JUNE 2021

Advancing the Policy Environment to Address the Unique Needs of Partial Dual Eligible Beneficiaries

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Overview

Much policy attention and innovation over the past decade has focused on "dual eligible" beneficiaries—individuals who qualify for both Medicare and Medicaid. However, nearly all of this work has focused on "full dual eligible" beneficiaries, Medicare beneficiaries who are also entitled to full Medicaid benefits. "Partial dual" beneficiaries receive financial assistance for certain Medicare costs (e.g., premiums, cost-sharing) from their state Medicaid program but do not qualify for full Medicaid benefits like long-term services and supports (LTSS) or behavioral health (BH) services, typically due to income or assets that exceed Medicaid eligibility thresholds.

Because partial dual beneficiaries lack full Medicaid benefits, policymaking that centers around integration between Medicare and Medicaid has largely ignored, and in some instances explicitly excluded, the 3.6 million partial duals in the Medicare program. Integration is a critically important goal; however, focusing exclusively on integration rather than the broader complexity of all dual eligible beneficiaries has negatively impacted program opportunities for partial duals. Another consequence of partial dual beneficiaries not being the focus of policymaking or research is that they tend to be a poorly understood part of the Medicare and Medicaid populations.

The purpose of this report is to highlight the characteristics of partial dual beneficiaries and to identify potential policy opportunities to address their complex needs. To better understand the partial dual eligible population compared to the full dual eligible population and to Medicare-only beneficiaries, we analyzed data from the 2018 Medicare Current Beneficiary Survey (MCBS) and the 2018-2020 Master Beneficiary Summary File (MBSF).[1]

Our findings demonstrate that partial dual beneficiaries are a high-need subset of the Medicare population, in many instances mirroring the full dual population in their level of medical and functional needs. Based on these findings and detailed in this report, we recommend that policymakers consider the following approaches to ensure partial dual beneficiaries have access to appropriately designed programs and products:

1. Partial dual beneficiaries should [continue to] be permitted to enroll in Dual Eligible Special Needs Plans (D-SNPs);
2. The Centers for Medicare & Medicaid Services' (CMS) definition of look-alikes should exclude partial dual beneficiaries from the numerator of the calculation;
3. Medicare Advantage supplemental benefits should be targetable based on dual eligibility status;
4. States and CMS should fund a dual eligible deeming period; and
5. CMS should test programs that address LTSS needs in partial dual beneficiaries.

For additional detail on partial dual eligibles and related analytics, see the companion chart book resource.

1 The data sources include Traditional Fee-for-Service (FFS) and Medicare Advantage beneficiaries. Unless otherwise noted, analysis includes both programs.

What Is Partial Dual Eligibility?

Partial dual beneficiaries are a small but rapidly growing share of the Medicare population. Nearly one in five Medicare beneficiaries is dual eligible, and among dual eligible beneficiaries, 27% are partial duals. Moreover, the number of Medicare beneficiaries who are partial duals is growing faster than the number who are full duals, with overall growth rates of 10% and 6%, respectively, between 2015 and 2019.[i]

All dual eligible beneficiaries receive Medicare out-of-pocket cost support from their state Medicaid program through the Medicare Savings Program (MSP), but the degree of this support varies based on an individual's income and asset levels (Figure 1). To receive full Medicaid benefits (*full* duals), an individual must also meet Medicaid eligibility qualifications, which typically are more stringent than MSP financial requirements and may include a level of care need. In some instances, a dual eligible beneficiary may have income and assets that exceed MSP eligibility but can qualify for full Medicaid benefits through special income levels or by spending assets down to Medicaid status ("other full benefit dual eligibles" or FBDEs).

Figure 1. Categories of Dual Eligibility through the Medicare Savings Program

Medicare Savings Program Category	Financial Eligibility		Financial Support
	Income	Assets	
Qualified Medicare Beneficiary (QMB)	<100% FPL*	<3x SSI¥ limit	Medicare Part A[2] and B premiums, deductibles, coinsurance, and copayments
Specified Low-income Beneficiary (SLMB)	100% up to 120% FPL	<3x SSI limit	Medicare Part B premiums
Qualifying Individual (QI)	120% up to 135% FPL	<3x SSI limit	Medicare Part B premiums; limited to a first-come, first-serve basis
Qualified Disabled and Working Individual (QDWI)	<200% FPL	<2x SSI limit	Medicare Part A premiums for certain disabled, working individuals under age 65

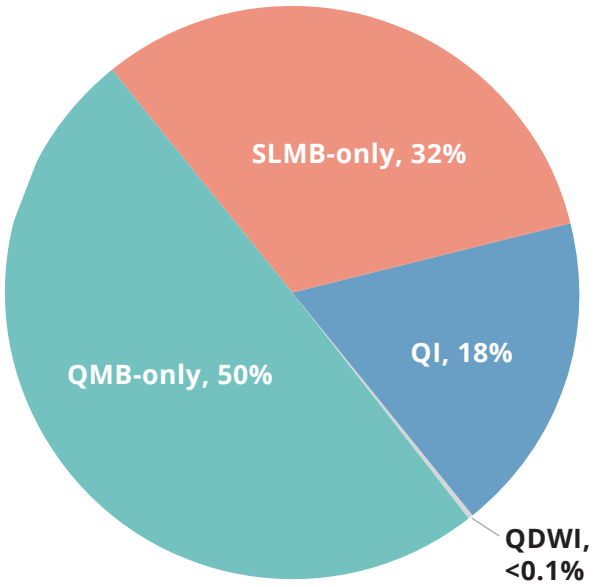
* FPL = Federal Poverty Level. In 2021, the FPL annual income limit for an individual is $12,880.

¥ SSI = Supplemental Security Income. In 2021, the SSI resource limit for an individual is $2,000.

2 Medicare beneficiaries not eligible for Social Security or Railroad Retirement Board retirement or disability benefits are subject to a Part A premium. This represents a small portion of the Medicare population: in 2019, 1.2% of the Medicare population, or 748,802 individuals (see CMS Program Statistics, MCDR Premiums), were subject to a Part A premium.

Half (50%) of all partial dual beneficiaries are enrolled in the Qualified Medicare Beneficiary (QMB) MSP, meaning they receive full Medicare cost-sharing and premium support from their state Medicaid program (Figure 2).[ii] While Qualified Disabled and Working Individual (QDWI) is an eligibility category within the MSP, few beneficiaries qualify via this pathway.

Figure 2. Percent of Partial Dual Eligibility by MSP

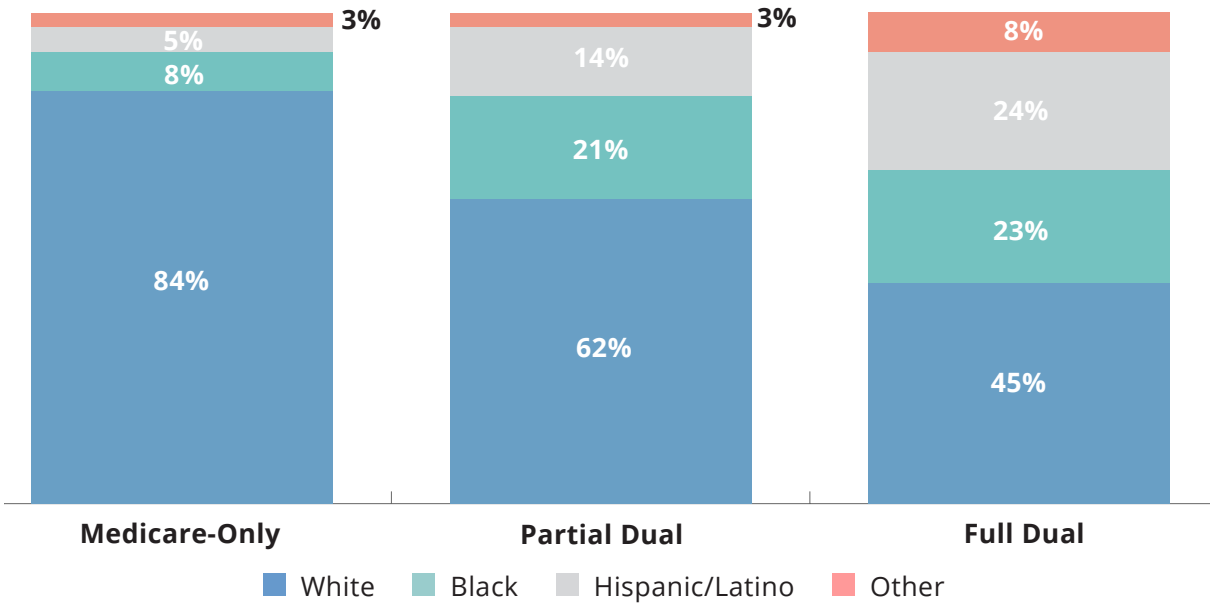


Partial Dual Beneficiaries Experience Social, Functional, and Medical Needs at Rates Similar to Full Duals[3]

Along multiple dimensions, partial dual beneficiaries are more similar to full duals than they are to Medicare-only beneficiaries. Demographically, partial and full dual beneficiaries are more likely to be under age 65 than Medicare-only beneficiaries, with 42% of each partial duals and full duals aged 65 and younger, compared to 8% of Medicare-only beneficiaries. Individuals under age 65 qualify for Medicare due to disability or end-stage renal disease (ESRD).

Partial and full dual beneficiaries are also more likely to be Black or Hispanic/Latino than Medicare-only beneficiaries, at 35% of partial duals and 47% of full duals, compared to only 13% of the Medicare-only population (Figure 3).

Figure 3. Percent of Medicare Beneficiaries by Race/Ethnicity



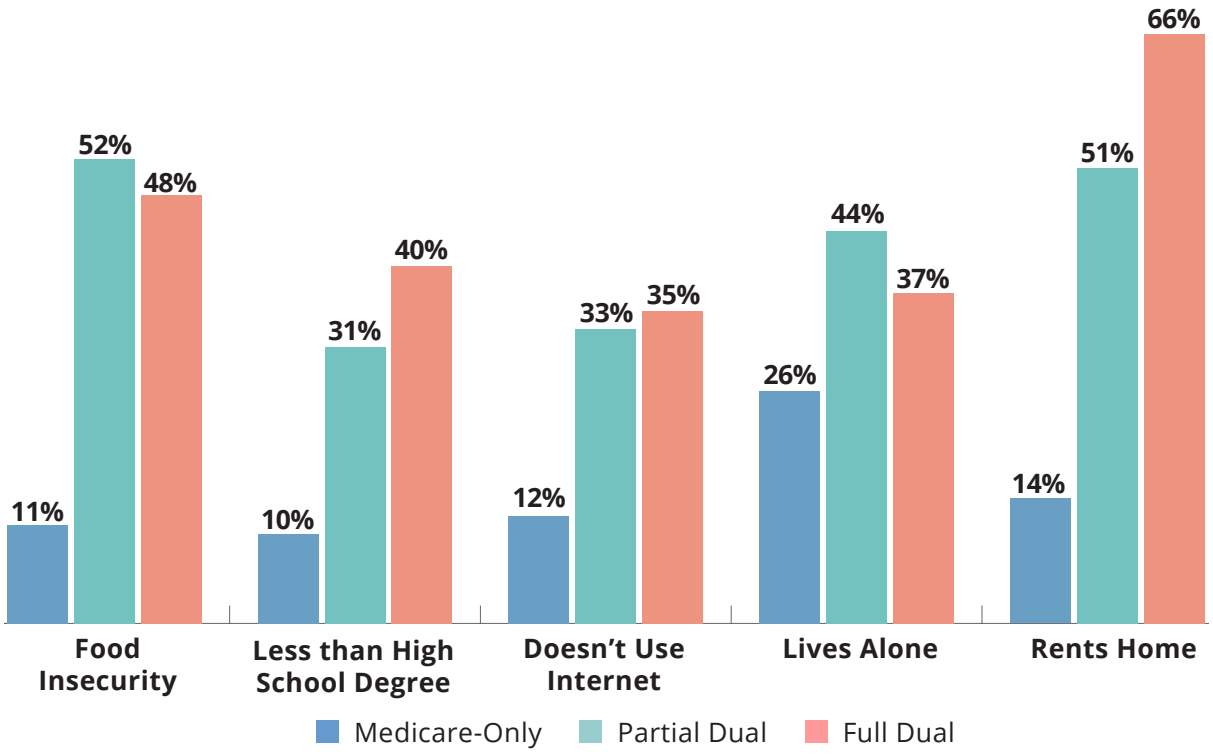
3 Unless otherwise noted, data and outcomes in this report exclude individuals living in assisted living and nursing facilities. Because the majority of nursing home residents are full dual beneficiaries and because Medicaid coverage of assisted living varies considerably by state, including beneficiaries in these facilities results in inaccurate comparisons.

Social Needs

Because of their lower income and resource levels, all dual beneficiaries are at increased risk of having unmet social needs. Evidence points to unmet social needs as leading to significantly more encounters with the healthcare system,[iii, iv] decreased life expectancy, and increased morbidity and premature mortality.[v]

Across each of the five social needs assessed in this report, partial dual beneficiaries experience rates of need similar to full duals (Figure 4). For example, partial and full dual beneficiaries are more than four times as likely as Medicare-only beneficiaries to experience food insecurity,[4] with approximately half of partial and full duals reporting food insecurity compared to 11% of Medicare-only beneficiaries.

Figure 4. Prevalence of Select Social Needs Markers among Medicare Beneficiaries



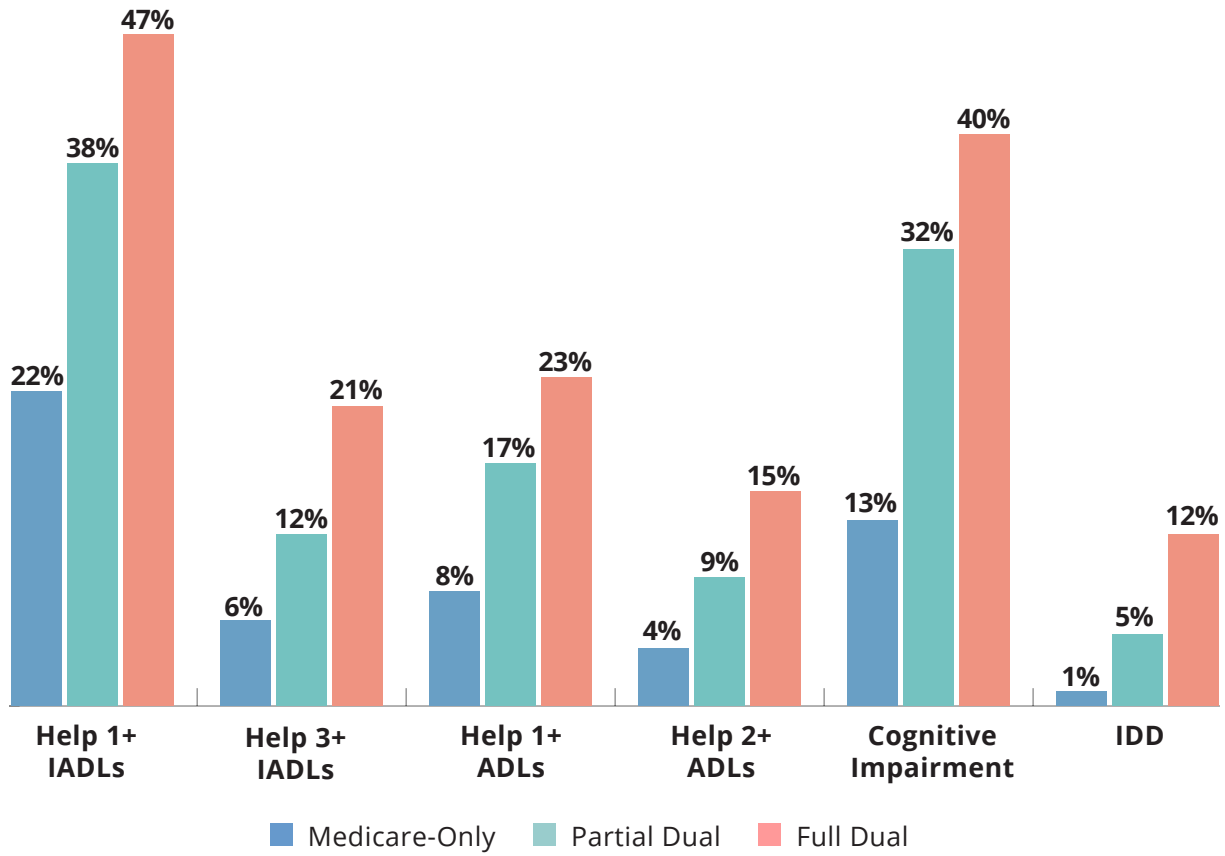
4 Food insecurity is defined as the "lack of consistent access to enough food for an active, healthy life" by the US Department of Agriculture.

Functional Frailty and Cognitive Impairment

While full dual beneficiaries with functional frailty and/or cognitive impairment may access LTSS through their Medicaid coverage, partial duals do not have a comprehensive or systematic way to receive these benefits. Despite these differences in access to services, partial dual beneficiaries experience high levels of LTSS need. Although a lower percentage of partial dual than full dual beneficiaries need LTSS, partial duals are considerably more likely than Medicare-only beneficiaries to experience functional frailty and cognitive impairment (Figure 5).

For example, partial dual beneficiaries are more than twice as likely as Medicare-only beneficiaries to need help with activities of daily living (ADLs) like bathing and getting dressed. Partial duals also are more than twice as likely than Medicare-only beneficiaries to have cognitive impairment or intellectual and developmental disabilities (IDD).

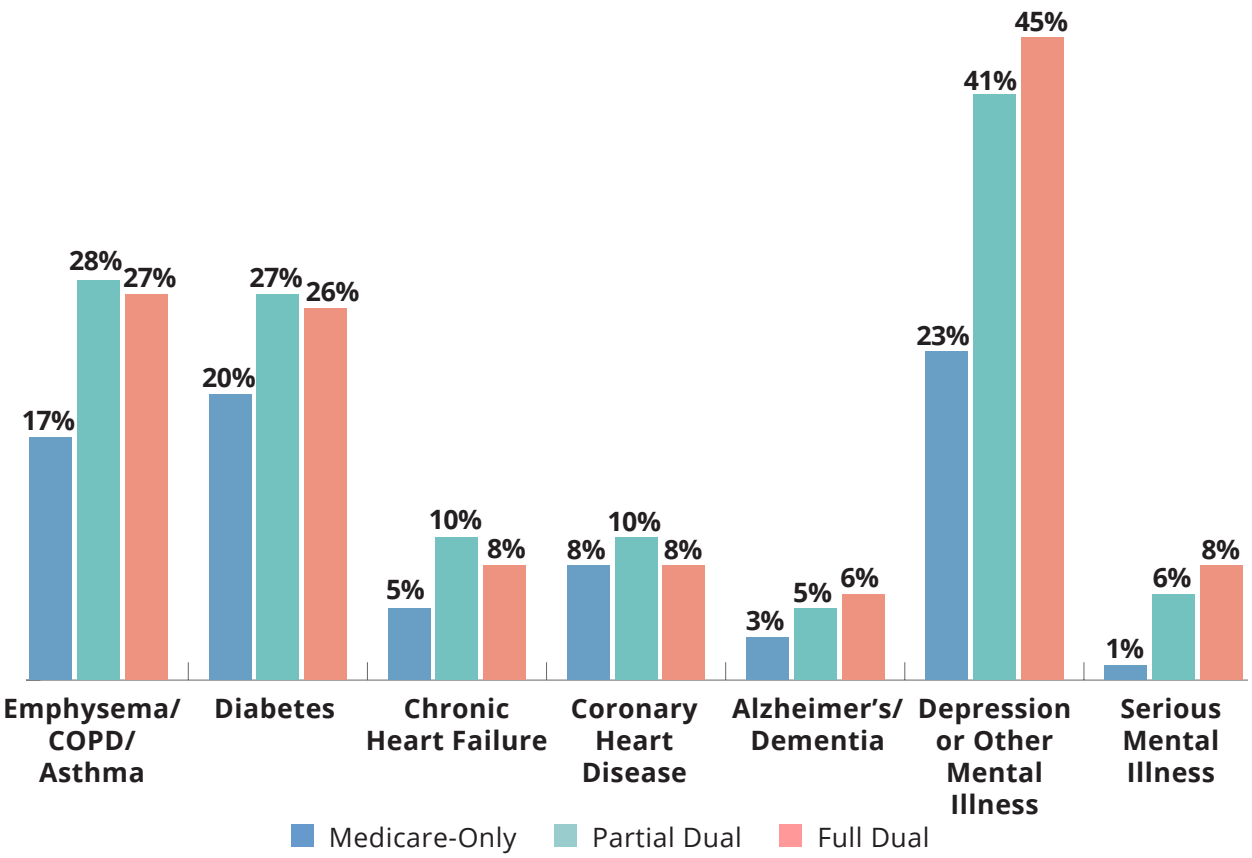
Figure 5. Prevalence of Select LTSS Markers Among Medicare Beneficiaries



Medical Needs

Partial and full dual beneficiaries have similar prevalence rates across numerous chronic physical and mental health conditions, and in nearly all instances, these rates are higher than the Medicare-only population (Figure 6). Partial duals also are likely to experience multiple chronic conditions, with 56% reporting four or more chronic conditions compared to 53% of full duals and 45% of Medicare-only beneficiaries (data not shown in graph).

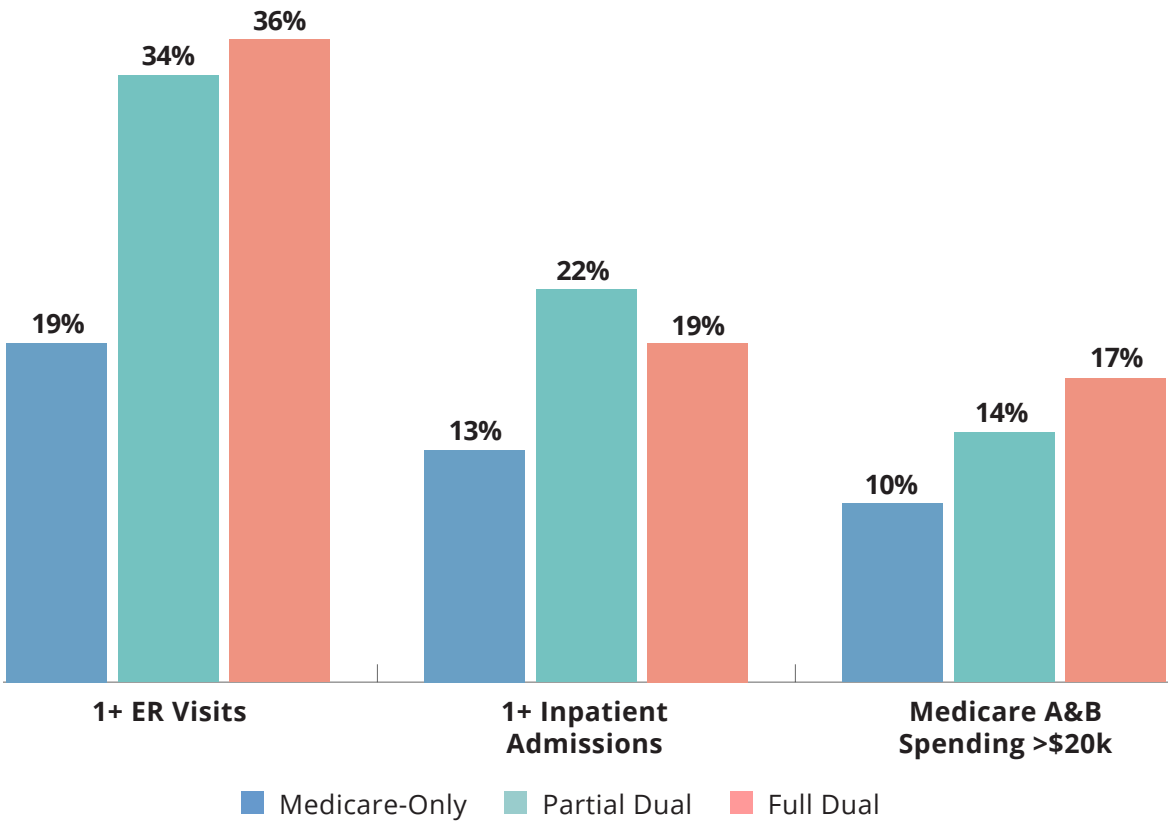
Figure 6. Prevalence of Select Chronic Conditions Among Medicare Beneficiaries



Partial Dual Beneficiary Medicare Utilization and Spending Is Similar to Full Dual Experiences

The combination of social, functional, and medical needs experienced by partial dual beneficiaries results in higher Medicare utilization and spending, at rates and amounts similar to full duals (Figure 7). For example, 34% of partial dual beneficiaries had at least one emergency room (ER) visit in 2018, compared to 36% of full duals and 19% of Medicare-only beneficiaries. Partial dual beneficiaries were also more likely to have an inpatient admission than Medicare-only beneficiaries, at rates similar to full duals. Total annual Medicare Parts A and B spending for partial dual beneficiaries was between that of Medicare-only beneficiaries and full duals, at an average of $9,888 for partial duals compared with $7,889 for Medicare-only beneficiaries and $12,857 for full duals (data not shown in graph).[5]

Figure 7. Acute Care Utilization Among Medicare Beneficiaries



5 Spending and utilization in this analysis were identified using Medicare Fee-for-Service (FFS) claims data and therefore are limited to beneficiaries enrolled in FFS only.

Partial Dual Beneficiaries Experience High Rates of Eligibility Churn[6]

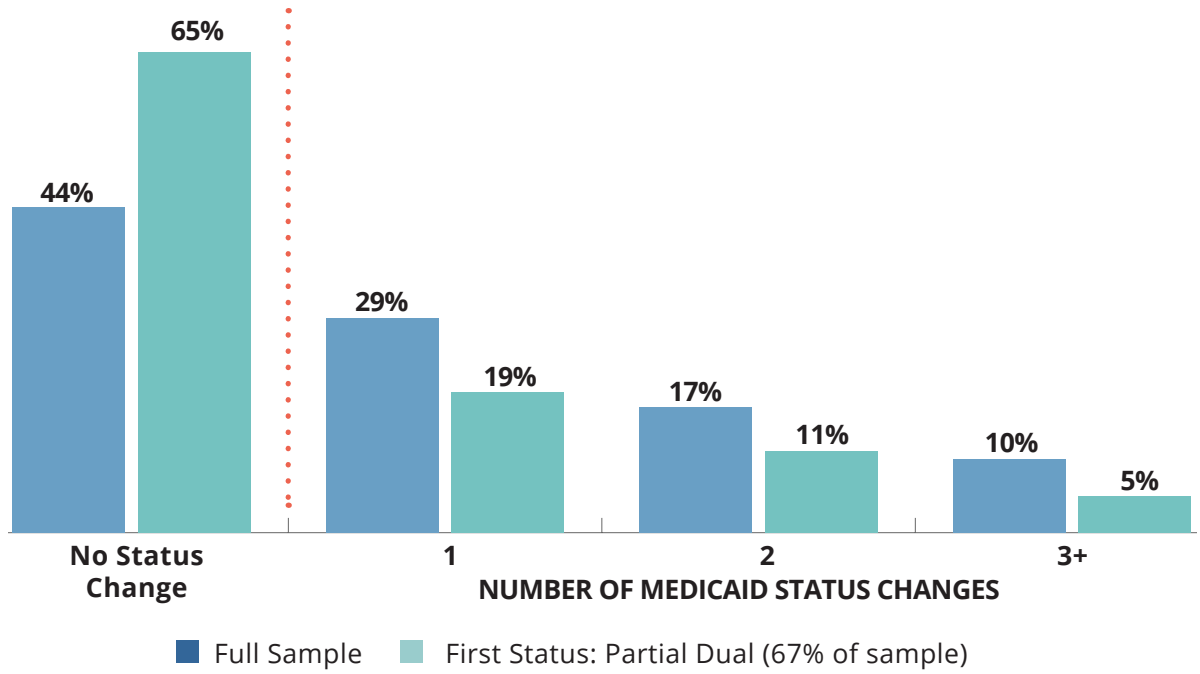
In addition to demographics, medical and functional needs, and Medicare utilization, we assessed volatility in dual eligibility status among partial dual beneficiaries. This offers insight into the likelihood of a partial dual beneficiary gaining full Medicaid eligibility, the number of changes in and duration of eligibility status, and the potential impact on an individual's access to consistent healthcare coverage. In particular, coverage volatility can cause disruptions in benefit access, provider relationships, and ultimately receipt of ongoing care; for example, if an individual has to move between plan designs or from Medicare Advantage (and/or Medicaid managed care) to Medicare Fee-for-Service (FFS).

For purposes of this study, Medicaid coverage change was defined as a shift between partial dual, full dual, and Medicare only. Instances when a partial dual changed MSP programs but remained a partial dual (e.g., QMB to SLMB) were not counted.

Number of Dual Eligibility Statuses

Our analysis found that among Medicare beneficiaries with any partial dual status during a 30-month period, 56% have a Medicaid coverage change ("Full Sample" in Figure 8). Among those who *began* the 30-month period as partial duals ("First Status: Partial Dual" in Figure 8), a third experience at least one change in coverage, and 16% have multiple coverage changes (e.g., losing and then regaining coverage). Over a 12-month period, 17% of partial dual beneficiaries have a Medicaid coverage change (data not shown).

Figure 8. Eligibility Churn Among Partial Dual Beneficiaries



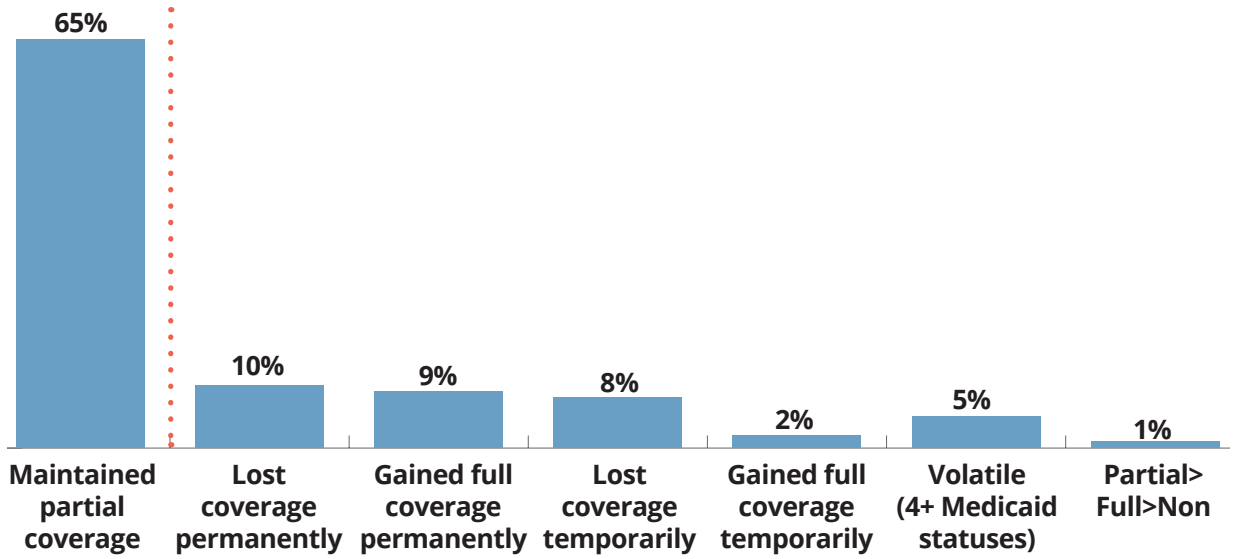
6 Eligibility "churn" statistics provided in this report include all partial dual eligibles, regardless of residence in the community or a facility, due to the source of data (MBSF) used to quantify eligibility status changes.

Type of Dual Eligibility Status Changes

Among beneficiaries in the 30-month study period, we identified six distinct types of coverage volatility (Figure 9). It is important to note that these categories reflect only the 30-month period and that an individual may have other coverage changes after the end of the period. For example, if an individual had partial dual coverage for 29 months and lost coverage during month 30, that person was categorized as "lost coverage permanently" regardless of what happened after the date of available data.[7] The six categories of coverage change we defined are:

1. **Lost coverage permanently.** Partial dual beneficiaries who lost partial dual status at some point during the study window and remained Medicare-only throughout the rest of the 30-month study period.
2. **Gained full coverage permanently.** Partial dual beneficiaries who gained full dual status at some point during the study window and retained full dual status throughout the remainder of the 30-month study period.
3. **Lost coverage temporarily.** Partial dual beneficiaries who temporarily became Medicare-only during the 30-month study period and then regained partial dual status.
4. **Gained full coverage temporarily.** Partial dual beneficiaries who temporarily gained full dual status during the 30-month study period and then returned to partial dual status.
5. **Volatile.** Partial dual beneficiaries who changed eligibility status at least four times during the 30-month study period.
6. **Partial → full → non.** Partial dual beneficiaries who temporarily gained full dual status, lost dual status altogether, and remained Medicare-only throughout the rest of the study period.

Figure 9. Types of Eligibility Status Changes Among Partial Dual Beneficiaries

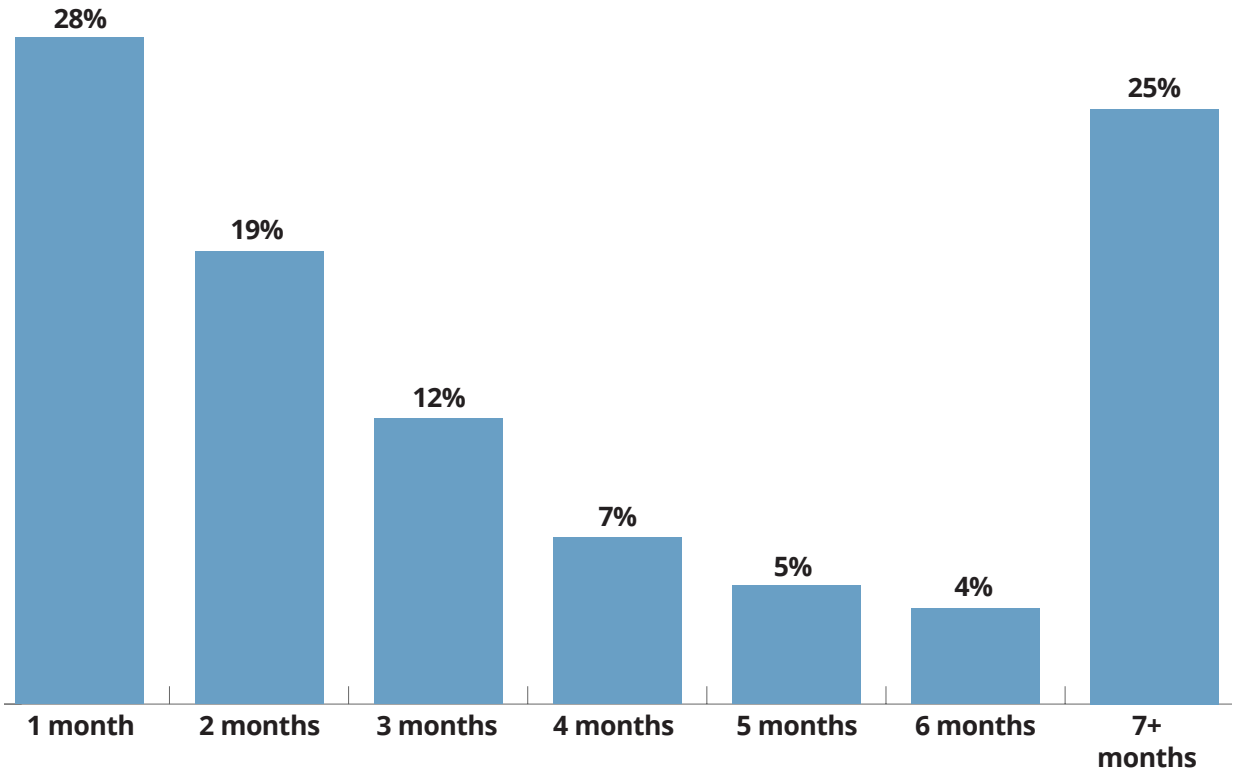


7 Beneficiaries were included in the analysis if they had one or more months with partial dual status and at least 12 months of Medicare coverage over the 30-month study period. The analysis is limited to those whose first status during the study period is partial dual, including individuals who entered the study after month 1 (i.e., newly Medicare eligible individuals with between 12 and 30 months of Medicare enrollment during the study period). Individuals who died during the 30-month study period were categorized based on their Medicare/Medicaid status immediately preceding death.

Length of Dual Eligibility Loss

Among partial dual beneficiaries who began the 30-month study as partial duals and who temporarily lost dual eligibility status during the study period, initial loss of eligibility was most commonly one-month in length (Figure 10). Nearly half of partial dual beneficiaries who temporarily lost dual eligibility regained it within two months, and nearly 60% regained it within three months.

Figure 10. Length of Initial Medicaid Eligibility Gap Among Partial Dual Beneficiaries with Temporary Medicaid Loss



Policy Implications

To date, policy conversations and recommendations regarding dual eligible beneficiaries have focused on the integration of Medicare and Medicaid benefits, financing, and administration. Integration is a critically important goal; however, focusing exclusively on integration rather than the broader complexity of dual beneficiaries has negatively impacted program opportunities for partial duals. Because a partial dual beneficiary does not have Medicaid benefits to integrate (beyond Medicare cost-sharing supports), various policy recommendations have excluded these individuals with complex social, functional, and medical needs. Some policy recommendations have gone so far as to explicitly prohibit partial dual beneficiaries from duals-targeted programs.

For example, some state Medicaid programs do not allow partial dual beneficiaries to enroll in D-SNPs. At the same time, if a non-Special Needs Plan (SNP) Medicare Advantage plan designs a benefit package that meets the needs of partial dual beneficiaries, and as a result enrolls a high portion of partial duals, that plan is subject to CMS' current definition of "D-SNP look-alike" and CMS will not permit the plan to operate.[vi] In this situation, partial dual beneficiaries are left without access to a product designed to meet their unique needs.

This lack of access to meaningful, targeted programs also occurs in states that choose not to enter into contracts with D-SNPs. For example, some states do not allow *any* dual eligible Medicare programs into the state or alternatively, may focus state efforts exclusively on the Medicare-Medicaid Plan (MMP) program, which excludes partial dual beneficiaries.

Additionally, current policy and program design recommendations being considered by Congress and other groups to augment or replace existing duals programs with a new "unified" program explicitly exclude partial dual beneficiaries.[vii] These efforts similarly could result in a loss of meaningful program access for partial duals depending on how the policies are implemented.

Recommendations

Policymakers and experts should consider the duals population inclusive of their complex needs, in addition to the important role of integration.

1. Partial dual beneficiaries should [continue to] be permitted to enroll in D-SNPs

Contrary to concerns that have been voiced by some organizations, including partial dual beneficiaries in a D-SNP *does not* interfere with the plan's ability to serve full duals. As our research demonstrates, many of the clinical and non-clinical care needs between the two populations are similar. Further, D-SNPs are able to create multiple sets of member materials based on plan alignment (e.g., a single member ID card for enrollees aligned with the D-SNP for Medicare and Medicaid coverage alongside D-SNP-only member ID cards for members only served by the D-SNP for Medicare coverage).

The high-touch model associated with Medicare Advantage SNPs, particularly D-SNPs, enables these plan types to effectively target the unique needs of partial dual enrollees. D-SNPs are designed with an evidence-based model of care that includes care management processes and systems specific to dual beneficiaries. Among the requirements of the model of care are an individualized care plan for every enrollee as well as an interdisciplinary care team for each enrollee that reflects expertise in the unique social and clinical needs of dual beneficiaries.

Additionally, D-SNPs are designed with a benefit package that is particularly meaningful to a low-income population with complex care needs. For example, in 2021, a third of D-SNPs offered special supplemental benefits for the chronically ill (SSBCI), compared with 12% of non-SNPs.[viii] These benefits are non-medical in nature and include services like social and recreational activities, meal delivery, non-medical transportation, and pest control. Similarly, D-SNPs are more likely than non-SNPs to offer supplemental benefits that are LTSS-like in nature, such as in-home support services and respite care/ caregiver supports. In 2021, 25% of D-SNPs offered LTSS-like benefits, compared with only 9% of non-SNPs.[ix]

Furthermore, allowing partial dual enrollment in a D-SNP helps create continuity in an individual's relationships with their plan, providers, and case managers if the individual moves into full dual status. As our research and others' research[x] has shown, approximately 10% of partial duals make this shift over a 30- to 36-month period. Coupled with a deeming period (discussed more below), allowing partial dual beneficiaries to enroll in D-SNPs could reduce the negative impacts of eligibility churn.

CMS and states should continue to allow partial dual beneficiaries to enroll in D-SNPs, including "integrated" D-SNPs and alongside full duals, to allow for the targeted model of care and targeted benefits described above.

2. CMS' definition of look-alikes should exclude partial duals from the numerator of the calculation

Non-SNP Medicare Advantage plans should be permitted to design a benefit structure appropriate to the needs of partial duals. As noted above, if a non-SNP Medicare Advantage plan deploys a benefit package that attracts a large percentage of partial dual beneficiaries, that plan is likely to be considered a "look-alike" by CMS' current definition, and therefore not permitted to operate. This is particularly problematic in states where partial duals are excluded from Medicare-Medicaid integrated programs, as the current look-alike definition forces them into Medicare FFS or Medicare Advantage plans designed to serve the broader Medicare population. CMS should modify the definition of "look-alike" so that it excludes partial dual beneficiaries from the numerator of the calculation.

3. Medicare Advantage supplemental benefits should be targetable based on dual eligibility status

In recognition of the impact of social need on an individual's well-being, beginning in January 2020 Medicare Advantage plans were permitted to offer the SSBCI benefits described above. A year prior to this, CMS began allowing Medicare Advantage plans to target benefits through a mechanism referred to as "uniformity flexibility." Both of these newer authorities allow Medicare Advantage plans to target medical and/or non-medical benefits to a subset of their plan enrollment based on clinical conditions.

Non-medical benefits can be particularly valuable to partial dual beneficiaries who lack access to Medicaid LTSS and who have high rates of social need. Congress (with purview of SSBCI) and CMS (with purview of uniformity flexibility) should expand targeting criteria to allow Medicare Advantage plans to target these benefits based on dual eligibility status, in addition to targeting based on clinical conditions. While a non-SNP may not have the dual eligible model of care that accompanies a D-SNP, expanded supplemental benefit authority would allow Medicare Advantage plans enrolling both Medicare-only and partial dual beneficiaries to offer benefits that can more meaningfully meet the unique needs of partial duals. Similarly, it could be to the advantage of full dual beneficiaries if a Medicare plan is able offer supplemental benefits that complement the beneficiaries' Medicaid coverage, with non-medical benefits targeted to full duals only.

4. States and CMS should fund a dual eligible deeming period

A deeming period is a period of time during which a SNP continues to provide coverage to an enrollee who loses SNP eligibility, if it is likely the individual will regain eligibility for the SNP. This can be a strong tool for preventing disruption that would otherwise occur due to eligibility volatility, but can have negative financial implications for D-SNPs if an individual does not regain Medicaid eligibility.

Currently, some state programs require D-SNPs to offer a deeming period, and CMS allows plans to offer a deeming period for up to six months. However, if an individual loses Medicaid eligibility altogether or shifts into an MSP with additional cost-sharing liability (e.g., QMB to SLMB), it can result in a D-SNP covering out of pocket costs for the individual during the deeming period and not recouping these costs if the individual does not regain dual eligibility. This can create disincentives to offer a deeming period.

This is particularly challenging in instances where a D-SNP includes cost-sharing as part of its negotiated payment to a provider. To prevent the provider from incurring a financial loss and protect the beneficiary from balance billing, a D-SNP typically would continue to pay the negotiated amount, inclusive of Medicare cost-share.

To maximize the use and financial predictability of deeming periods, states and CMS should fund at least some portion of the period in instances when an individual does not regain eligibility for the SNP. For example, states and CMS could cover a three-month deeming period, allowing D-SNPs to offer another three months beyond this.

5. CMS should test programs that address LTSS needs in partial dual beneficiaries

CMS, through the Center for Medicare and Medicaid Innovation (CMMI) and/or the Medicare-Medicaid Coordination Office (MMCO), should test a program that allows Medicare Advantage plans (e.g., D-SNPs) to provide an expanded set of LTSS to partial dual beneficiaries with functional frailty and/or cognitive impairment. This sort of model has been proposed by Congress and received bipartisan support, and likely could be accomplished with existing CMS demonstration authority. Specifically, the Community-Based Independence for Seniors Act has been introduced by Congress numerous times, including in 2015, 2017, and 2019. The pilot would provide a limited set of services to low-income Medicare beneficiaries aged 65 and older who are unable to perform at least two ADLs. The proposed legislation limits benefits to $400 per beneficiary per month and includes homemaker services, home-delivered meals, transportation services, respite care, adult day care services, safety and other equipment, and other services the Secretary deems appropriate.[xi] Of note, the proposed legislation assumes the program would be budget neutral across Medicare and Medicaid after year three.

Conclusion

Our research shows that partial dual beneficiaries are much more similar in their needs and experiences to full duals than they are to the Medicare-only population. As policymakers continue to seek solutions to improve care and experiences of dual beneficiaries, it is important that partial duals be an intentional part of the conversation. To date, the policy and program approaches have ignored or even explicitly excluded partial dual beneficiaries, leaving this vulnerable population without appropriate options.

Policymakers can take numerous approaches to allow Medicare Advantage plans to meet the needs of partial dual beneficiaries without interfering with broader approaches to integrate across Medicare and Medicaid.

Acknowledgment

Supported by Anthem Public Policy Institute – working to advance meaningful change in our healthcare system. For more information, visit anthempublicpolicyinstitute.com.

References

i MMCO Statistical & Analytic Reports. Ever-enrolled Trends Report (2006-2019 Data). Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics

ii MMCO Statistical & Analytic Reports. Enrollment Snapshot, Quarterly Release March 2020. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics

iii Assessing the Impact of Social Needs and Social Determinants of Health on Health Care Utilization: Using Patient- and Community-Level Data. June 2020. Available at https://www.liebertpub.com/doi/abs/10.1089/pop.2020.0043?journalCode=pop

iv The Commonwealth Fund, Review of Evidence for Health-Related Social Needs Interventions. July 2019. Available at https://www.commonwealthfund.org/sites/default/files/2019-07/COMBINED-ROI-EVIDENCE-REVIEW-7-1-19.pdf

v Singh GP, Daus GP, Allender M et al. Social Determinants of Health in the United States: Addressing Major Health Inequality Trends for the Nation, 1935-2016. January 2018. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5777389/

vi CMS. Dual Eligible Special Needs Plan (D-SNP) "Look-Alike" Transitions for Contract Year (CY) 2021. June 2020. Available at https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cy21%20d-snp%20look-alike%20transition%20hpms%20memo%20final_9.pdf

vii For additional detail, see MACPAC's March 2021 Report to Congress, Chapter 4, Establishing a Unified Program for Dually Eligible Beneficiaries: Design Considerations.

viii ATI Advisory and LTQA. Data Insight: Special Supplemental Benefits for the Chronically Ill in Plan Year 2021. Available at https://atiadvisory.com/wp-content/uploads/2021/01/ATI-Advisory-Data-Insight_Special-Supplemental-Benefits-for-the-Chronically-Ill-in-Plan-Year-2021.pdf

ix ATI Advisory and LTQA. Data Insight: New Primarily Health-Related Benefits in 2021 Medicare Advantage Plans. Available at https://atiadvisory.com/wp-content/uploads/2020/10/ATI-Advisory-Data-Insight_Medicare-Advantage-2021-New-Primarily-Health-Related-Benefits.pdf and internal (unpublished) ATI analysis of PBP files

x MedPAC June 2019 Report to Congress, Chapter 12. Promoting integration in dual-eligible special needs plans.

xi Community-Based Independence for Seniors Act of 2019, H.R. 3461, 116th Cong. (2019). Available at https://www.congress.gov/bill/116th-congress/house-bill/3461/text?r=6&s=1.

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