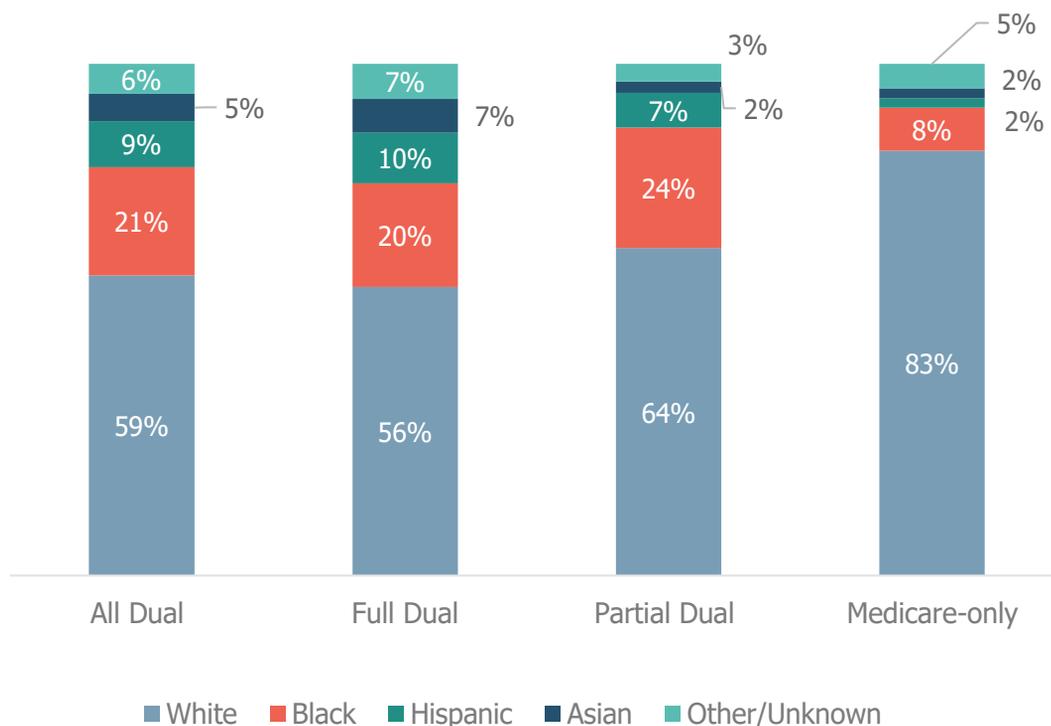
Age of Medicare Beneficiaries by Dual Status



- Dual beneficiaries, particularly full dual beneficiaries, are disproportionately younger than Medicare-only beneficiaries.
- Dual beneficiaries under 65 are entitled to Medicare when they receive Social Security or Railroad Retirement Board disability benefits for at least 25 months. Younger dual beneficiaries are more likely to be male and Black or Hispanic.¹
- Programs designed to serve dual beneficiaries must reflect this heterogeneity in age and disability status among dual beneficiaries and their care needs. Typical Medicare and Medicaid care models are not sufficient to meet the full spectrum of dual beneficiary needs. For example, Medicare programs often focus on an older adult population, while Medicaid program design may target population cohorts separately (e.g., children separate from young adults separate from older adults).

Dual Beneficiaries Are More Diverse Than Medicare-Only Beneficiaries

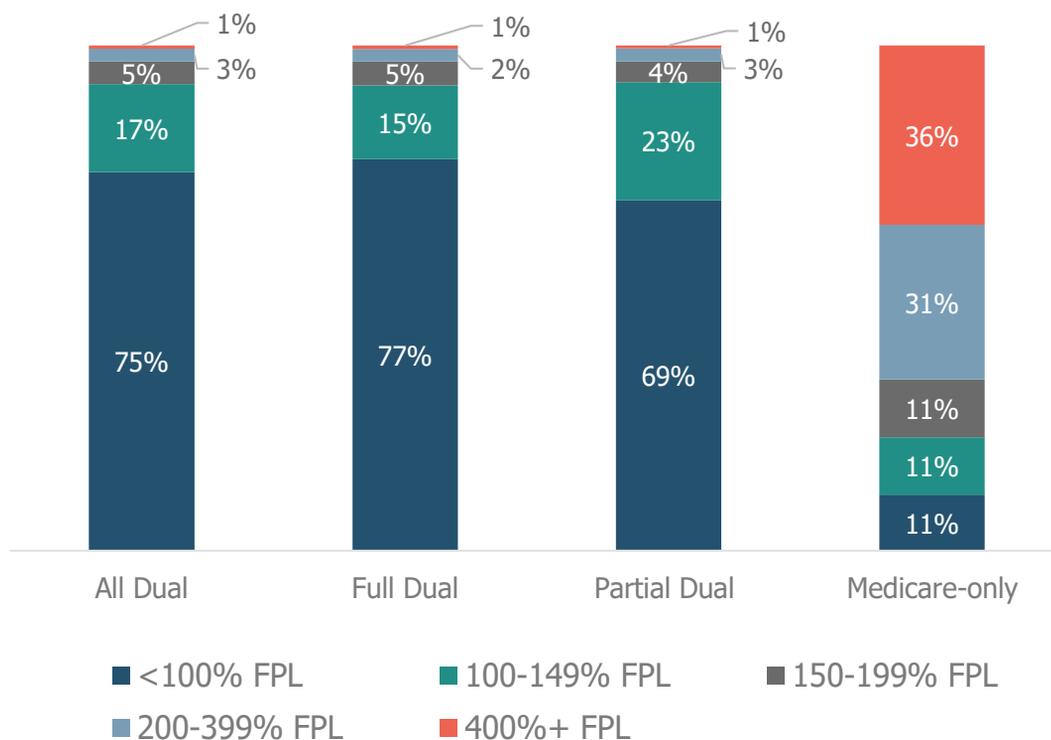
Race and Ethnicity of Medicare Beneficiaries by Dual Status



- Dual beneficiaries are more likely to be Black or Hispanic than Medicare-only beneficiaries. It is important to consider the impact of systemic racism as well as the cultural differences that shape beneficiaries' experiences when interacting with the healthcare system.
- Person-centered and culturally humble approaches are critical for advancing equitable access and outcomes. Policies, providers, and programs impacting dual beneficiaries must build in health equity as a foundational priority.

Dual Beneficiaries Are Far More Likely to Live in Poverty Than Medicare-Only Beneficiaries

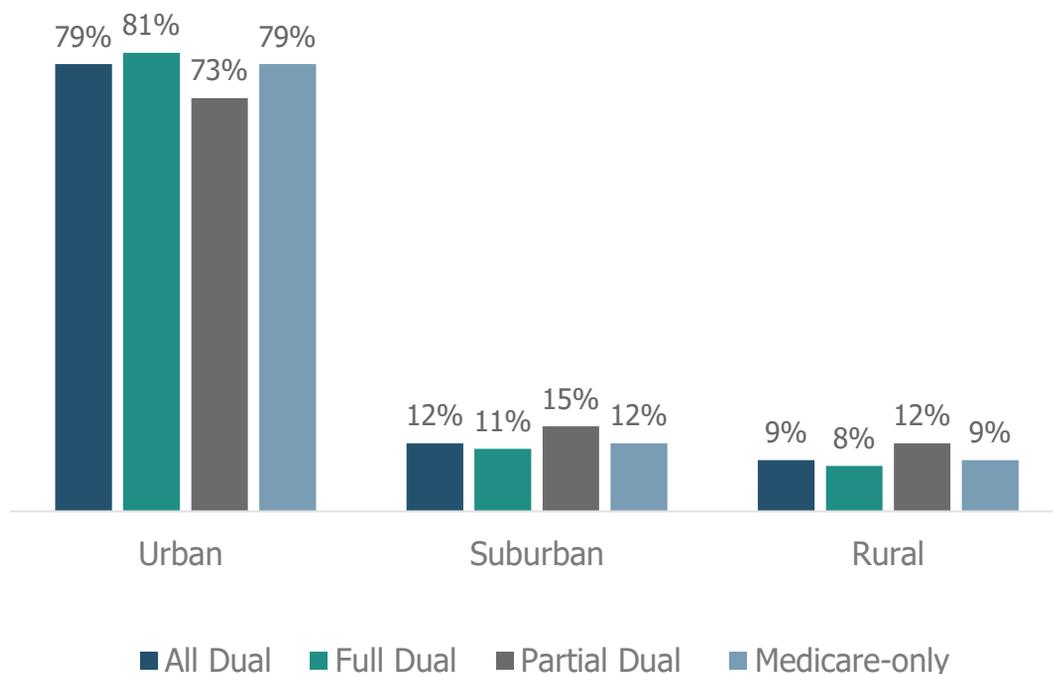
Income Relative to Federal Poverty Level (FPL) of Medicare Beneficiaries by Dual Status



- As of 2022, the federal poverty level (FPL) for one person is \$13,590 per year, and for a family of two is \$18,310 per year.¹ Dual beneficiaries, due to the nature of Medicaid eligibility requirements, are far more likely than Medicare-only beneficiaries to have an annual income below the FPL.
- Annual income is strongly associated with unmet social needs and increased morbidity and mortality.² Income-related health disparities appear to be growing over time.³
- Non-primarily health-related supplemental benefits offered by Medicare Advantage plans can play an important role in addressing the social needs and improving the overall health of dually eligible beneficiaries.

One in Five Medicare Beneficiaries Live in Rural or Suburban Areas, Which May Bring Access Challenges

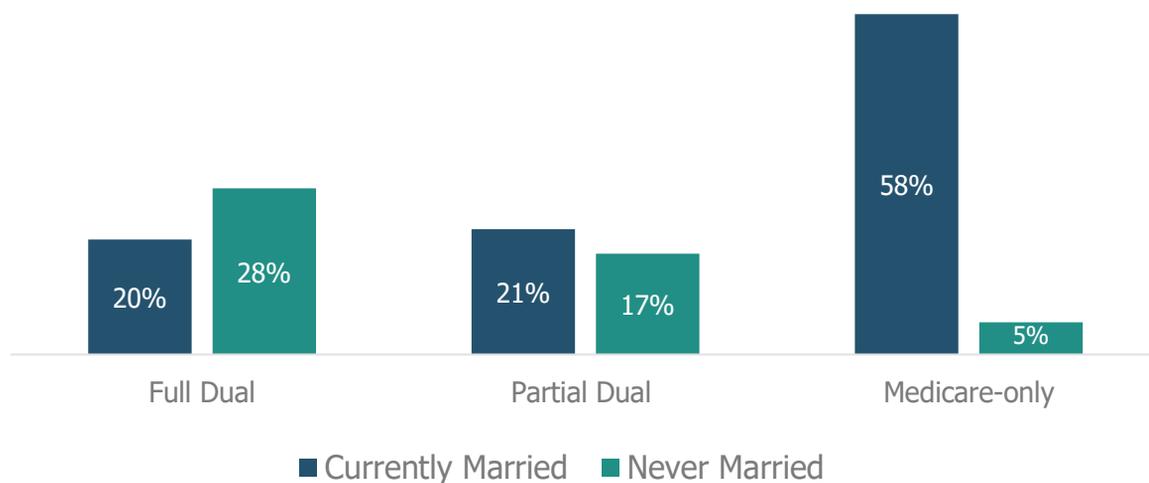
Percent of Medicare Beneficiaries Living Urban, Suburban, or Rural Areas by Dual Status



- Four in five Medicare beneficiaries (dual and Medicare-only) live in urban areas, but a remaining one in five live in suburban or rural areas.
- Partial dual beneficiaries are somewhat less likely than full dual beneficiaries and Medicare-only beneficiaries to live in urban areas.
- Beneficiaries in suburban and rural areas may experience more challenges in accessing specialized healthcare services when needed and may have less access to public transportation and job opportunities. Such challenges may be particularly impactful for dual beneficiaries due to their lower incomes.

Dual Beneficiaries Are Less Likely to Be Married Currently or to Have Ever Been Married Than Medicare-Only Beneficiaries

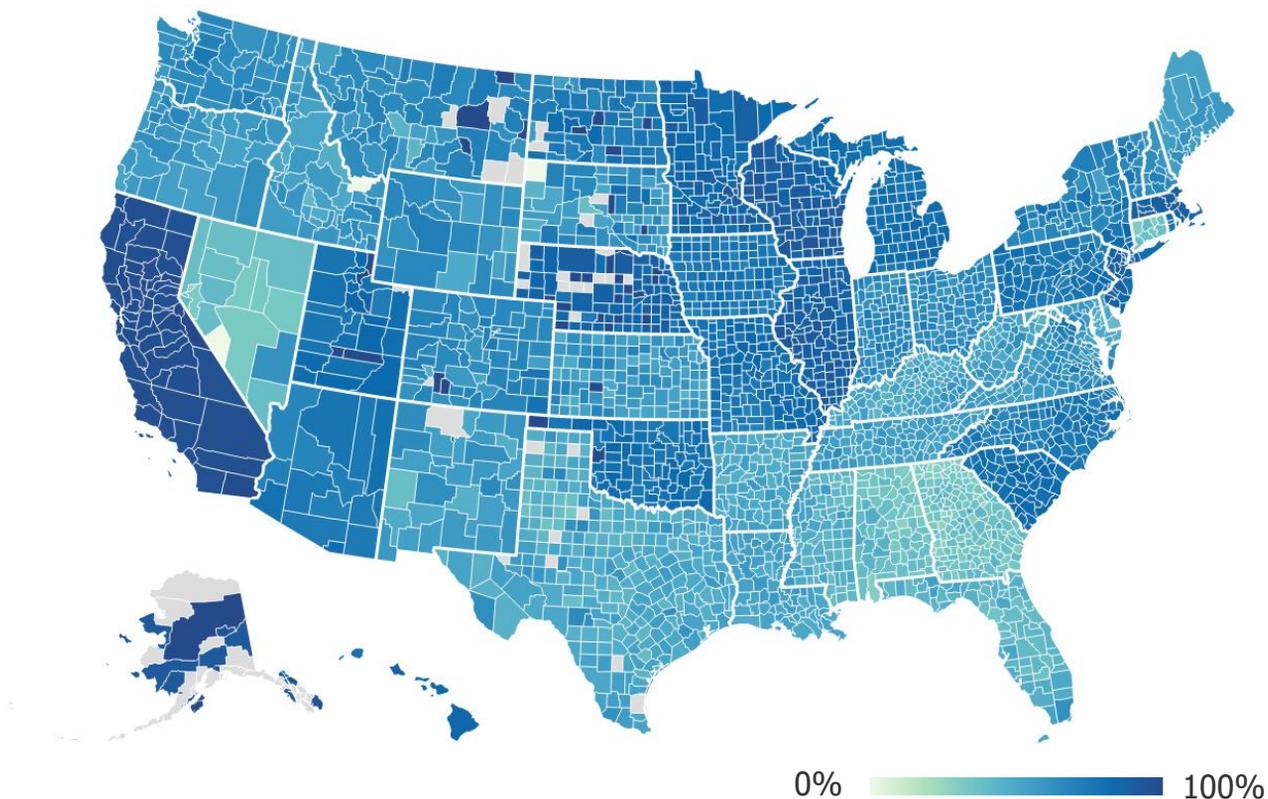
Marital Status of Medicare Beneficiaries by Dual Status



- Dual beneficiaries are far less likely than Medicare-only beneficiaries to be currently married. Those needing help with [Instrumental] Activities of Daily Living (IADLs or ADLs) may face challenges in accessing non-spousal informal supports to continue living in the community, a particularly salient concern for partial dual beneficiaries who cannot access Medicaid long-term services and supports (LTSS).
- Marital status is related to utilization as well; married Medicare beneficiaries are less likely to use inpatient care or skilled nursing facilities and more likely to use outpatient care.¹
- Dual beneficiaries are also far less likely to have ever been married. Depending on state eligibility requirements for Medicaid LTSS, some dual beneficiaries may choose not to marry or may divorce to obtain or maintain Medicaid benefits.

Most Dual Beneficiaries Qualify for “Full” Medicaid Benefits, but Eligibility Varies Considerably Nationwide

Percent of Dual Beneficiaries Receiving Full Benefits (Not Partial Dual Beneficiary) by County

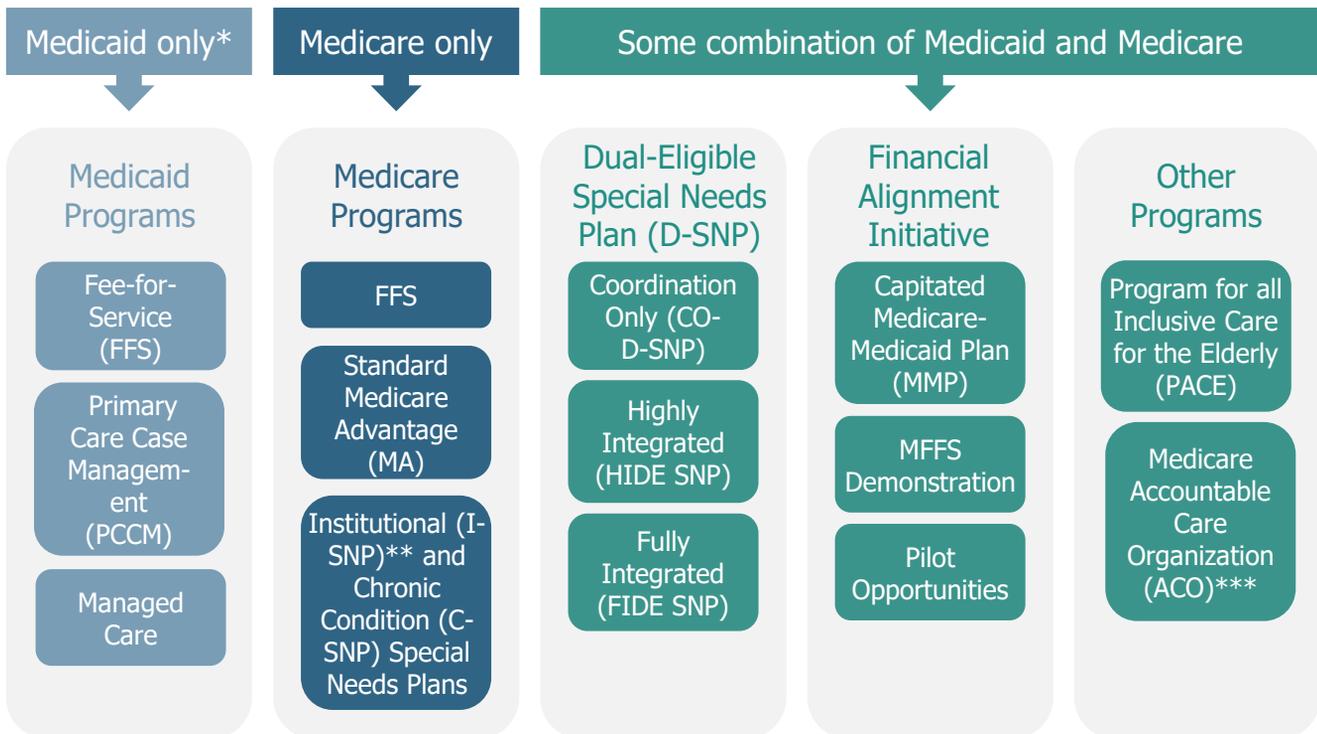


- Full dual beneficiaries meet state Medicaid eligibility criteria to receive full Medicaid benefits such as behavioral health services and LTSS. Partial dual beneficiaries may have behavioral health and LTSS needs, but only qualify for Medicaid (eligibility criteria vary by state) to pay some portion of their Medicare out-of-pocket expenses and do not receive Medicaid BH or LTSS.
- Integrated approaches for dual beneficiaries tend to focus on full dual beneficiaries but partial dual beneficiaries often have similar social and health needs. Partial dual beneficiaries may be unable to access high-touch care integrated models available to full dual beneficiaries. Alternatives should be considered that meet their high level of need.

Delivery System Access

Key Takeaways

Dual beneficiaries have access to many different combinations of Medicaid and Medicare coverage (at least [43 combinations](#) exist across the programs in the visual below, with [more than 100 options](#) available in some counties). Certain programs are designed to create a meaningfully integrated beneficiary experience. However, only half of dual beneficiaries have access to these integrated programs and seven percent of full dual beneficiaries are enrolled in them. Access to a meaningfully integrated health plan varies widely by state and rurality, but not by race and ethnicity.



* Medicaid programs can be coupled with Medicare; typically occurs through D-SNP

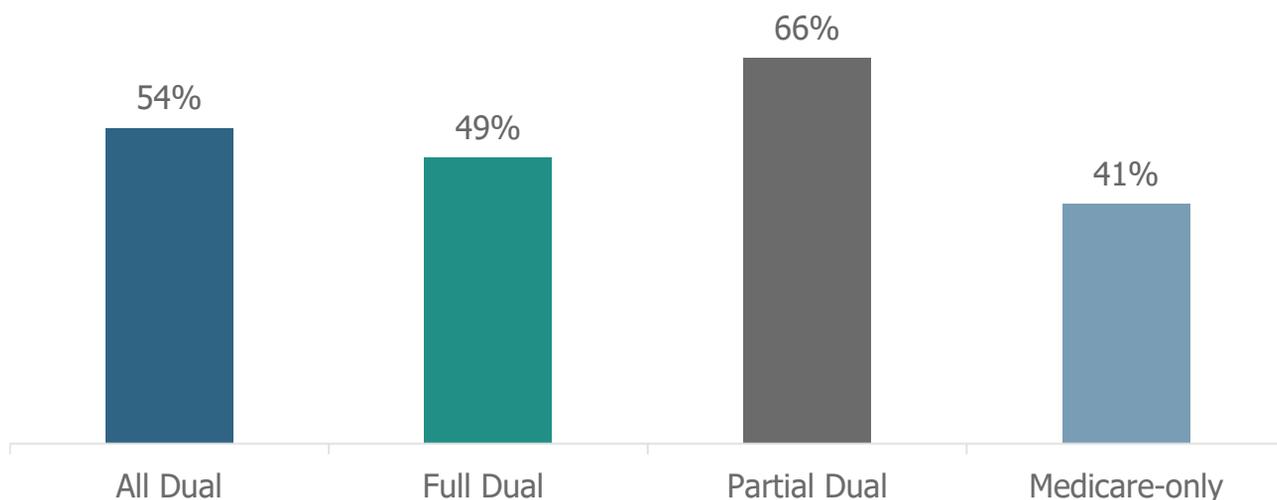
** States are beginning to explore I-SNP and Medicaid collaboration

*** The Medicare ACO Reach model has potential to collaborate with Medicaid

As detailed in each section that follows, the wide variation in dual beneficiaries' access to and enrollment in integrated health plans across geography points to the importance of expanding integrated models.

Dual Beneficiaries Are More Likely to Enroll in Medicare Advantage Plan Than Medicare-Only Beneficiaries

Percent of Beneficiaries Enrolled in Medicare Advantage, by Dual Status



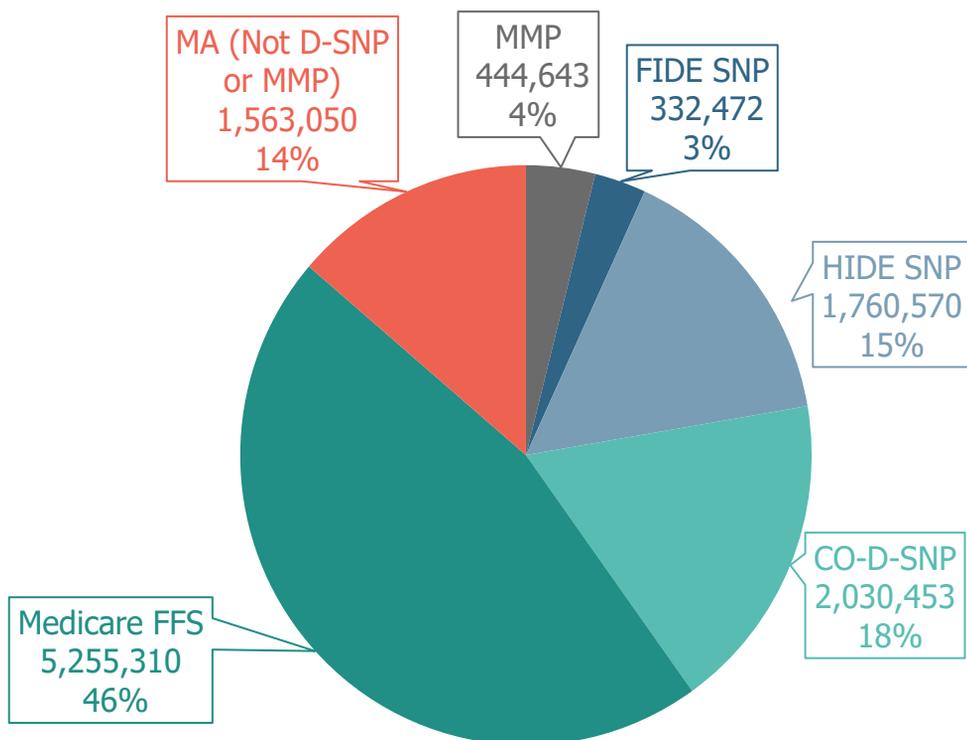
- Historically, dual beneficiaries were less likely to enroll in Medicare Advantage than Medicare-only beneficiaries, but, in recent years, this trend has changed as a result of broadened Medicare Advantage supplemental benefits and growth of D-SNP availability.
- Because it serves over half of dual beneficiaries, Medicare Advantage has unprecedented opportunity to support the unique needs of these individuals. Policies that redesign Medicare Advantage should consider the impact on dual beneficiaries as the program increasingly plays an important role in their outcomes.

Medicare Advantage Enrollment Rate by Geography

	Dual Beneficiaries	Full Dual Beneficiaries	Partial Dual Beneficiaries	Medicare-only Beneficiaries
Urban	56%	52%	69%	43%
Suburban	47%	40%	58%	38%
Rural	41%	35%	53%	30%

While Meaningfully Integrated Products Are Available to Half of Dual Beneficiaries, Only Seven Percent Are Enrolled

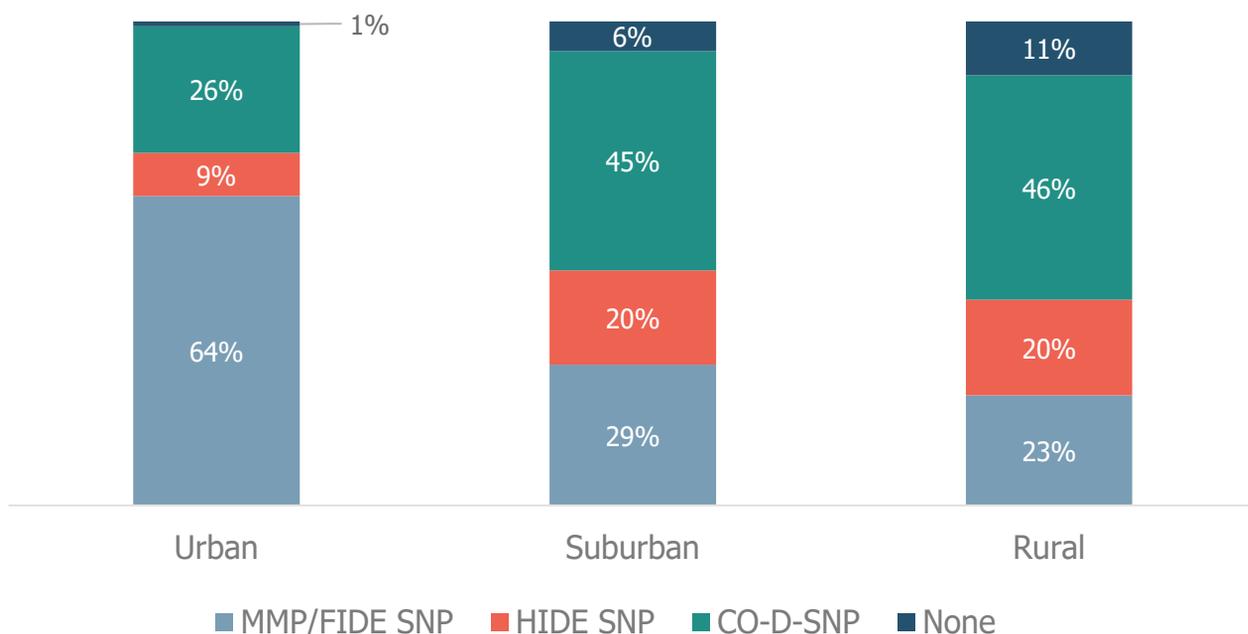
Rate of Enrollment of all Dual Beneficiaries in Integrated Products



- Approximately 14% of dual beneficiaries are enrolled in a Medicare Advantage plan that is not a D-SNP. Some of these plans are D-SNP “look-alikes” that advertise to dual beneficiaries but do not provide integrated care.
- Enrollment channels and incentives should encourage dual beneficiaries to choose meaningfully integrated products. State Health Insurance Assistance Programs (SHIP) representatives and other enrollment support entities should be trained on the value of integrated care and how to best advise dual beneficiaries.

Beneficiaries Living in Rural Counties Are Less Likely to Have Access to Integrated Products

Percent of Full Dual beneficiaries by Most Integrated Product in County



- Full dual beneficiaries in urban counties are nearly three times more likely than those in rural counties to have a FIDE SNP or MMP offered in their county. Only one in four full dual beneficiaries in rural counties can enroll in a meaningfully integrated product.
- Policymakers have an opportunity to evaluate barriers to integrated program offerings in rural communities and determine whether incentives or other policy approaches can expand access.
- Access to integrated products varies less by race and ethnicity than by geography. Rates of access are lowest among Black full dual beneficiaries and highest among Hispanic full dual beneficiaries.

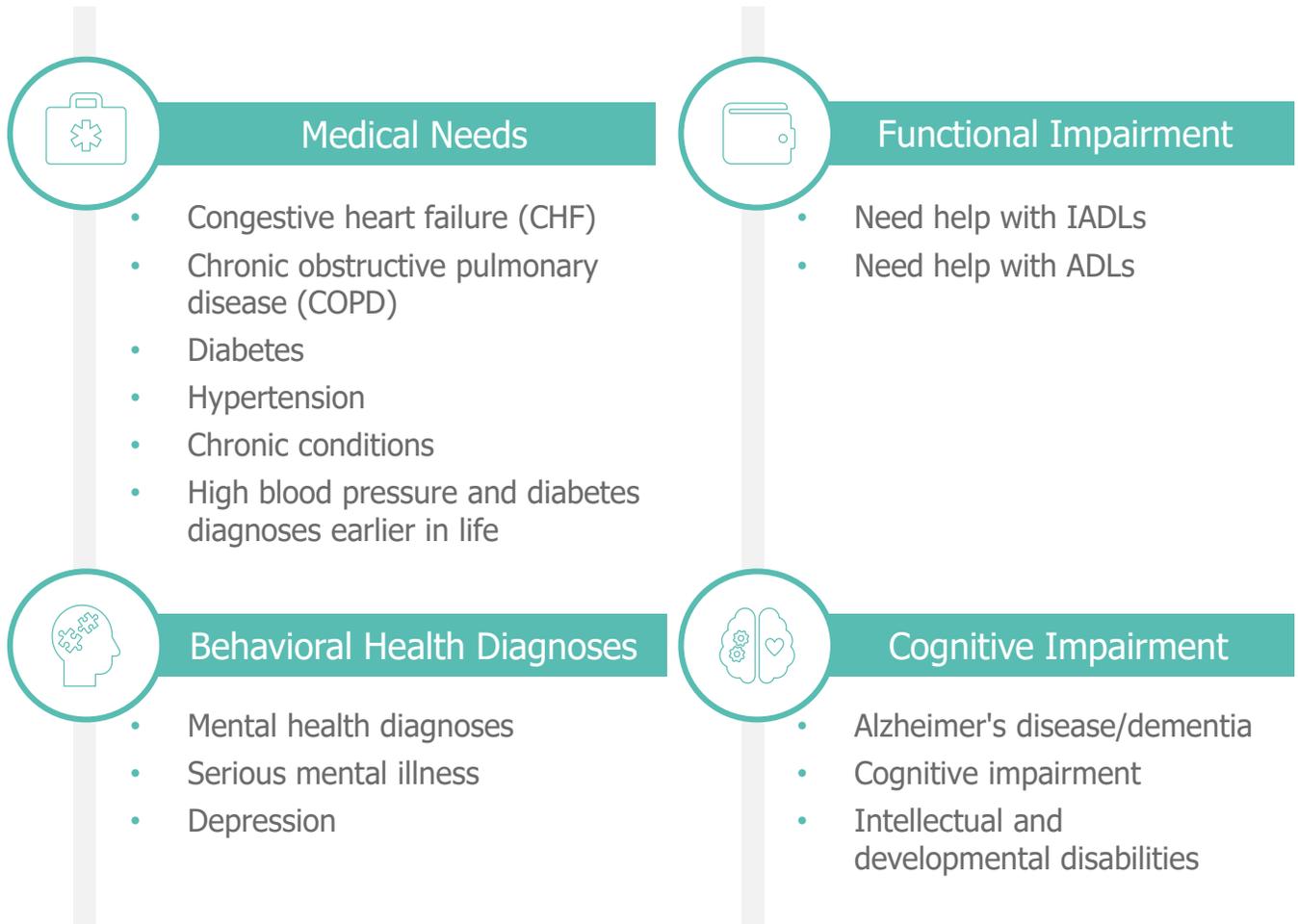
Percent of Full Dual Beneficiaries with Access to Integrated Product

	White	Black	Hispanic	Other
MMP or FIDE SNP	56%	51%	69%	47%

Health Status

Key Takeaways

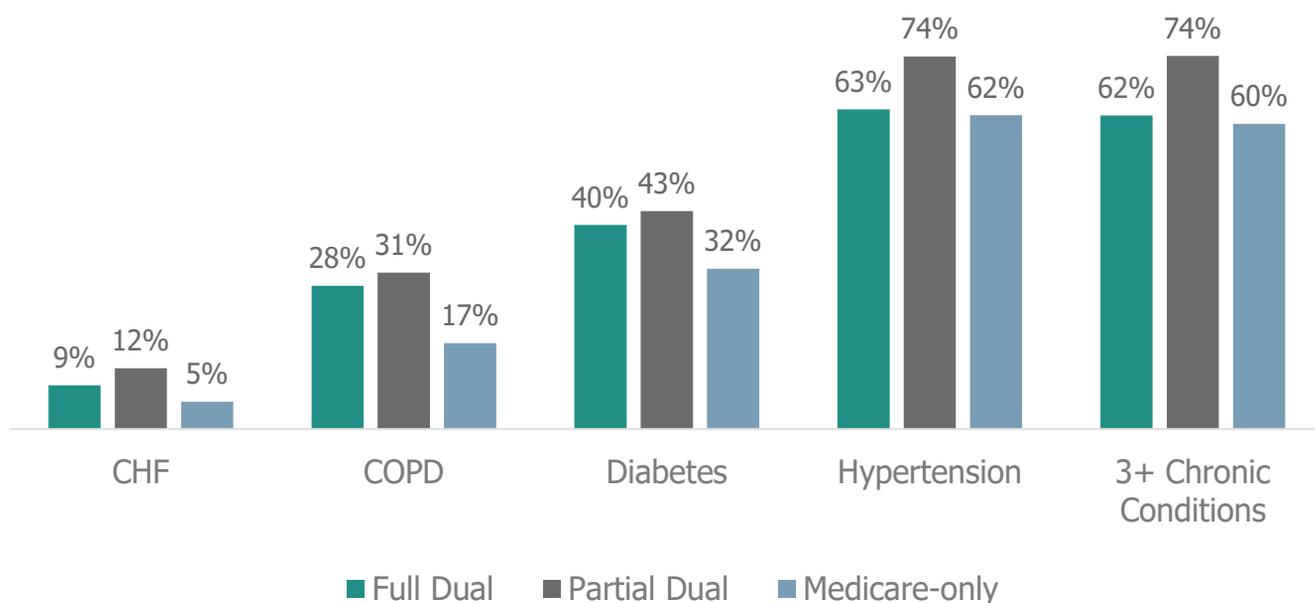
Given the interaction between social, functional, and medical needs, dual beneficiaries tend to require higher-touch programs that can integrate services across these needs. This interaction of needs coupled with fragmented delivery systems results in higher costs to both the Medicare and Medicaid programs. Dual beneficiaries are likely to experience:



As detailed in each section that follows, the complex care needs of dual beneficiaries underscore the need for integrated and high-touch healthcare.

Dual Beneficiaries Have More Chronic Conditions Than Medicare-Only Beneficiaries

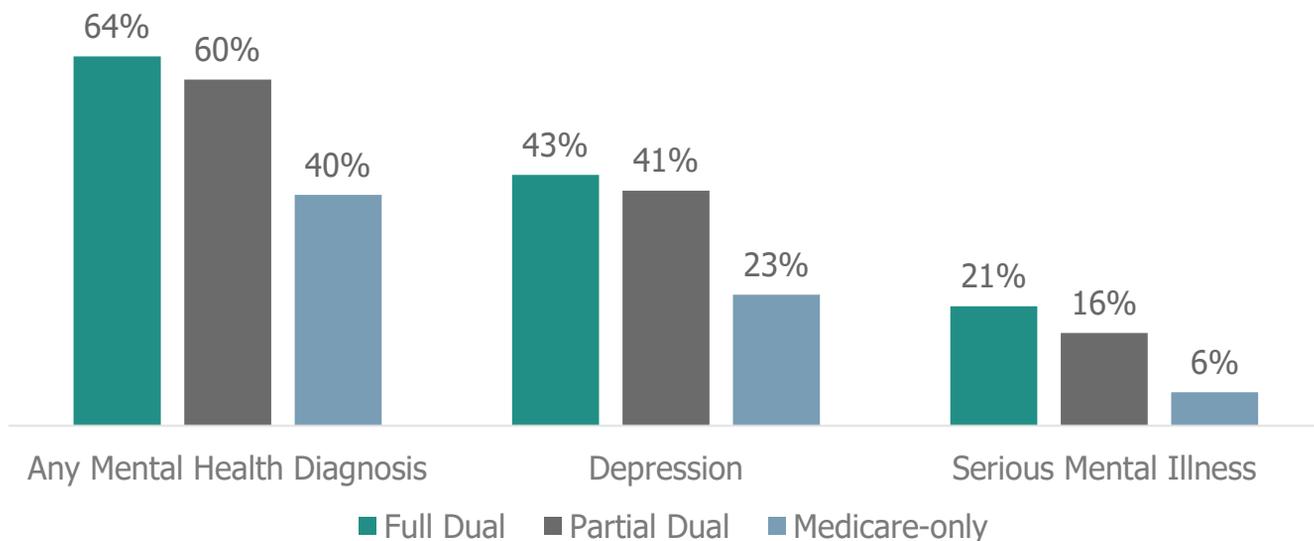
Rates of Select Health Conditions Among Medicare Beneficiaries by Dual Status



- Dual beneficiaries, particularly partial dual beneficiaries, have higher rates of chronic conditions such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, and hypertension (high blood pressure) than Medicare-only beneficiaries.
- Higher rates of chronic disease are linked to more frequent hospital visits, greater prescription drug use, and can impact quality of life and mental health. The risk of an avoidable hospitalization (for conditions that can more appropriately be treated in primary care settings) increases by a factor of 1.35 for each additional chronic condition.¹
- Due to this higher disease burden, dual beneficiaries stand to benefit from integrated high-touch models of care that include seamless and personalized care coordination to comprehensively manage chronic conditions.
- Additionally, interactions between medical chronic conditions and functional needs (ADLs) can drive up system costs, and thus would benefit from strong integration across programs serving these needs.

Dual Beneficiaries Experience Higher Rates of Behavioral Health Diagnoses Than Medicare-Only Beneficiaries

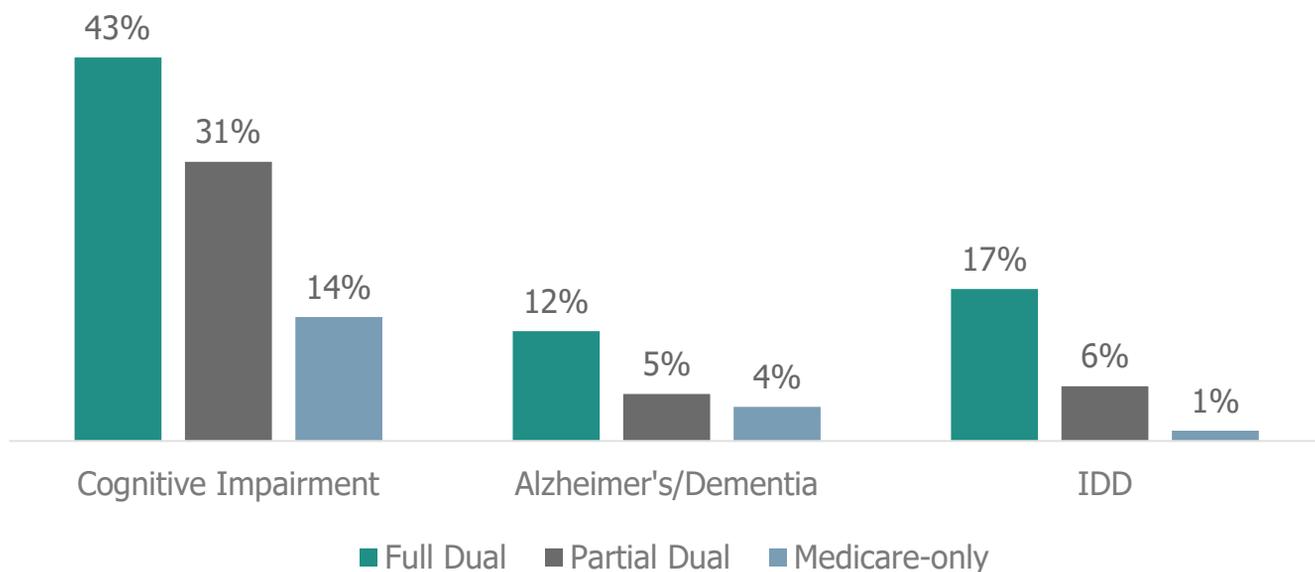
Rates of Behavioral Health Diagnoses Among Medicare Beneficiaries by Duals Status



- Dual beneficiaries, particularly full dual beneficiaries, have higher rates of depression and serious mental illness compared to Medicare-only beneficiaries. Among full dual beneficiaries, rates of depression are nearly two times higher, and rates of serious mental illness are over three times higher.
- Behavioral health is often carved out of state Medicaid managed care programs. When Medicaid benefits are not effectively integrated with Medicare, dual beneficiaries may experience barriers to coordinated physical and behavioral healthcare. Dual beneficiaries need access to holistic program design with limited Medicaid carve-outs, integration of physical health and behavioral health care, and access to crisis services during mental health emergencies.
- Partial dual beneficiaries also experience high rates of behavioral health needs but do not have access to Medicaid-covered behavioral health services.

Dual Beneficiaries Are More Likely to Have Cognitive Needs Than Medicare-Only Beneficiaries

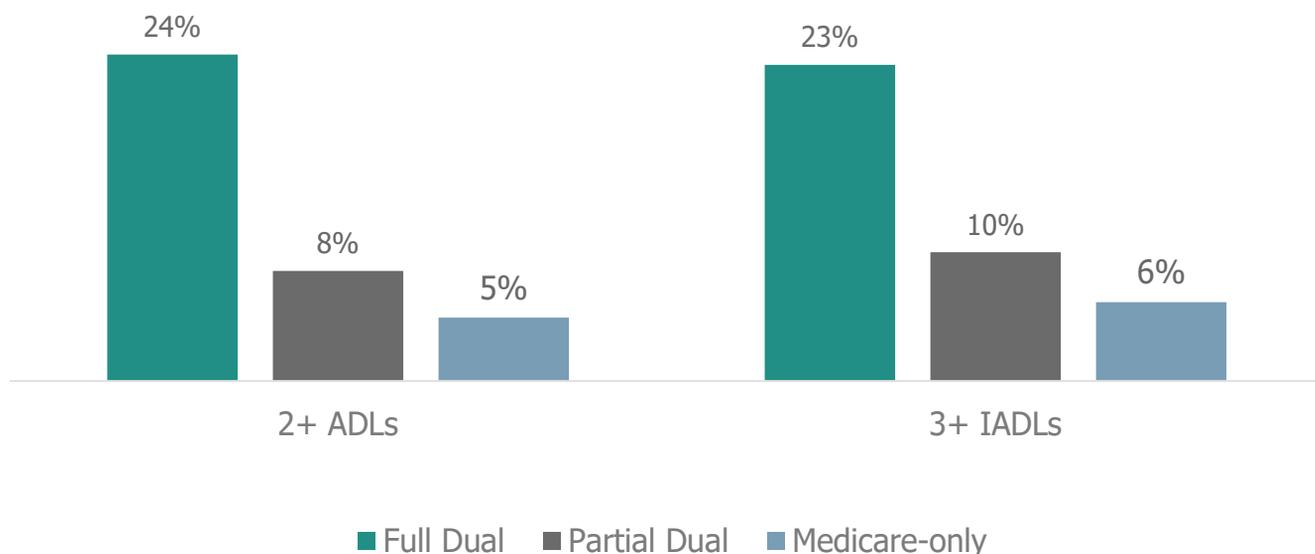
Rates of Cognitive Needs Among Medicare Beneficiaries by Duals Status



- Compared to Medicare-only beneficiaries, full dual beneficiaries are three times more likely to experience cognitive impairment as well as Alzheimer's disease and other dementias. Partial dual beneficiaries are over two times as likely to experience cognitive impairment than are Medicare-only beneficiaries.
- Both full and partial dual beneficiaries are considerably more likely than Medicare-only beneficiaries to experience intellectual or developmental disabilities (IDD), at 17 times and 6 times more likely, respectively.
- Individuals with cognitive needs often require assistance with everyday activities such as bathing, dressing, managing medications, managing finances, and shopping. Holistic program design where LTSS are meaningfully integrated with Medicare-covered benefits is critical for dual beneficiary quality of life, health outcomes, and ability to avoid unnecessary long-term institutional care.
- Partial dual beneficiaries do not have a systematic way to access LTSS, as they do not qualify in their state for full dual Medicaid-covered services.

Full Dual Beneficiaries Are More Likely to Need Help with Daily Tasks Than Medicare-Only Beneficiaries

Percent of Medicare Beneficiaries with ADL and IADL Limitations by Dual Status

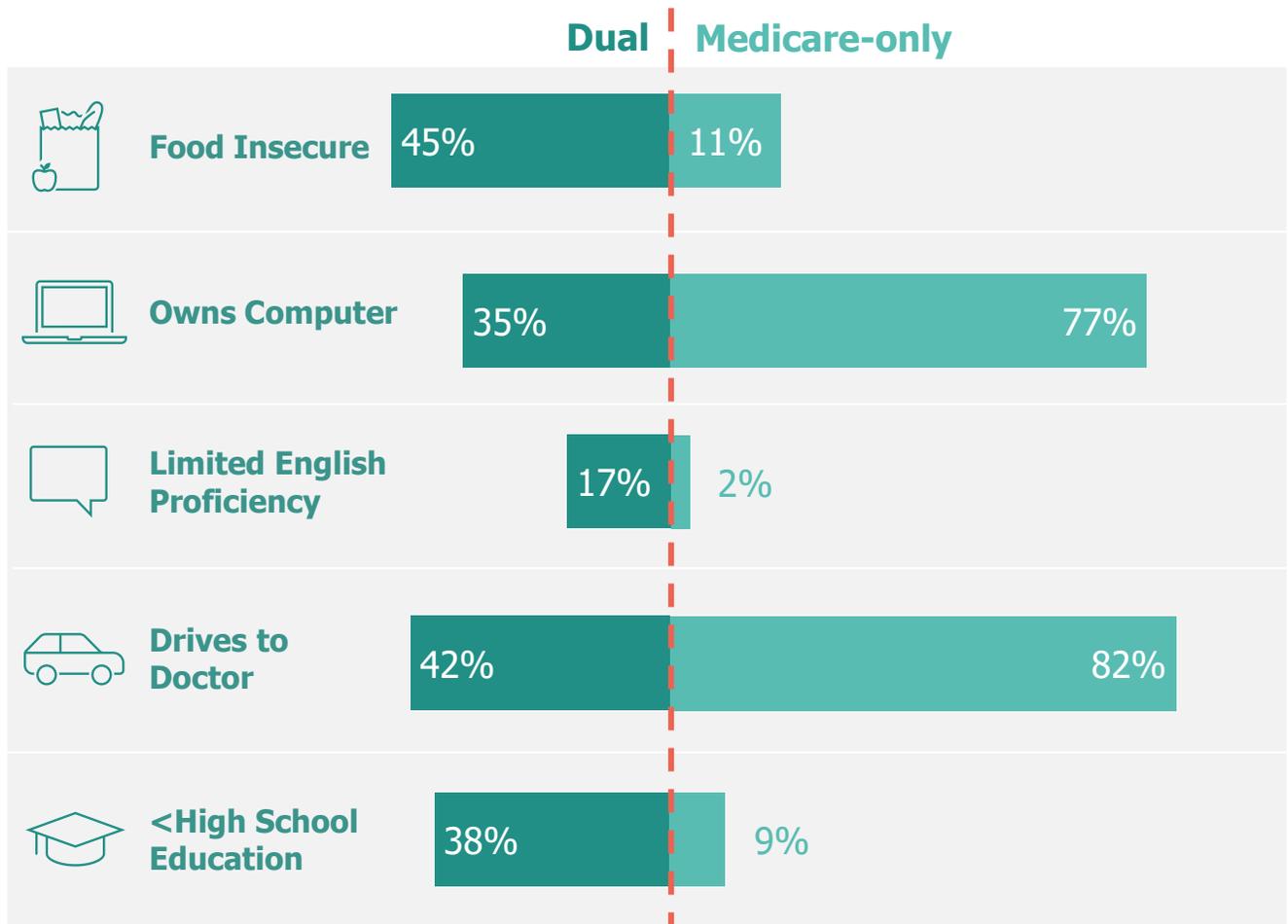


- ADLs are self-care tasks such as bathing, toilet hygiene, and eating. IADLs are tasks done each day to care for self and home such as housework, preparing meals, and managing medications and personal finances. Support for those daily needs is critical to helping beneficiaries remain in their home.
- LTSS care is siloed in Medicaid and acute care in Medicare. As assistance with daily tasks impact beneficiaries' health directly, coordination of Medicare and Medicaid is critically important for those with ADL and IADL needs.
- Compared to Medicare-only beneficiaries, full dual beneficiaries are approximately four times more likely to need help with ADL and IADL limitations, and partial dual beneficiaries are nearly twice as likely to need help with these challenges. However, Medicaid level of need criteria (to determine beneficiary eligibility for LTSS) vary considerably across states resulting in inequity in access to services.

Social Determinants of Health

Key Takeaways

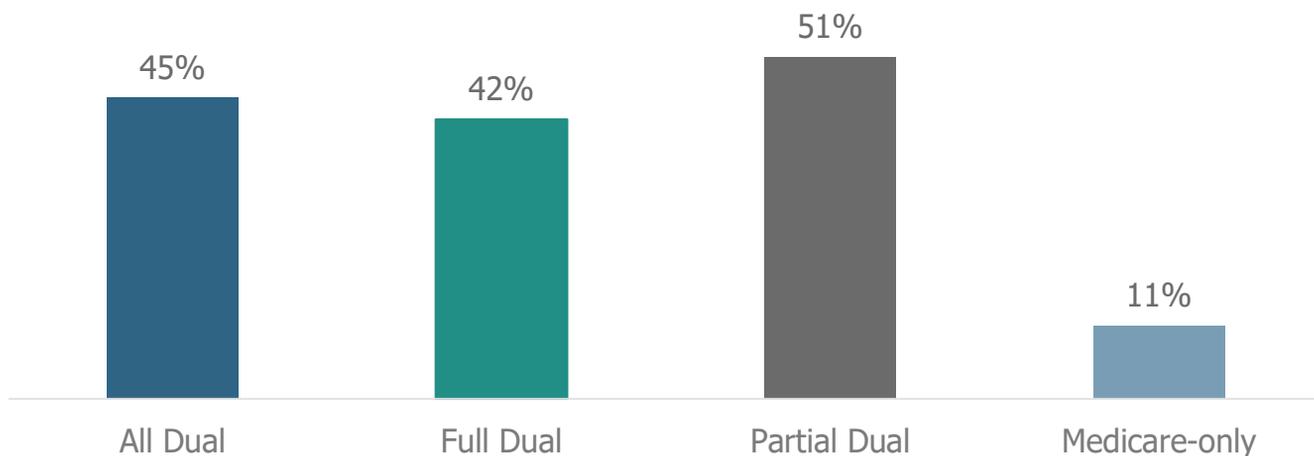
Social Determinants of Health (SDOH) are the “conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.”¹ Increased social risk factors and unmet social needs are a key driver of health disparities. Due to their lower income and resource levels, dual beneficiaries are at increased risk of having unmet social needs, for example:



As detailed in each section that follows, the wide-ranging social needs of dual beneficiaries illustrate the importance of whole-person care and linguistically accessible services and communications.

Dual Beneficiaries are Four Times More Likely to Experience Food Insecurity Than Medicare-Only Beneficiaries

Rates of Food Insecurity Among Medicare Beneficiaries by Dual Status



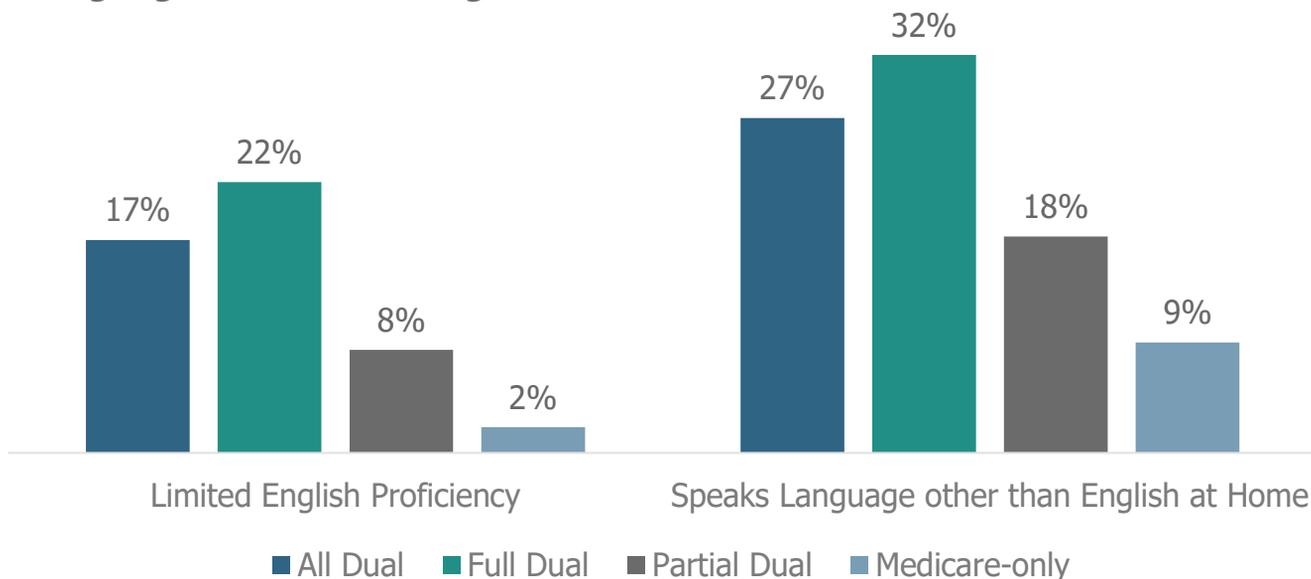
- Food insecurity is defined as the “lack of consistent access to enough food for an active, healthy life” by the US Department of Agriculture. Dual beneficiaries are disproportionately likely to experience food insecurity, which is linked to higher rates of high blood pressure, diabetes, cardiovascular disease, and stroke.¹ As shown below, beneficiaries with food insecurity are also more likely to use the emergency department.
- Supplemental benefits (e.g., food and produce, meals), offered by Medicare Advantage plans, including D-SNPs, can provide meaningful supports to dual beneficiaries by bolstering regular access to foods that are affordable and appropriate for dietary needs.

Percent of Beneficiaries with One or More Emergency Department Visits per Year

	Dual Beneficiaries	Full Dual Beneficiaries	Partial Dual Beneficiaries	Medicare-only Beneficiaries
Food Insecure	34%	33%	36%	27%
Not Food Insecure	27%	28%	27%	16%

Dual Beneficiaries are Less Likely to Speak English Fluently or at Home Than Medicare-Only Beneficiaries

Percent of Beneficiaries With Limited English Proficiency or Who Speak a Language Other Than English at Home



- Compared to Medicare-only beneficiaries, dual beneficiaries are three times more likely to speak a language other than English at home and nine times more likely to have limited English fluency.
- Across dual and Medicare-only beneficiaries, individuals who do not speak English well report finding Medicare harder to understand than those who do speak English well. It is important that coverage and health education materials be provided in the beneficiary’s preferred language and that beneficiaries can access culturally competent providers and translation services as needed.

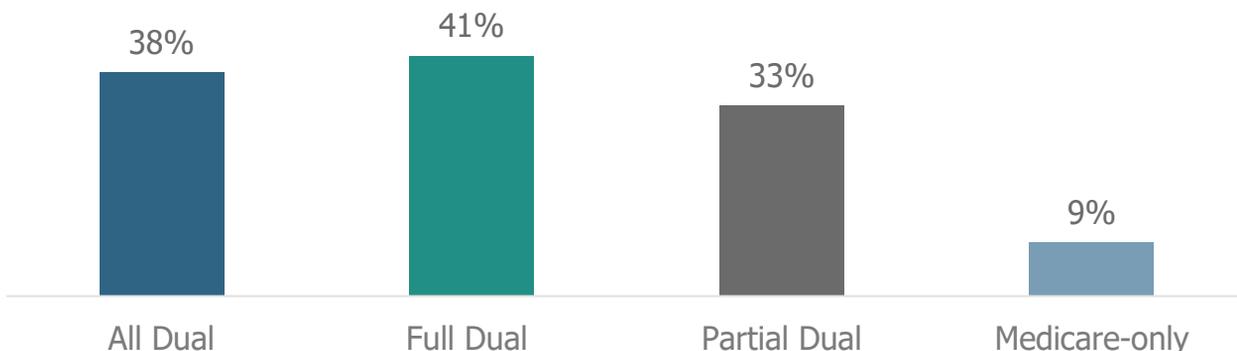
Percent of Medicare Beneficiaries who Respond that Medicare is “Easy” or “Somewhat Easy” to Understand



Source: 2019 Medicare Current Beneficiary Survey. Note: Limited English proficiency includes beneficiaries who report speaking English “not at all” or “not well” and excludes those who report speaking English “well” or “very well.”

Dual Beneficiaries Are Four Times More Likely Than Medicare-Only Beneficiaries to Have Less Than a High School Education

Percent of Medicare Beneficiaries with Less Than a High School Education



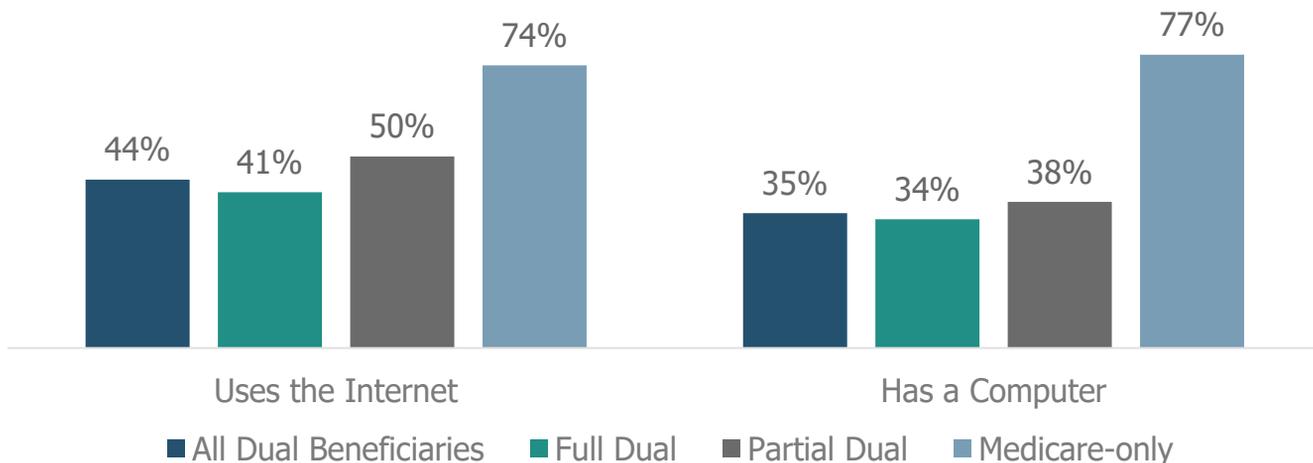
- Compared to Medicare-only beneficiaries, dual beneficiaries are over four times as likely to have not completed high school. Lower educational attainment is associated with shorter lifespans¹ and higher rates of emergency room use (see table below), particularly for partial dual beneficiaries.
- Individuals with lower educational attainment are more likely to have low health literacy - the ability to understand and use health information to make appropriate health decisions.² Low health literacy is associated with higher healthcare utilization and expenditures.³
- Programs inclusive of health literacy interventions are particularly important for dual beneficiaries. The use of easy to understand written and visual materials, video tutorials, and health literacy training for physicians is associated with increases in the appropriate use of health care services.⁴

Percent of Beneficiaries with One or More Emergency Department Visits per Year

	Dual Beneficiaries	Full Dual Beneficiaries	Partial Dual Beneficiaries	Medicare-only Beneficiaries
Less than HS Education	37%	35%	42%	24%
At Least HS Education	33%	33%	32%	17%

Dual Beneficiaries Use Internet and Have Computers at Approximately Half the Rate of Medicare-Only Beneficiaries

Rates of Internet Usage and Computer Ownership of Medicare Beneficiaries by Dual Status



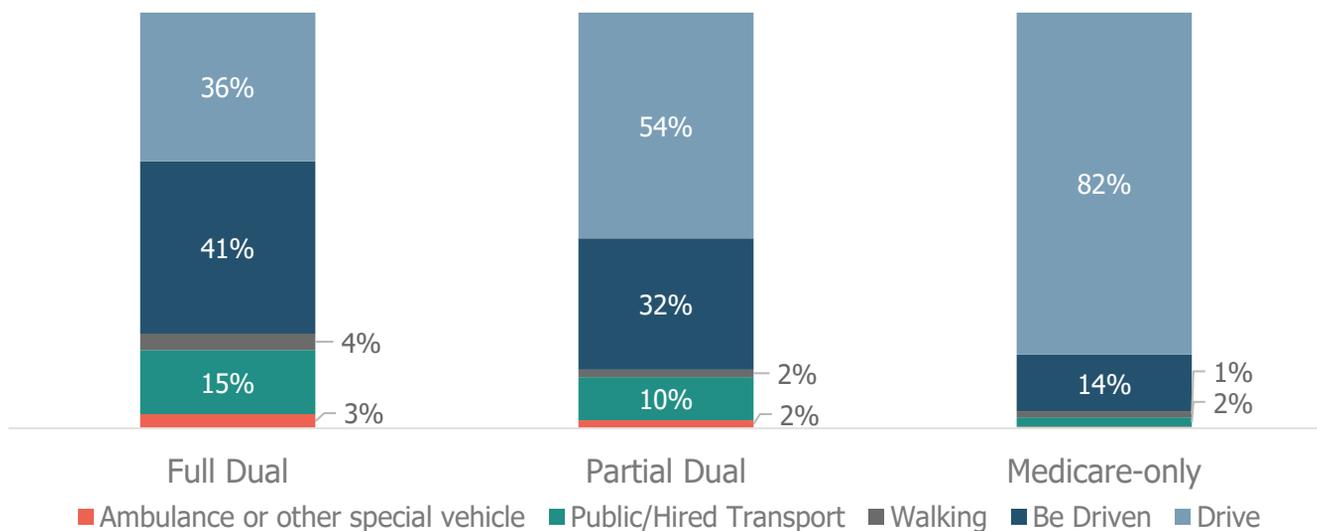
- Internet usage and computer ownership support telehealth use, access to health education and other resources, and social connectedness. During the pandemic, some dual beneficiaries were unable to access expanded video telehealth options.¹ Prioritization of reimbursement for audio-only telehealth could support equitable access to telehealth going forward.
- Devices provided by Medicare supplemental benefits or Home and Community Based Services (HCBS) that are used for clinical purposes could be used for social connectedness and internet searching as well.
- Organizations communicating with dual beneficiaries, especially those over the age of 65 with markedly lower rates of internet use and computer ownership, should ensure that print and telephone-based resources are comparable to online resources in content and language/disability accessibility.

Internet Use and Computer Ownership by Dual Status and Age

	All Dual <65	All Dual 65+	Medicare-only <65	Medicare-only 65+
Uses Internet	64%	30%	77%	74%
Has Computer	48%	26%	70%	77%

Full Dual Beneficiaries More Likely to Rely on Others to Get to the Doctor Than Medicare-Only Beneficiaries

Beneficiaries' Transportation to the Doctor by Dual Status



- Dual beneficiaries are less likely to drive themselves to the doctor, even when compared to Medicare-only beneficiaries with the same level of need for support with daily tasks (ADLs). Dual beneficiaries are also most likely to rely on public transportation or hired transportation. Support for transportation needs, inclusive of those experiencing mobility challenges, is critical for dual beneficiaries who disproportionately rely on others for getting to medical care. This support might include D-SNP supplemental benefits or Medicaid covered transportation services, and should be integrated across the programs.

Transportation to Doctor by Dual Status and ADL Limitations

	Dual	Medicare-only	Dual 2 or More ADLs	Medicare-only 2 or More ADL
Drive	42%	82%	15%	32%
Be Driven	38%	14%	64%	64%
Public/Hired	14%	2%	10%	2%
Ambulance	3%	0%	8%	1%
Walk	3%	1%	2%	0%

Source: 2019 Medicare Current Beneficiary Survey. Notes: ADLs – Activities of Daily Living Limitations that a beneficiary needs help with; Due to rounding, percentages may not sum to 100%.

Living Environment & Caregiving

Key Takeaways

The environment in which a Medicare beneficiary lives and the strength of their social support network have major implications for their wellbeing and health outcomes.



Housing

Seventeen percent of full dual beneficiaries live in institutional or facility settings compared to three percent of partial and Medicare-only beneficiaries. Of beneficiaries living in the community, dual beneficiaries are three times less likely to own their home compared to Medicare-only beneficiaries.



Household Composition

Dual beneficiaries are more likely to live alone while Medicare-only beneficiaries are more likely to live with a spouse/partner only. This trend is not consistent across race/ethnicity. Among Black beneficiaries, but not Hispanic or white beneficiaries, dual beneficiaries are more likely to live alone than Medicare-only beneficiaries.



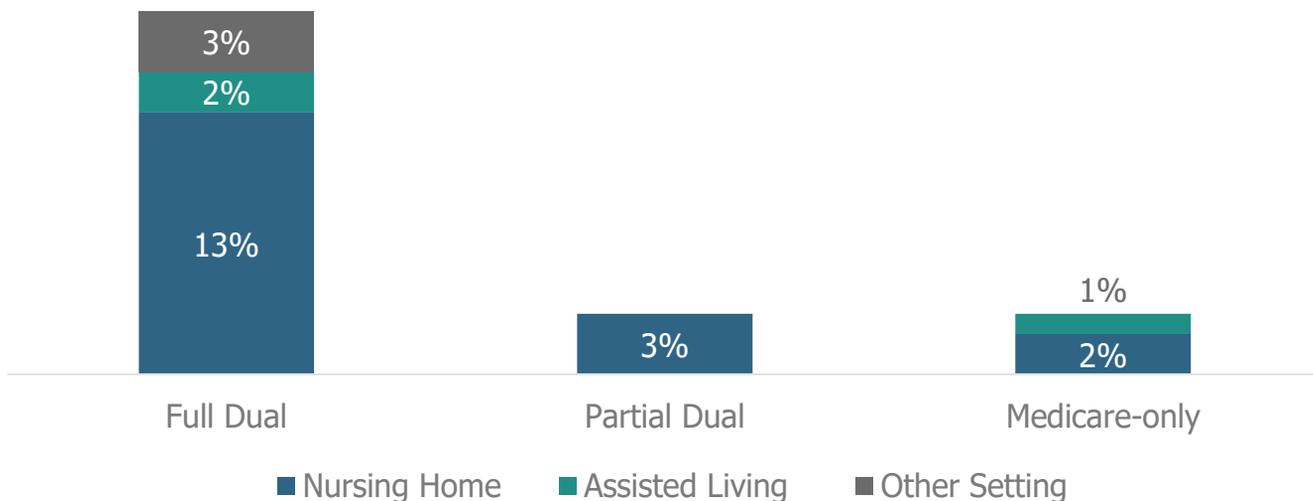
Caregivers

Medicare-only beneficiaries are more likely to be helped by a spouse/partner while dual beneficiaries are more likely to be helped by child/grandchild. Dual beneficiaries disproportionately rely on support from non-spouse female relatives.

As detailed in each section that follows, dual beneficiaries' living environments and use of informal caregiving supports differ in important ways from Medicare-only beneficiaries.

Nearly 1 in 5 Full Dual Beneficiaries Live in an Institutional or Facility Setting

Residential Setting of Medicare Beneficiaries by Dual Status



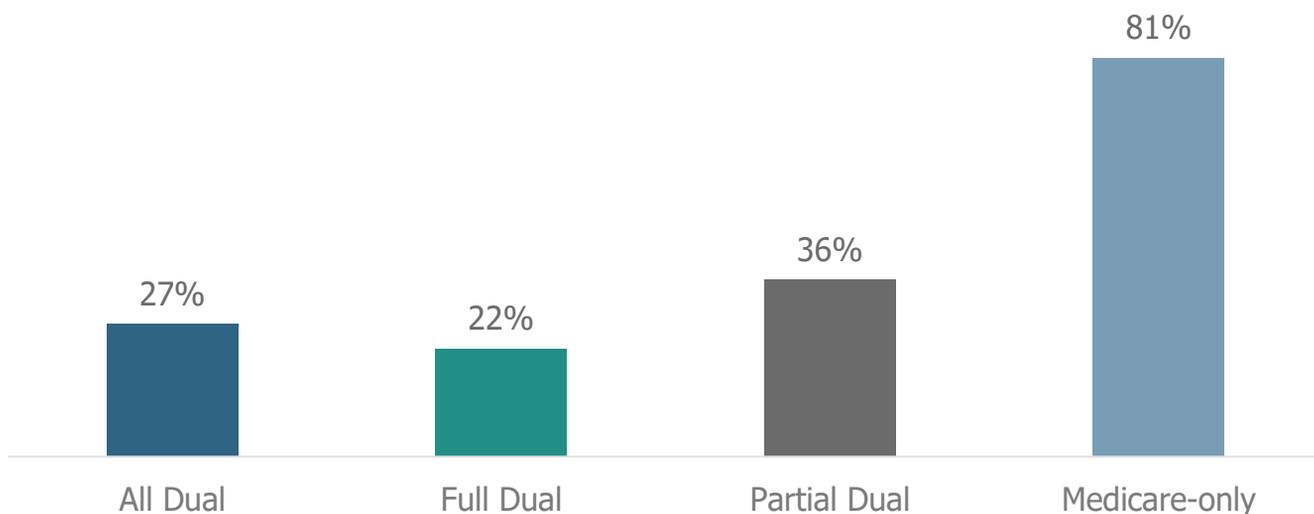
- Given the focus of integrated programs on helping an individual remain at home, meaningful integration differs for beneficiaries in the community versus a long-stay institutional or facility setting. Because nearly one in five dual beneficiaries lives in an institutional or facility setting, it is important to consider how Medicare and Medicaid can coordinate to serve these beneficiaries.
- Dual and Medicare-only beneficiaries with similar levels of functional need reside in institutional and facility settings at different rates. Dual beneficiaries with two or more ADLs are less than half as likely to be in assisted living facilities, likely as they are priced out of this setting. Because nursing homes are the only long-term care setting where room and board are covered, many dual beneficiaries are not able to independently afford assisted living, even if that setting would better match their care needs.

Residential Setting of Medicare Beneficiaries with 2+ ADLs

	Nursing Home	Assisted Living	Other Institutional or Facility Setting	Any Institutional or Facility Setting	Community
All Dual	37%	3%	6%	46%	54%
Medicare-only	15%	9%	3%	27%	73%

Community Dual Beneficiaries Are Three Time Less Likely to Own Their Homes as Medicare-Only Beneficiaries

Rates of Home Ownership of Medicare Beneficiaries by Dual Status



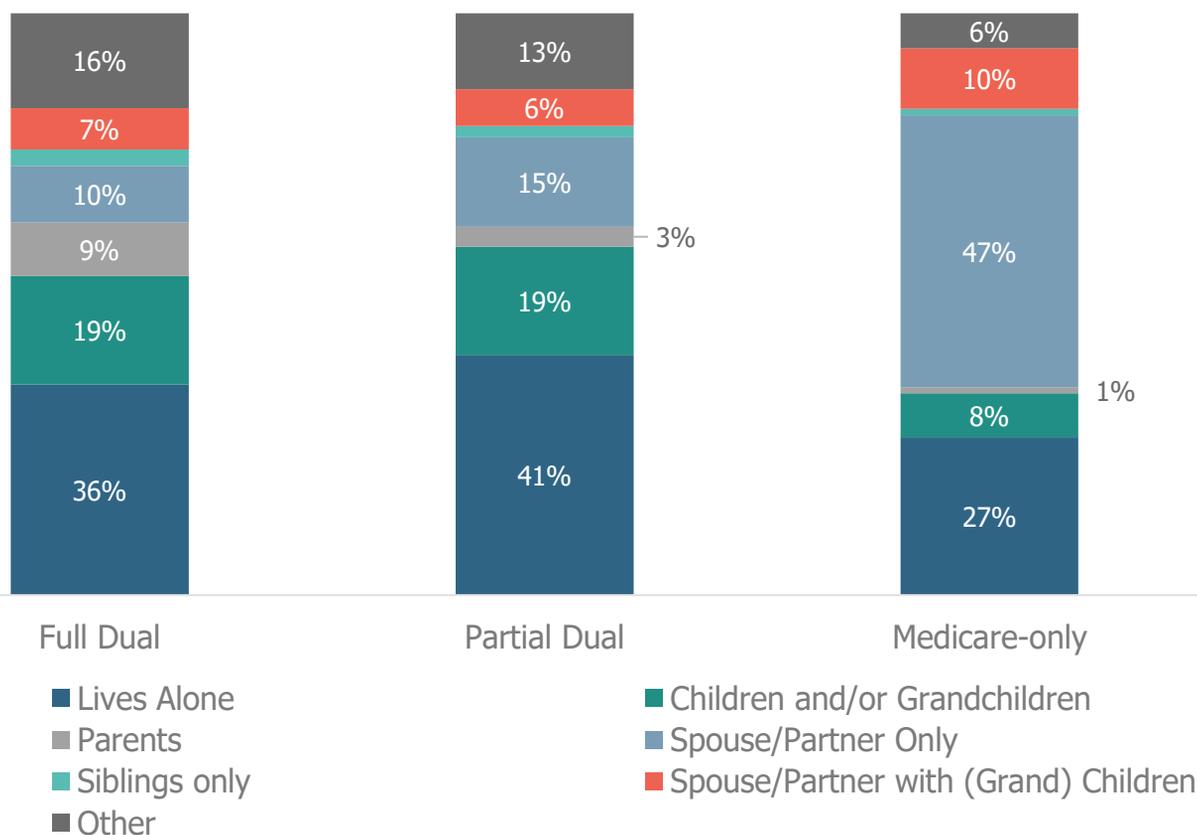
- Few dual beneficiaries living in the community own their homes. Over half of dual beneficiaries rent their residence and one in five are part of other arrangements, such as living with family. Furthermore, across dual status, those with ADL needs are less slightly likely to own their home (see table below).
- Home modifications that support beneficiaries remaining in the community may not be feasible in rental facilities. Disruptions in housing associated with renting can also lead to institutionalization if alternative housing that can accommodate an individual’s needs cannot be found.
- D-SNP supplemental benefits may offer limited housing supports and some Medicaid programs provide housing navigation services, but neither are currently widely offered.

Percent of Community Medicare Beneficiaries who Own Their Home

	Dual Beneficiaries	Full Dual Beneficiaries	Partial Dual Beneficiaries	Medicare-only Beneficiaries
0-1 ADL	27%	22%	36%	81%
2+ ADLs	24%	21%	33%	68%

Dual Beneficiaries Are More Likely to Live Alone or with Children and/or Grandchildren Than Medicare-Only Beneficiaries

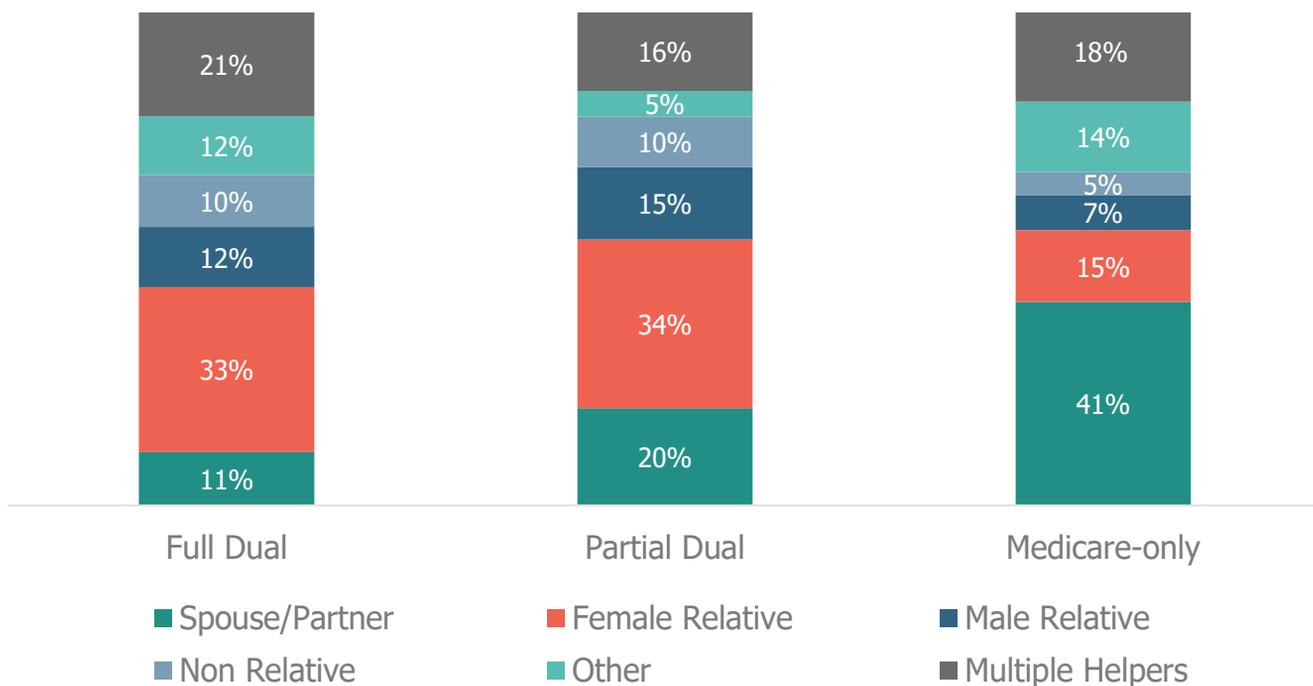
Household Composition by Dual Status



- The needs of dual beneficiaries have an outsized impact on their families. Dual beneficiaries are one and a half times more likely than Medicare-only beneficiaries to live alone and twice as likely to live with a children and/or grandchildren without a spouse or partner. As skilled care increasingly shifts to the home, special attention is needed for dual beneficiaries living alone or lacking regular support from family members.
- Social isolation and loneliness are risk factors for high blood pressure, heart disease, obesity, anxiety, depression, cognitive decline, Alzheimer’s disease, and death.¹ Because dual beneficiaries live alone at higher rates than Medicare-only beneficiaries, it may be valuable to target risk prevention efforts to this population.

Dual Beneficiaries Less Likely to Receive Help From a Spouse, More Likely to Rely on Other Female Relatives

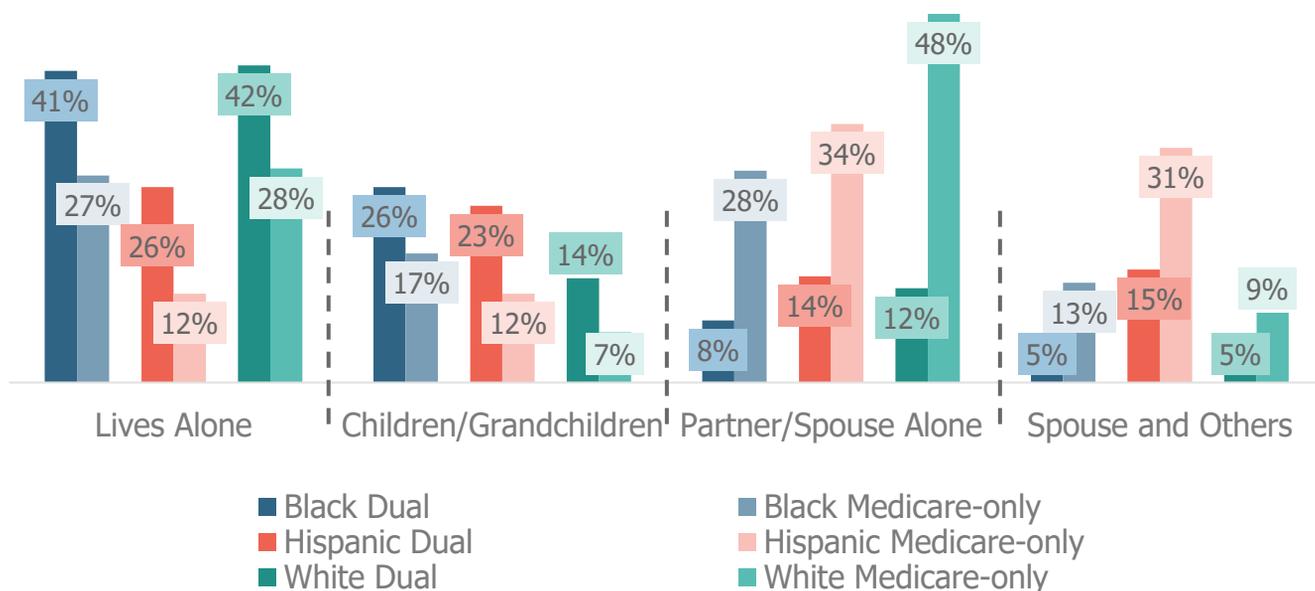
Gender and Type of Medicare Beneficiary Helper by Dual Status



- Medicare-only beneficiaries are more likely to be cared for by their spouse or partner than dual beneficiaries. Dual beneficiaries are twice as likely to be helped by a non-spouse female relative compared to Medicare-only beneficiaries.
- Women are disproportionately likely to experience the financial consequences of caregiving as they are more likely to leave the workforce after assuming caregiving responsibilities.^{1,2} Targeting caregiver supports, home and community-based services, and integrated healthcare coverage for dual beneficiaries may help alleviate the disproportionate financial impact of caregiving on women – promoting gender equity more broadly and increasing the stability of caregiver arrangements for dual beneficiaries who do not receive assistance from a spouse.

Among Black Beneficiaries, but not Hispanic or White Beneficiaries, Dual Beneficiaries More Likely to Live Alone Than Medicare-Only

Household Composition by Race, Ethnicity, and Program



- Living alone can pose a health risk to Medicare beneficiaries, especially beneficiaries with 2+ ADLs. For example, adults living alone are 20% more likely to self-report falls than those who do not live alone.¹ Black dual beneficiaries with 2+ ADLs are more likely to live alone than other groups with similar complex care needs.
- Those with persistent disabilities later in life are more likely to live alone than those without disabilities. Having a disability and living alone is associated with protracted health problems, an increased chance of nursing home admission, and increased risk of death.²

Percent of Beneficiaries with 2+ ADLs who Live Alone by Race, Ethnicity, and Dual Status

Black Dual	Black Medicare-only	Hispanic Dual	Hispanic Medicare Only	White Dual	White Medicare-only
30%	10%	12%	7%	19%	21%

Utilization & Spending

Key Takeaways

Dual beneficiaries use the emergency department, hospital, and home health at higher rates than Medicare-only beneficiaries. Medicare spends more per beneficiary on dual beneficiaries relative to Medicare-only beneficiaries, especially on Part D. All analyses use Medicare Claims data for Fee-for-service (FFS) beneficiaries. Utilization and cost data for Medicare Advantage beneficiaries is not available.



Race & Ethnicity

Hispanic dual beneficiaries are less likely to have an inpatient admission but are similarly likely to have visited the emergency department.



Age

Medicare spending varies across age by dual status, but hospital utilization is similar for beneficiaries under and over the age of 65.



Disability

Medicare spending on beneficiaries with 2+ ADL limitations is consistent across dual status, but those with 2+ ADLs have higher utilization.



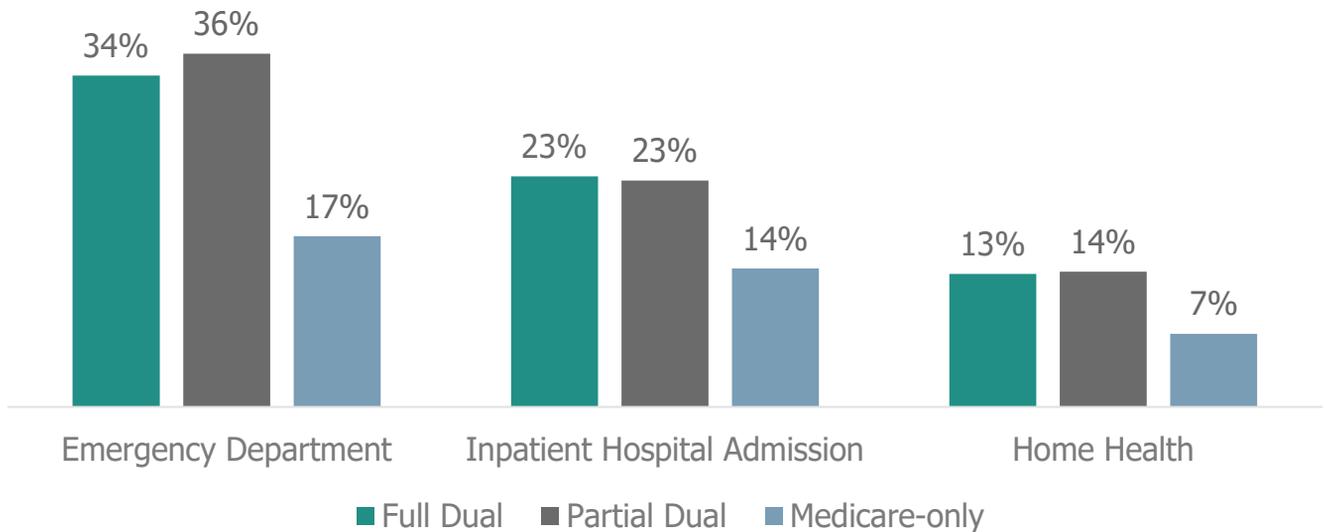
Behavioral Health

Dual beneficiaries with a mental health diagnosis are more likely to visit the emergency department or have an inpatient hospitalization.

As detailed in each section that follows, dual beneficiaries tend to have higher utilization and spending, but with variation by demographics, suggesting opportunities for tailored approaches to integrating care.

Dual Beneficiaries Use the Emergency Department, Hospital, and Home Health at Higher Rates Than Medicare-Only Beneficiaries

Percent of FFS Beneficiaries With at Least One Emergency Department Visit, Inpatient Hospitalization, or Home Health Visit by Dual Status



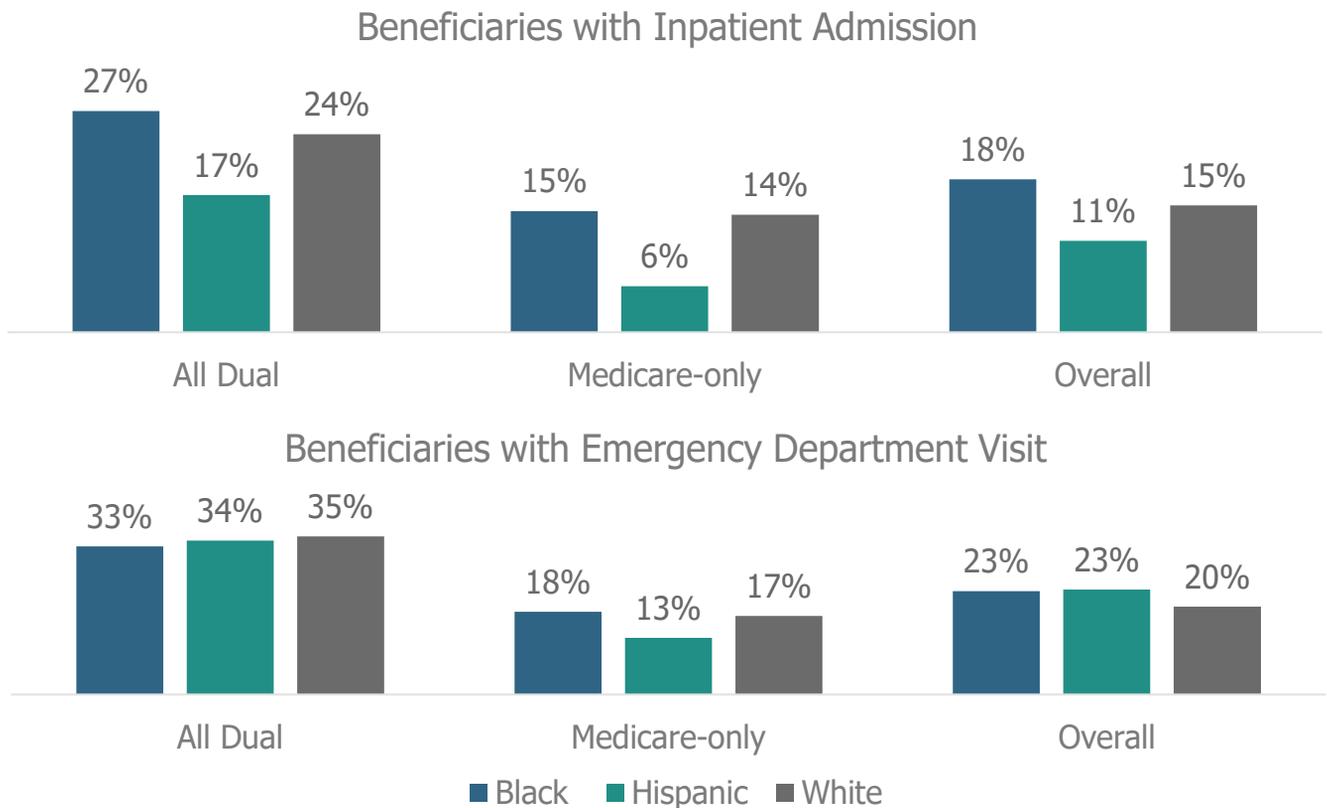
- Dual beneficiaries use the emergency department and home health services at twice the rate of Medicare-only beneficiaries, and inpatient hospitalization rates are more than 60 percent higher among dual beneficiaries.
- Efforts to integrate between Medicaid and Medicare have been shown to reduce Medicare utilization. As a result, states continue to be interested in opportunities to share in Medicare savings with CMS in part to account for state costs associated with implementing and maintaining an integrated program.¹

Average Number of Visits Among Medicare Beneficiaries with at Least One Visit

	All Dual Beneficiaries	Full Dual Beneficiaries	Partial Dual Beneficiaries	Medicare-only Beneficiaries
Inpatient Hospitalization	1.9	1.9	2.1	1.6
Emergency Department	2.0	2.0	2.0	1.5

Dual Eligible Beneficiaries More Likely to Use Inpatient and Emergency Care Than Medicare-only Beneficiaries, with Variation by Race and Ethnicity

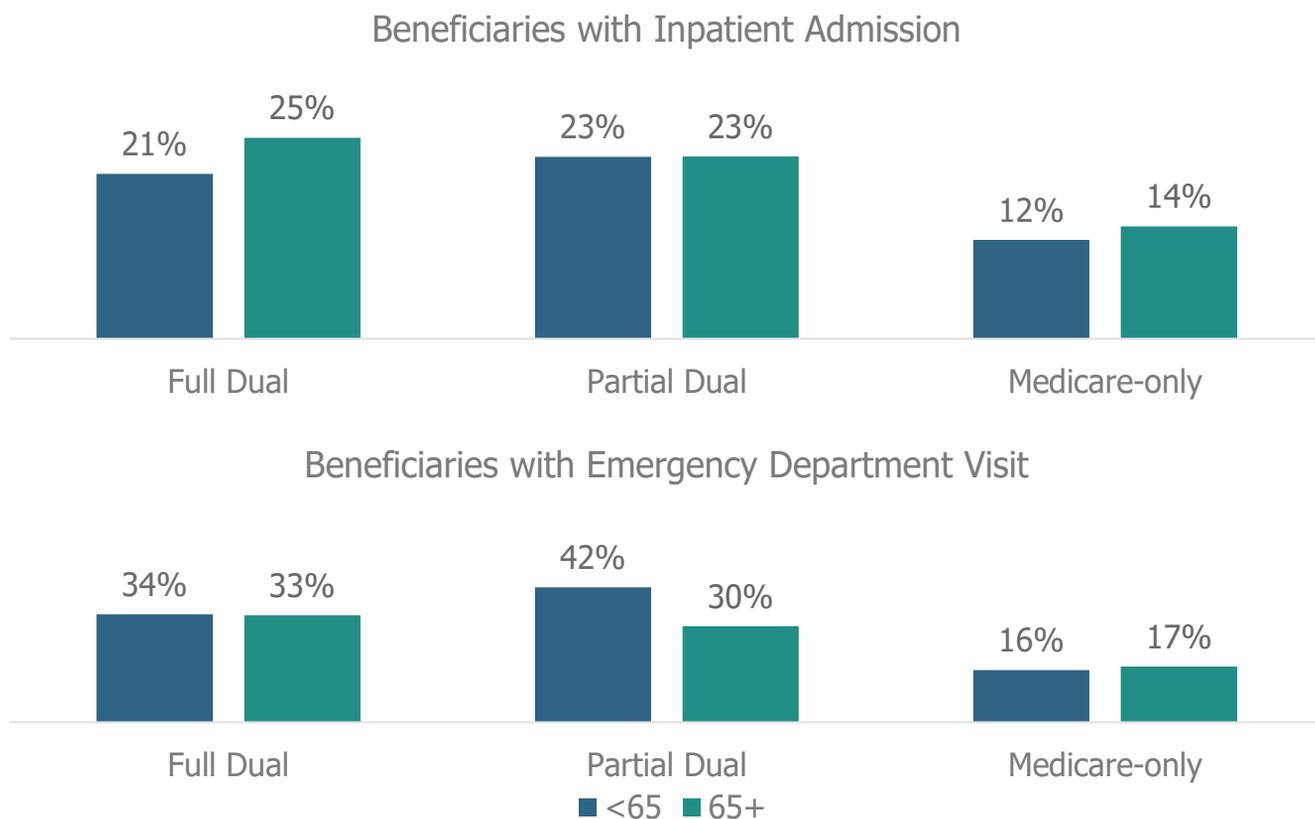
Percent of FFS Beneficiaries with at Least One Emergency Department Visit or Inpatient Hospitalization, in 2019 by Dual Status, Race, and Ethnicity



- Among Medicare FFS beneficiaries, Black and Hispanic beneficiaries are more likely to have one or more emergency department visit than white beneficiaries, but that trend is reversed among dual beneficiaries where white beneficiaries have a higher emergency department utilization rate.
- While Hispanic beneficiaries are less likely than Black and white beneficiaries to have an inpatient admission in 2019, they are similarly likely to have visited the emergency department which may point to barriers in accessing alternatives to emergency care.
- It is important for policies and programs to be mindful of the interaction between race, ethnicity and utilization of inpatient and emergency department services.

Hospital Utilization Similar Across Age and Dual Status for Medicare Beneficiaries

Percent of FFS Beneficiaries with at Least One Emergency Department Visit or Inpatient Hospitalization in 2019 by Dual Status and Age

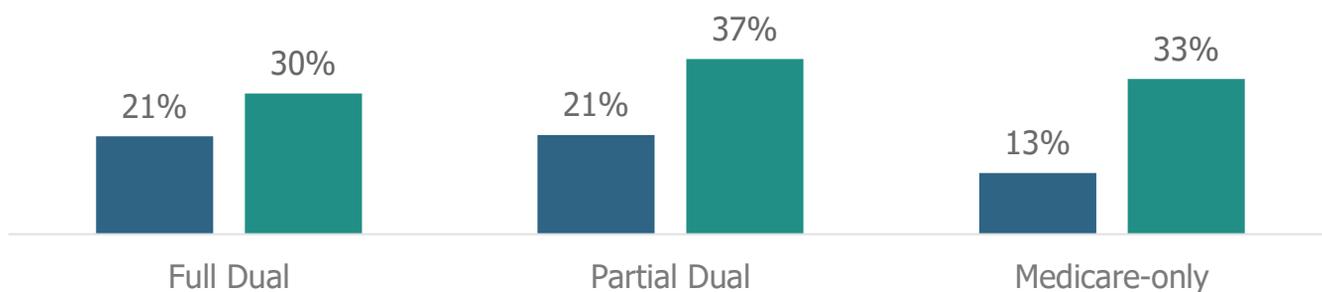


- Across dual status and age, a similar percent of Medicare beneficiaries use inpatient hospital care and the emergency department, apart from partial dual beneficiaries under age 65, who are most likely to visit the emergency department. Mental health may play a role in this trend; those with mental health diagnoses are more likely to visit the hospital (page 41), and 6 in 10 partial dual beneficiaries have one or more mental health diagnoses (page 21).
- Partial dual beneficiaries under the age of 65 qualify for Medicare because of a disability or diagnosis, while partial dual beneficiaries over 65 may have qualified because of age, leading to different levels of clinical need in this group. However, because nearly half of partial dual beneficiaries visited the emergency department at least once in 2019, they are an important group to target services and programs toward.

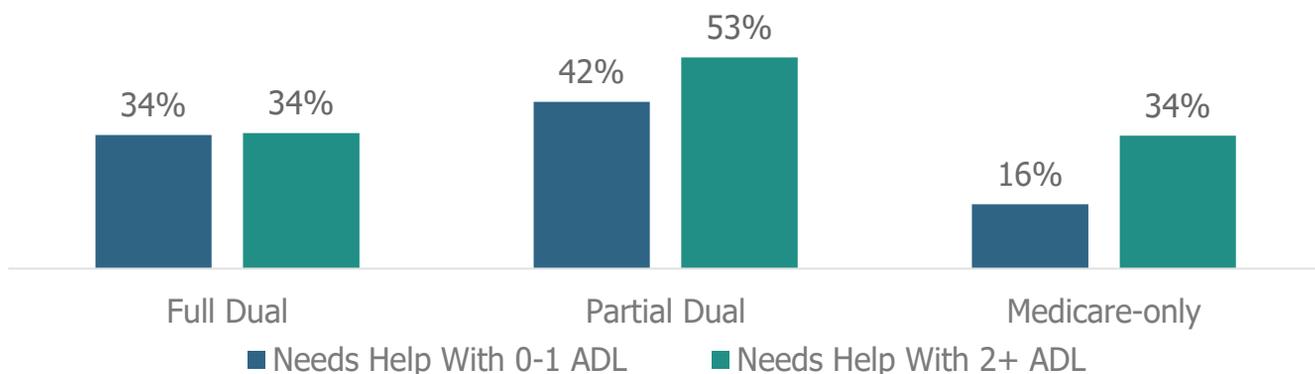
Beneficiaries Who Need Help With 2+ ADLS Are More Likely to Have an Inpatient Admission or Emergency Department Visit

Percent of FFS Beneficiaries with at Least One Emergency Department Visit or Inpatient Hospitalization in 2019 by Dual Status and ADLs Needs Help With

Inpatient Admissions Among Beneficiaries



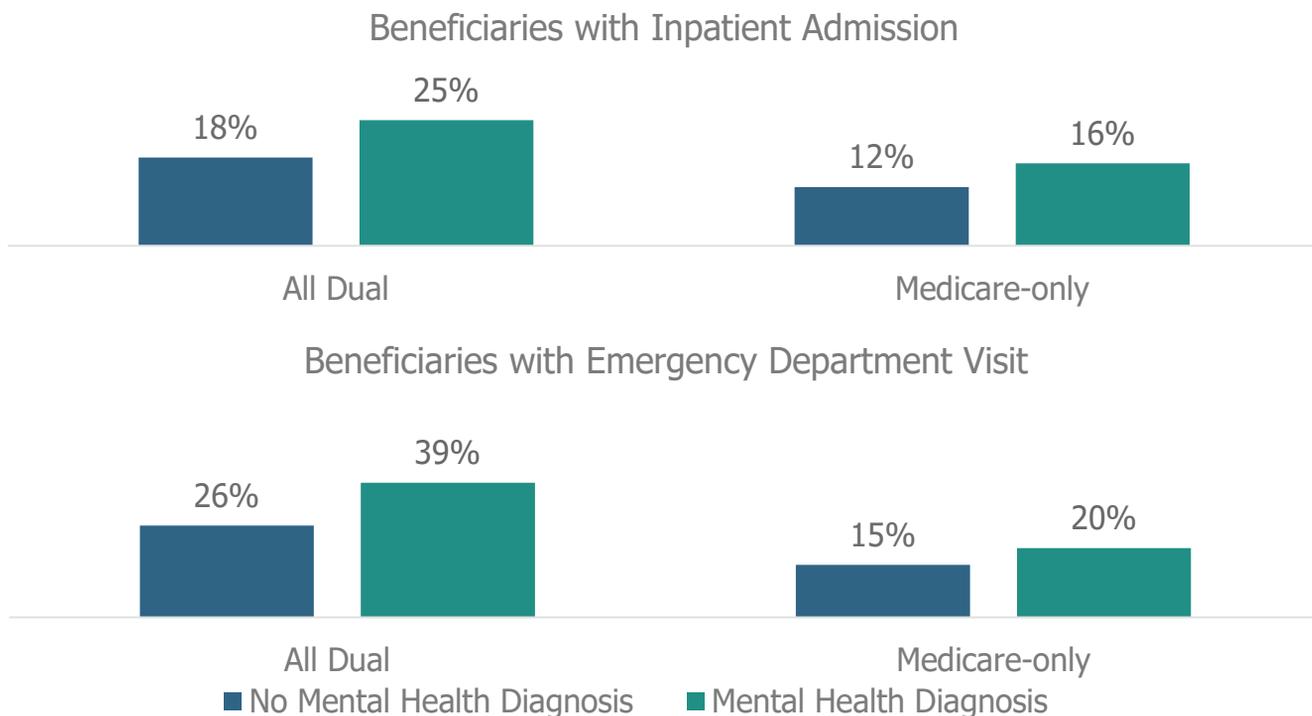
Beneficiaries with Emergency Department Visit



- Those who need help with two or more ADLs are more likely to use the hospital. However, the number of ADLs a beneficiary needs help with is a stronger predictor of high utilization for partial dual and Medicare-only beneficiaries, who lack access to Medicaid LTSS.
- Because full dual beneficiaries are eligible for full Medicaid benefits, they are more likely than partial dual beneficiaries to have their ADL needs met in nursing homes or through HCBS. Partial dual beneficiaries use the hospital at high rates, which could indicate unmet ADL need. Transitioning partial duals with ADL limitations to full benefit coverage sooner could reduce utilization. Policymakers should consider programs that target early LTSS needs and pre-dual beneficiaries.

Across Dual Status, Medicare Beneficiaries With Mental Health Diagnoses Use the Hospital at Higher Rates

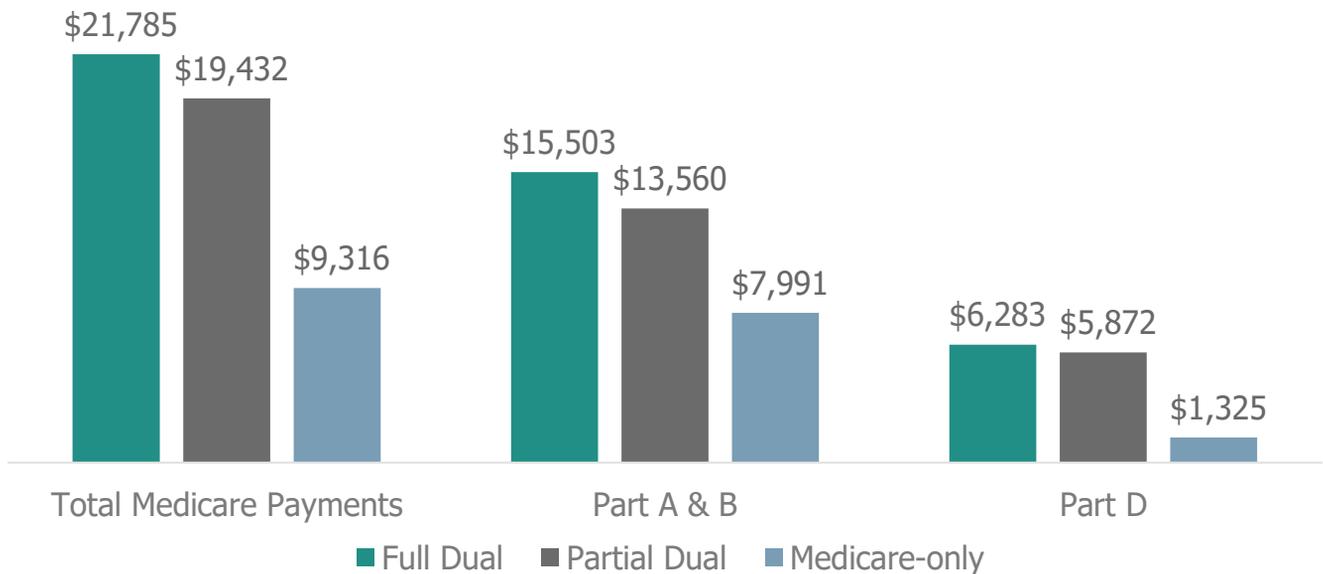
Percent of FFS Beneficiaries with at Least One Emergency Department Visit and Inpatient Admission in 2019 by Dual Status and Mental Health Diagnosis



- Behavioral healthcare is critically important, especially for the nearly two out of three dual beneficiaries with a mental health diagnosis. However, dual beneficiaries often must navigate different systems of care for their physical and behavioral health needs, and partial dual beneficiaries lack access to Medicaid-covered behavioral health services. Further, states often administer behavioral health benefits in systems that are separate from physical health and LTSS.
- Integrating mental health, substance use, and primary care services (through integrated plan products and care management approaches) produces the best outcomes and is the most effective approach to caring for people with complex behavioral and physical health care needs.¹

Medicare Spends More per Beneficiary on Dual Beneficiaries than Medicare-Only Beneficiaries, Especially on Part D

Average Annual Medicare Payments per FFS Beneficiary by Dual Status



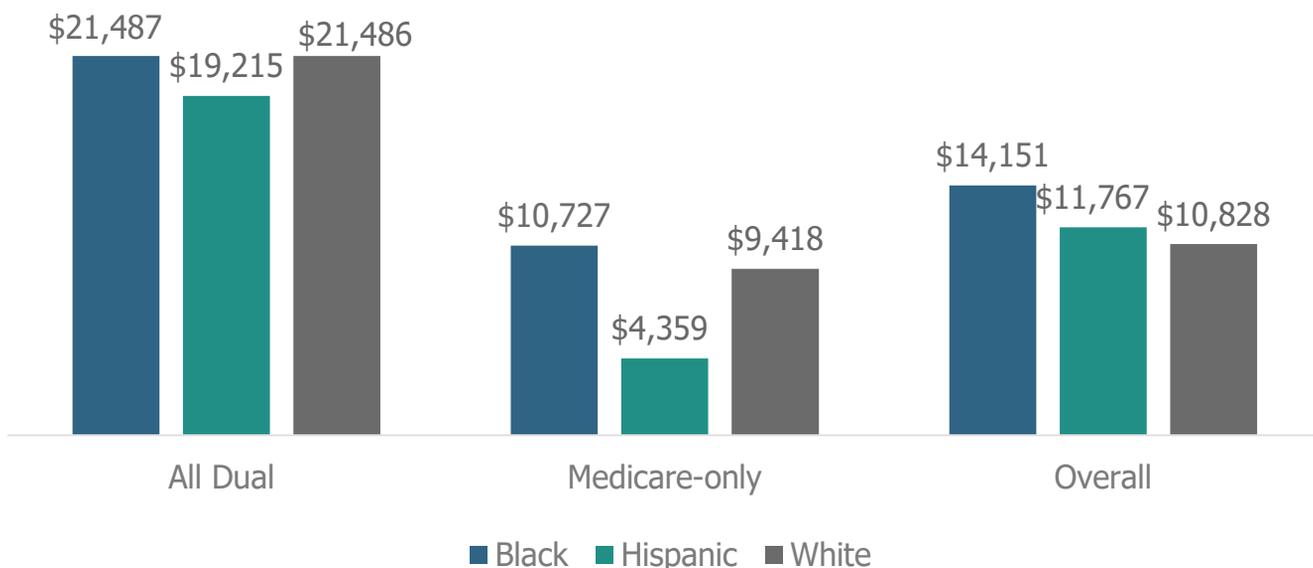
- The cost difference of serving a dual beneficiary compared to a Medicare-only beneficiary is related to both medical services delivered via Medicare Parts A & B, as well as pharmacy/drug costs associated with Part D.
- Integration policy solutions need to consider the whole person, inclusive of medical, pharmaceutical, and non-medical needs.
- Beyond integration, programs serving partial dual beneficiaries should recognize the high needs and resulting costs of this population.

Total Medicare Payments by Dual Status

	All Dual Beneficiaries	Full Dual Beneficiaries	Partial Dual Beneficiaries	Medicare-only Beneficiaries
Total Medicare Payments	\$21,203	\$21,785	\$19,432	\$9,316

Medicare Spending Varies by Race and Ethnicity Across Programs

Average Medicare Payments per FFS Beneficiary by Race, Ethnicity, and Dual Status



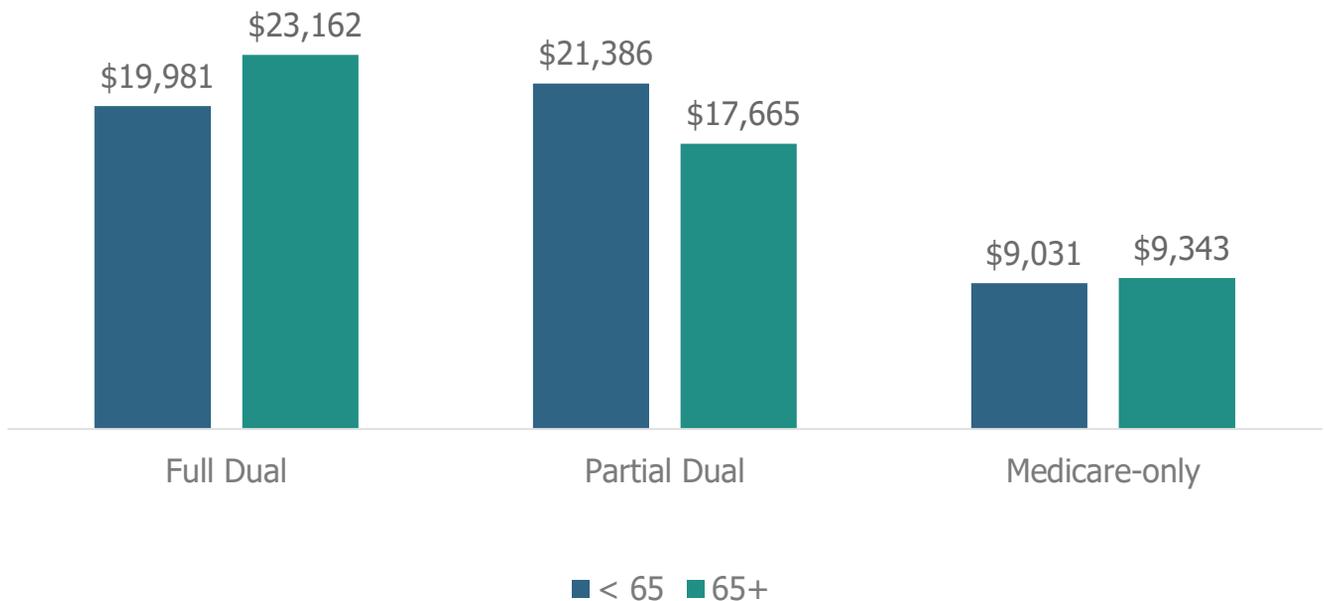
- On average, Medicare spends more on Black and Hispanic beneficiaries; however, there is a strong interaction between race/ethnicity and dual eligibility (and rates of dual eligibility vary by race and ethnicity as shown in the table below).
- Understanding these patterns can inform broader efforts to support health equity. For example, low spending in one demographic can be a product of effective health strategies or it can represent access issues. While Hispanic Medicare-only beneficiaries have the lowest spending of the racial and ethnic groups represented, they also have a low number of inpatient hospitalization visits relative to the number of emergency department visits, suggesting a higher proportional reliance on emergency departments.

Percent of Medicare Beneficiaries with Dual Status

	Black Beneficiaries	Hispanic Beneficiaries	White Beneficiaries
Percent Dual	36%	51%	13%

Medicare Spending Varies Across Age by Dual Status

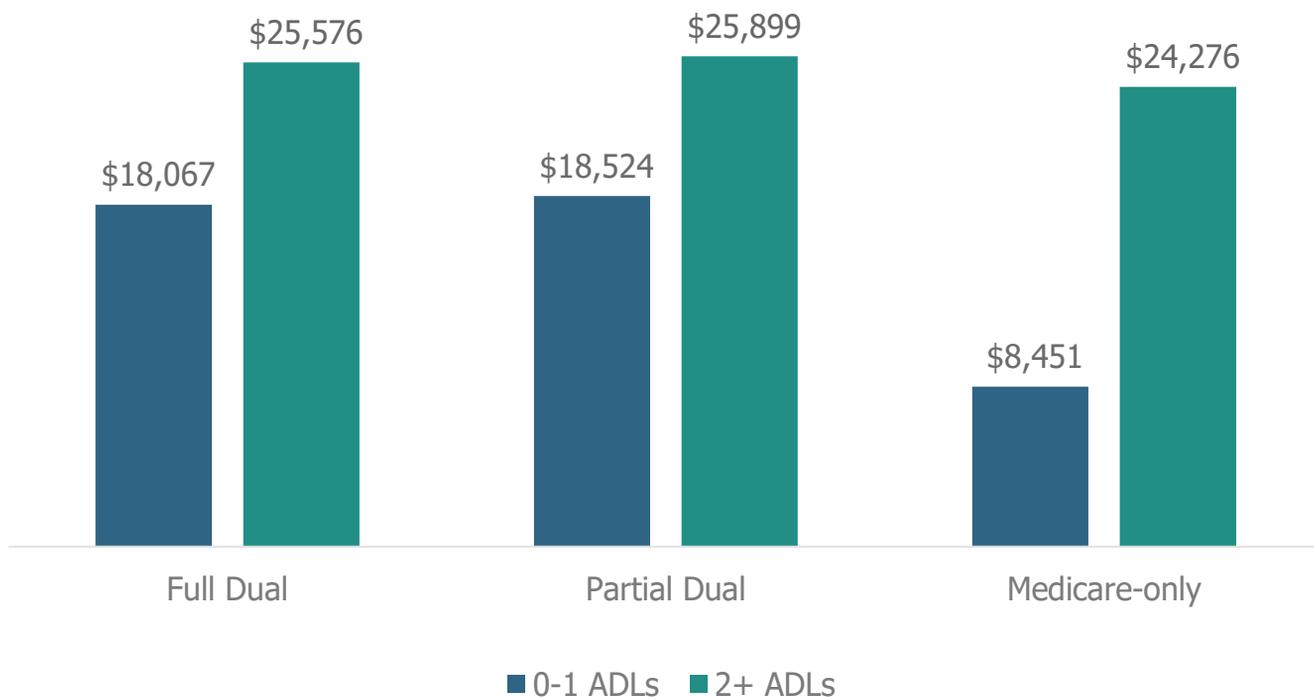
Average Medicare Payments per FFS Beneficiary by Age and Dual Status



- Individuals under the age of 65 may be eligible for Medicare if they have a disability that qualifies for Social Security benefits or if they are receiving dialysis/transplant for End Stage Renal Disease (ESRD).
- Higher Medicare spending on partial dual beneficiaries under age 65 may suggest gaps in coverage or unmet needs. This also may reflect high rates of disability among these individuals, but a lack of Medicaid LTSS to help manage their disability. The consequence is increased medical (Medicare) utilization often in the form of emergency department visits and hospitalizations.

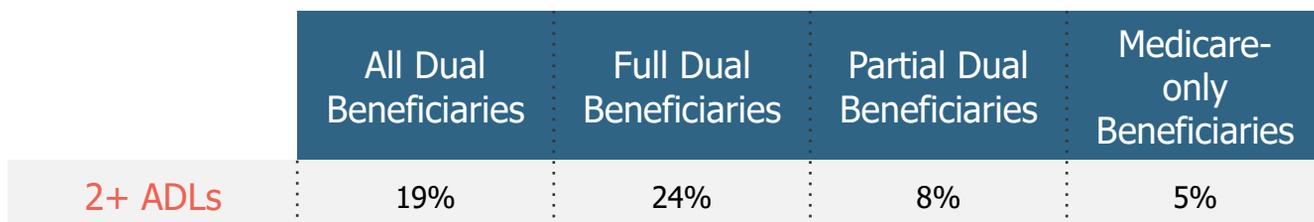
Medicare Spending on Beneficiaries Who Need Help With 2+ ADLs is Similar Across Dual Status

Average Medicare Payment per FFS Beneficiary by Activity of Daily Living (ADL) Limitations and Dual Status



- ADL limitations are strong indicators of clinical need, and a quarter of full dual beneficiaries need help with two or more ADLs.
- Across dual status, Medicare pays similar amounts for beneficiaries who need help with two or more ADLs, suggesting that functional frailty is an important driver of high Medicare spending.

Percent of Medicare Beneficiaries with 2+ ADLs



Methods

Medicare Current Beneficiary Survey 2019 Data and 2020 COVID Supplement

Variable Definitions

Activities of Daily Living: These are defined in the MCBS as: (1) eating, (2) bathing or showering, (3) dressing, (4) getting in and out of bed or a chair (transferring), (5) using the toilet, and (6) walking across the room. Respondents are coded as being impaired in an ADL at the “Help” level – that is, individuals who received assistance from another person to perform the activity—including assistance in physically doing the activity, instruction, supervision, and “standby” help.

Chronic Conditions: A count of positive responses to the survey question “Has a doctor ever told you that you have [condition]?” for the following twelve conditions: (1) Hypertension, (2) Hyperlipidemia, (3) CHF, (4) Other heart disease, (5) Stroke, (6) Cancer, (7) Arthritis, (8) Alzheimer’s/Dementia, (9) Depression, (10) Osteoporosis, (11) Emphysema/asthma/COPD, and (12) Diabetes. Dual Eligibility Dual eligibility (i.e., Medicaid eligibility) is identified in the 2019 MCBS through the community survey and administrative data.

Dual Eligibility: Dual eligibility (i.e., Medicaid eligibility) is defined as at least one month of Medicaid enrollment over the study year, as recorded in the state Medicare Modernization Act (MMA) files (i.e., this variable is not based on state buy-in data.)

Federal Poverty Level (FPL): Federal poverty level is derived from the Census Bureau which creates these thresholds to estimate the number of Americans in poverty each year. The thresholds are specific to age (above or below 65) and size of family unit. In 2018, the poverty threshold for individuals aged 65 and over was \$12,043 for an individual, and \$15,193 for a two-person household. 39% of FFS beneficiaries live below 200% FPL, whereas 53% of MA enrollees live below 200% FPL.

Income: Income values are reported in 2019 dollars.

Instrumental Activities of Daily Living (IADLs): This analysis includes six Instrumental Activities of Daily Living: (1) using the telephone, (2) light housework, (3) heavy housework, (4) preparing meals, (5) shopping, and (6) managing money.

Medicare Advantage Enrollment: Medicare Advantage (MA) enrollment is defined as at least one month of coverage under MA during the study year, using CMS-derived variables that describe Medicare managed care membership.

Methods Continued

2021 Q2 Master Beneficiary Summary File (MBSF)

Data presented in all other pages were ATI Advisory analyses of the Medicare Beneficiary Summary File for March 2021, a licensed 100% extract of administrative records. Medicare beneficiaries were assigned to a geography based on their county of residence in the file (FIPS code). Race and ethnicity, age, and gender are based on designations in that file. Racial/ethnic groups were approximated by an algorithm-based variable, the RTI Race Code, which still may result in undercounting of the Hispanic and Asian categories. This allows for comparison of rates by race or ethnicity but limits the accuracy of tallies of racial or ethnic groups using these classifications. The race and ethnicity categories in this chartbook are as provided from the CMS administrative data, which are derived from race/ethnicity identified by the U.S. Social Security Administration.

MA status is based on the HMO indicator provided in the file, which captures all forms of Part C coverage including Special Needs Plans, the Program for All-Inclusive Care for the Elderly, and Employer Group Waiver Plans. Dual eligibility status is based on a state buy-in indicator provided in the file, and represents full dual eligibility. While there is no statistical sampling, any data point that represents between one person and 10 people is suppressed in compliance with federal privacy rules.

Urban-Rural classification in this chartbook come from MA Network Adequacy criteria, as codified in federal regulations.

- Rural – Rural counties are those counties designated as Rural or as Counties with Extreme Access Considerations (CEAC)
- Suburban – Suburban counties are those counties designated as Micro
- Urban – Urban counties are those counties designated as Large Metro

2022 March CMS Enrollment files

CMS Medicare Advantage/Part D Contract and Enrollment Data was used to calculate the number of beneficiaries enrolled in plans. The Monthly Enrollment by Contract/Plan/State/County March 2022 file was used to estimate county-level enrollment and the MA Contract Service Area by State/County March 2022 file filtered out beneficiaries enrolled in geographies outside of a contract's service area. D-SNP type was identified using the Integration Status for Contract Year 2022 D-SNPs CMS file.

Overall estimates of enrollment in Medicare Advantage come from the MBSF (see preceding slide).