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Pathways to Medicare-Medicaid Eligibility: A Literature Review

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Pathways to Medicare-Medicaid Eligibility: A Literature Review

Introduction

More than 9 million older adults and younger individuals with disabilities participate in both the Medicare and Medicaid programs. Referred to as "Medicare-Medicaid enrollees" in this report,[1] in 2007 these individuals comprised 21 percent of Medicare enrollees and accounted for 36 percent of Medicare spending, and 15 percent of Medicaid enrollees and 39 percent of Medicaid spending. About three-quarters of Medicare-Medicaid enrollees receive the full array of benefits available from Medicaid; the remainder only receive Medicaid assistance with Medicare premiums and, for some, cost-sharing (Kaiser Family Foundation, 2011).

Medicare-Medicaid enrollees become eligible for both Medicare and Medicaid in a variety of ways. Workers aged 21-64 with disabilities who become eligible for Social Security Disability Insurance (SSDI) become eligible for Medicare after a two-year waiting period. Many have incomes low enough to qualify for Supplemental Security Income (SSI), which in most states makes them eligible to receive Medicaid benefits. Most adults aged 65 and older are entitled to Medicare benefits by virtue of their age. Many older adults with low incomes qualify for Medicaid benefits as well. Others with significant medical expenditures "spend down" to Medicaid eligibility.

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) conducted a literature review on pathways to Medicare-Medicaid eligibility at the request of the Medicare-Medicaid Coordination Office (MMCO) within the Centers for Medicare and Medicaid Services (CMS). This work was performed under Task Order RTOP CMS-10-022 awarded to Thomson Reuters (Healthcare), Inc., in 2010. The Hilltop Institute is a subcontractor to Thomson Reuters under this task order.

The purpose of the investigation into pathways to Medicare-Medicaid eligibility was to:

- Better understand the various pathways to Medicare-Medicaid eligibility, how and why an individual becomes eligible for both programs, and whether sub-populations of "pre-Medicare-Medicaid enrollees"[2] have different experiences.
- Present examples of the kinds of federal government- and state-sponsored programs and supports aimed at delaying or preventing a descent into functional decline and/or poverty as a way of postponing eligibility for publicly funded benefits.

[1] In the literature, this population is often referred to as "dual eligibles."
[2] In this report, individuals likely to become eligible for both Medicare and Medicaid will be referred to as "pre-Medicare-Medicaid enrollees." These are typically individuals with low incomes and disabling conditions and/or serious health issues. It is important to note, however, that not all pre-Medicare-Medicaid enrollees will become eligible for both programs.

- Better understand the kinds of services and supports that have been most effective in delaying or preventing a descent into functional decline and/or poverty for pre-Medicare-Medicaid enrollees.
- Better understand the barriers faced by individuals in becoming Medicare-Medicaid enrollees who could benefit from both Medicare and Medicaid services and how these barriers might be addressed.
- Present options discussed in the literature for policy change and the provision of services and supports that may delay or prevent a rapid descent into functional decline or poverty.
- Simplify the enrollment process for those who qualify and need Medicare and Medicaid benefits.

Investigation Framework and Research Questions

The framework developed at the outset of this investigation is presented in Appendix 1. It lists the topics to be investigated, anticipated data sources, and potential pathways to Medicare-Medicaid eligibility. Research questions were developed around this framework and include the following:

- Who are the pre-Medicare-Medicaid enrollees and what are their characteristics?
- What is the pathway(s) to Medicare-Medicaid eligibility for each group of pre-Medicare-Medicaid enrollees? Does the experience differ for different sub-groups?
- What kinds of clinical conditions or life events might trigger a rapid descent into functional decline?
- What factors or events might trigger a decline in income and/or assets such that an individual would meet financial eligibility requirements for public programs?
- What are the barriers to becoming eligible for both Medicare and Medicaid?
- What kinds of federal and state programs have been focused on assisting pre-Medicare-Medicaid enrollees?
- What are the perceived gaps in federal and state programs and options for policy and program change?
- Are there opportunities for addressing policy and program gaps in the Affordable Care Act (ACA)?

Methodology

This investigation involved a search of peer-reviewed journals; publicly available data, documents, and reports; and telephone and e-mail communications with subject matter experts and representatives from federal and state government agencies. The investigation focused on the research questions listed above.

Search strategies included querying online databases such as PAIS and PAIS Archive, EconLit, Social Services Abstracts, and SocIndex with Full Text. Academic literature was searched for articles relating to disability trends and policy; impact of chronic disease on functional decline; impact of the loss of a spouse on health status; poverty among older adults; predictors of nursing home admission; and Medicare, Medicaid, SSDI, and SSI trends and policy. Additional online searches were conducted using Google and Google Scholar to identify federal and state government resources and reports, as well as relevant academic research centers, think tanks, associations, and consulting firms focusing on health services research and policy. Articles and reports were selected for inclusion based on relevance to pre-Medicare-Medicaid enrollees and those enrolled in both Medicare and Medicaid—i.e., programs that could affect health status, independence, and income security; pertinent "trigger" events; and other information that could inform pathways to eligibility for both Medicare and Medicaid.

The literature review encompassed an investigation of the websites for federal agencies, including CMS, Administration on Aging (AoA), the U.S. Social Security Administration (SSA), Census Bureau, Veterans Administration, National Institutes of Health, and Medicare.gov. Also examined were websites for other organizations, such as the Kaiser Family Foundation, Urban Institute, National Health Policy Forum, Aging and Disability Resource Center Technical Assistance Exchange, Medicaid Institute, Commonwealth Fund, Mathematica Policy and Research, and RTI International.

Background: SSDI and SSI

Prior to discussing pathways to dual eligibility, a description of the SSDI and SSI programs is provided below as necessary background for understanding eligibility for public programs and potential pathways to Medicare-Medicaid eligibility. The discussion is limited to eligibility for adults in keeping with the focus of this investigation on pathways to eligibility for both Medicare and Medicaid.

Social Security Disability Income (SSDI)

SSDI, authorized under Title II of the Social Security Act, provides for payment of disability benefits to individuals who are "insured" under the Act by virtue of their contributions to the Social Security Trust Fund through the Social Security tax on their earnings. In other words, Title II authorizes benefits to workers with disabilities. Title II also provides for benefits to

certain individuals with disabilities who are dependents of insured individuals (Social Security Administration, 2011).

Three categories of individuals can qualify for benefits on the basis of disability:

- An insured worker with a disability who is under full retirement age (generally age 65).
- An individual who has had a disability since childhood (before age 22) who is a dependent of a parent entitled to Title II disability or retirement benefits or was a dependent of a deceased insured parent (an "adult child").
- A widow or widower aged 50 to 60 with a disability if the deceased spouse was insured under Social Security. (The disability for the widow(er) must have started before the deceased spouse's death or within seven years after the spouse's death.)

The law defines disability as:

> the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s):
>
> - that can be expected to result in death; or
> - that has lasted or can be expected to last for a continuous period of not less than 12 months. (Social Security Administration, 2011)

A qualifying impairment is defined as:

> A medically determinable physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings—not only by the individual's statement of symptoms. (Social Security Administration, 2011)

The SSA categorizes impairments for adults as follows:

1. Musculoskeletal System
2. Special Senses and Speech
3. Respiratory System
4. Cardiovascular System
5. Digestive System
6. Genitourinary Impairments
7. Hematological Disorders

8. Skin Disorders
9. Endocrine System
10. Impairments that Affect Multiple Body Systems
11. Neurological
12. Mental Disorders
13. Malignant Neoplastic
14. Immune System

Disability is determined by state Disability Determination Services (DDS) under contract with the federal government. Disability evaluations are conducted following a procedure called the "sequential evaluation process." For adults, there is a sequential review of current work activity, the severity of impairment, determining whether the impairment meets or medically equals impairment in the SSA's official Listing of Impairments, the individual's residual functional capacity, past work, age, education, and work experience.

SSDI benefits are subject to a five-month waiting period and begin in the sixth month after the date the disability began. There is no provision for presumptive disability under Title II.

SSDI is the pathway to Medicare coverage for people under age 65. Individuals who have been receiving SSDI benefits for at least 24 months are eligible to participate in Medicare. Individuals with "deemed" status—i.e., those with amyotrophic lateral sclerosis, who need long-term dialysis treatment for chronic kidney disease, or who require a kidney transplant—are not subject to the 24-month waiting period for Medicare and can enroll in Medicare immediately upon an SSDI eligibility determination.

An individual receiving SSDI benefits may qualify for SSI cash assistance if the individual's income from SSDI and all other sources is at or below the SSI payment standard (generally a maximum of $674 for individuals and $1,011 for couples in 2009). In this way, it is possible for an adult under the full retirement age[3] to be simultaneously eligible for SSDI, SSI, Medicare, and Medicaid benefits.

In 2009, the average monthly cash payment to workers with disabilities who received SSDI benefits was $1,064.30. Cash payments to workers with disabilities totaled $8.29 billion in 2009.

Employment supports that enable SSDI and SSI recipients to work without losing their right to SSDI and SSI cash benefits and Medicare and/or Medicaid are available. For example, the Ticket

[3] Age 65 for individuals born in 1937 or earlier; gradually increases to age 66 for individuals born in 1938-1942; age 66 for individuals born in 1943-1954; gradually increases to age 67 for individuals born in 1955-1959; and age 67 for individuals born in 1960 or later. See http://www.ssa.gov/retire2/retirechart.htm.

to Work program provides employment services, vocational rehabilitation services, and other support services. The Trial Work Period enables a beneficiary to test his or her ability to work while still receiving SSDI benefits.

When an SSDI recipient reaches full retirement age, SSDI cash payments are terminated and the individual begins receiving Social Security payments.

Supplemental Security Income (SSI)

SSI, authorized under Title XVI of the Social Security Act and administered by the SSA, provides stipends to persons with low income who also have disabilities, who are blind, or who are aged 65 and older, as defined below:

- **Aged**: Persons aged 65 and older.
- **Blind**: "Statutory blindness," which means a central visual acuity of 20/200 or less in the individual's better eye with use of a correcting lens; or a visual field limitation in the better eye, such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.
- **Adult with a Disability(s)**: An individual aged 18 or older by reason of a medically determinable physical or mental impairment(s) which results in the inability to do any substantial gainful activity and that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months.
- **Child with a Disability(s)**: An individual under age 18 by reason of a medically determinable physical or mental impairment(s) which results in marked and severe functional limitations and that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months (Social Security Administration, 2011).

The criteria and procedures used for disability determinations under SSI are identical to the criteria used for SSDI discussed above.

An applicant for SSI may be found "presumptively disabled or blind" and receive cash payments for up to six months while the formal disability determination is being processed. If the individual is determined not to have a disability, then the individual is not required to refund the payments.

The SSI payment standard is based on the person's eligibility category (i.e., aged, blind, or has a disability) and living arrangement. The maximum payment ($674 for individuals and $1,011 for couples in 2009) is generally cited for reference purposes and is made to persons aged 65 and older who are living on their own and responsible for payment of their household expenses. Persons with no income receive the maximum payment while those with some income receive a

supplementary payment that brings their income up to the applicable payment standard. For instance, a single 66-year-old who lives in his own apartment and has countable income of $400 from Social Security will receive an SSI payment of $274, bringing him up to the maximum payment standard. Unlike SSDI, there is an asset limit[4] of $2,000 for individuals and $3,000 for couples. Income standards generally increase each January, but there has not been an increase in these standards since 2009. In 2009, 7.7 million Americans received federally-administered SSI benefits.

In 2009, the average monthly federally-administered SSI payment was $498.75. Some states supplement the federal cash benefit; in such cases, the state's payment standard is greater than the federally-mandated level. In Massachusetts, for instance, the payment standard for an older adult living on his own is $803, not $674. In 2009, federally-administered SSI cash benefits totaled $46.6 billion.

In general, states are required to provide Medicaid coverage to individuals who are eligible for SSI. Thirty-nine states and the District of Columbia extend Medicaid eligibility through the SSI pathway. Eleven states—209(b) states—have more restrictive standards for Medicaid eligibility. These states had more restrictive Medicaid eligibility standards in 1972 when the SSI program was enacted and these rules were grandfathered under Section 209(b) of the Social Security Amendments of 1972. The 209(b) states are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia (AARP Public Policy Institute, 2010).[5]

SSI recipients are generally eligible for Section 8 Housing administered by the U.S. Department of Housing and Urban Development (HUD) and food stamps (the amount of the benefit varies by state).

Pathways to Medicare-Medicaid Eligibility

Overview of Pathways

Table 1, developed by The Kaiser Commission on Medicaid and the Uninsured in 2010 and updated by Hilltop, presents pathways to Medicaid eligibility for Medicare beneficiaries. This table *assumes the individual is already enrolled in Medicare* and details the various ways in which the individual might become eligible for Medicaid and thus a Medicare-Medicaid

[4] Countable assets include cash, bank accounts, investments, and the cash value of some life insurance policies. The home, one vehicle, household goods, and personal effects are not counted.
[5] The AARP Public Policy Institute's 2010 report, entitled *Access to Long-Term Services and Supports: A 50-State Survey of Medicaid Financial Eligibility Standards*, provides information on Medicaid financial eligibility standards, as well as home and community-based services waiver and nursing home eligibility standards, in all 50 states and the District of Columbia. AARP, in partnership with the Congressional Research Service, surveyed the states in order to prepare this report.

enrollee. SSI recipients are automatically eligible for Medicaid in most states. In addition, states have the option of providing Medicaid coverage to individuals with income at or below the federal poverty level ("State Poverty Level") and to those with significant medical expenses who "spend down" their income to state-specified levels ("Medically Needy"). The medically needy coverage group includes individuals in nursing facilities, those receiving coverage under HCBS waivers, and other noninstitutionalized individuals. States also have the option of providing Medicaid coverage to individuals needing LTSS if their incomes are at or below a special income standard—generally 300 percent of the SSI federal benefit rate (FBR), which was $2,022 per month in 2009[6] ("Special Income Rule for Nursing Home Residents" and "Home and Community-Based Service Waivers," respectively). The bottom section of Table 1 details the eligibility requirements for those who are not eligible to receive full Medicaid benefits, as well as the Medicaid benefits they are eligible to receive under the Medicare Savings Programs.

[6] Some states with medically needy programs for LTSS also offer coverage under the special income group. States without medically needy programs for older adults and individuals with disabilities in nursing facilities offer coverage for LTSS under the special income group. In these states, persons with income greater than the special income standard can qualify for Medicaid by directing income to a qualified income trust (commonly called a Miller trust), thereby reducing countable income to the special income limit. The money in the trust goes to pay for the individual's care, and any funds left in it on the death of the individual go to the state.

Table 1. Common Medicaid Eligibility Pathways for Medicare Beneficiaries

	Income Eligibility	Asset Limit	Medicaid Benefits in 2007
Individuals Eligible for Full Medicaid Benefits			
SSI Cash-Assistance-Related (mandatory)	SSI will supplement income up to $674 for individuals, $1,011 for couples living alone (2009 figures). The payment standard for nursing facility residents is $30.	$2,000 (individual) $3,000 (couple)	Full Medicaid benefits, including long-term care and prescription drugs that "wrap around" Medicare benefits. (Medicaid beneficiaries must enroll in Medicare Part D.) Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
State Poverty-Level (optional)	Up to 100% of the FPL. In 2011, $908 for an individual, $1226 for a couple.	Limits vary, but in most states $2,000 (individual), $3,000 (couple).	Full Medicaid benefits, including long-term care and prescription drugs that "wrap around" Medicare benefits. (Medicaid beneficiaries must enroll in Medicare Part D.) Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Medically Needy (optional)	Individuals who spend down their incomes to state-specific levels. Nursing facility residents must contribute most of their income to the cost of care.	Limits vary, but in most states $2,000 (individual), $3,000 (couple). If the individual is a nursing facility resident, the at-home spouse may keep up to $109,560 (2009) of the couple's combined assets.	Full Medicaid benefits, including LTSS, once the spend-down obligation is met. (Benefits may be more limited than those for other coverage groups listed in this chart.) Medicaid beneficiaries must enroll in Medicare Part D. Medicaid may also pay Medicare premiums (Parts A and B) and cost sharing, depending on income and living arrangement.
Special Income Rule for Nursing Home Residents (optional)	Individuals living in institutions with incomes up to 300% of the SSI federal benefit rate ($2,022 in 2009). Eligible individuals must contribute most of their income to the cost of care.	Limits vary, but in most states $2,000 (individual). The at-home spouse may keep up to $109,560 of the couple's combined assets.	Full Medicaid benefits, including long-term care and prescription drugs that "wrap around" Medicare benefits (Medicaid beneficiaries must enroll in Medicare Part D.) Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.
Home and Community-Based Services Waivers (optional)	Individuals who would be eligible if they resided in an institution. While many states use the special income rule for waivers, others have much lower income levels. Generally, eligible individuals must contribute some of their income to the cost of care. In most states, the asset limit is $2,000. The at-home spouse may also be eligible to retain some of the couple's combined assets.		Full Medicaid benefits, including services such as homemakers that are not generally covered by Medicaid. (Medicaid beneficiaries must enroll in Medicare Part D.) Medicaid may also pay Medicare premiums and cost sharing.
Medicare Savings Programs			
Qualified Medicare Beneficiaries (QMB) (mandatory)	Up to 100% of the FPL	Limits vary among states, but can be no lower than $6,600 (individual),	No Medicaid benefits. Medicaid pays Medicare premiums (Part B and, if needed, Part A) and cost sharing.

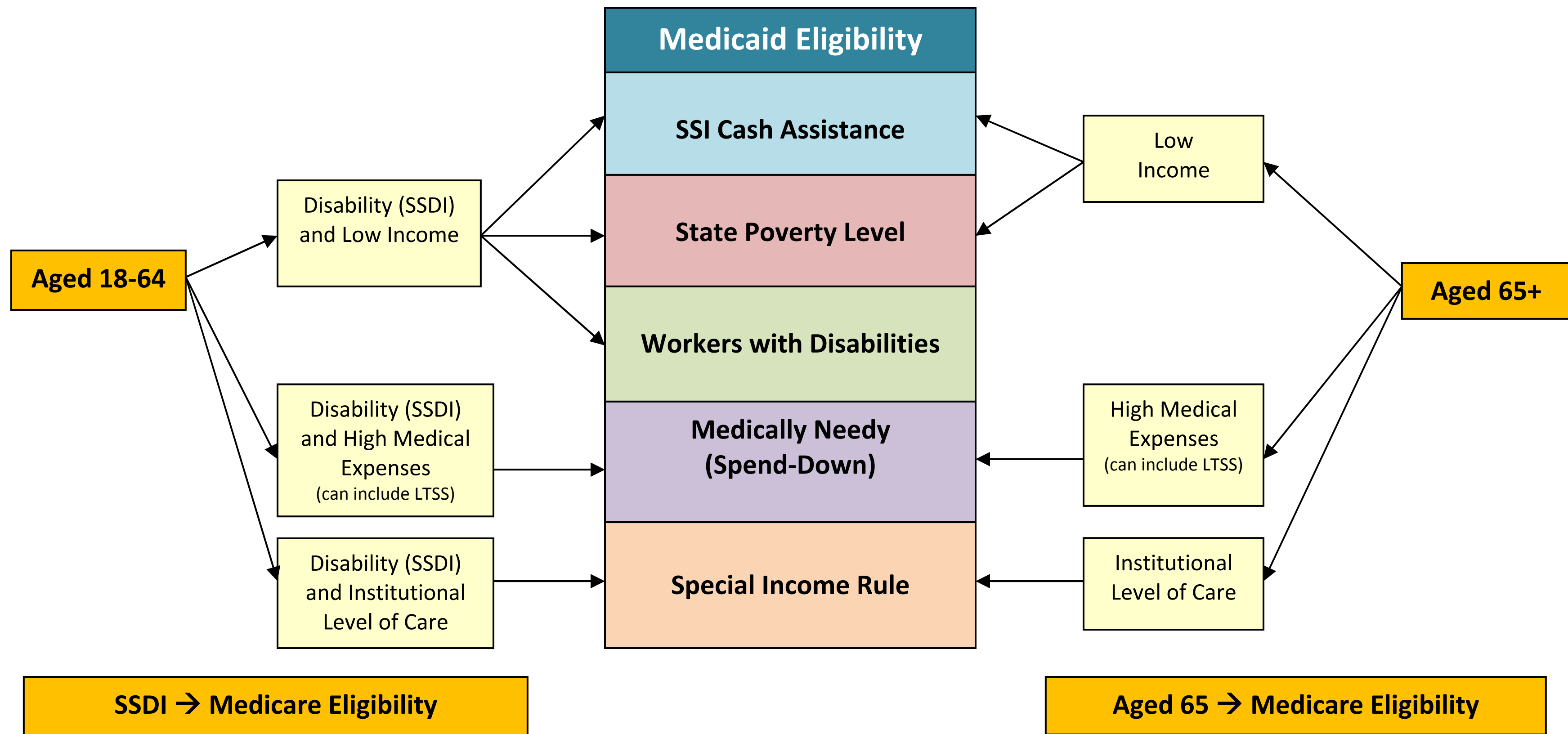
	Income Eligibility	Asset Limit	Medicaid Benefits in 2007
		$9,910 (couple).	
Specified Low-Income Medicare Beneficiaries (SLMB) (mandatory)	Between 100% and 120% of the FPL	Limits vary among states, but can be no lower than $6,600 (individual), $9,910 (couple).	No Medicaid benefits. Medicaid pays Medicare Part B premium.
Qualified Working Disabled Individuals (QWDI) (mandatory)	Working individuals with disabilities with income up to 200% of the FPL	$4,000 (individual) $6,000 (couple)	No Medicaid benefits. Medicaid pays Medicare Part A premium.
Qualifying Individuals (QI) (mandatory)	Between 120% and 135% of the FPL	Limits vary among states, but can be no lower than $6,610 (individual), $9,910 (couple).	No Medicaid benefits. Medicaid pays Medicare Part B premium. Federally funded, no state match. Participation may be limited by funding.

*In 2009, 100% of the FPL was $908 for individuals and $1,226 for couples per month in the 48 contiguous states and the District of Columbia. Higher FPLs apply in Alaska and Hawaii.
a) The maximum federal SSI payment in 2009 was $674 per month for individuals and $1,011 per month for couples. People with countable income below these levels qualify for benefits. In determining countable income, SSI disregards the first $20 of income from any source, plus the first $65 and half of all remaining earned income. (Some states using the "209(b) option" use different (more restrictive) income or asset requirements for Medicaid eligibility for SSI recipients.) These same income disregards are used in the poverty level and medically needy coverage groups as well as Medicare Savings Programs. The special income group uses gross income.
b) Section 1902(r)(2) of the Social Security Act allows states to use income and resource methodologies that are "less restrictive" than those that would otherwise apply, enabling states to expand eligibility above these standards.
c) Individuals eligible under the medically needy option have incomes that are too high to qualify under SSI or poverty-related levels. Unless their incomes fall below their state's medically needy standards for their family size, these individuals must incur sufficient medical expenses to reduce their income below those standards .Because the medically needy income level cannot be greater than 133% of the 1996 AFDC payment standard, medically needy income limits in many states are well below current SSI eligibility levels.
d) In 2009, 300% of SSI was $2,022 per month for an individual. Several states do not use the Special Income Rule, and a few other states use income limits that are below 300% of SSI.
e) States are not required to pay for Medicare cost-sharing if the Medicaid payment rates for a given service are sufficiently lower than the Medicare payment rates.
f) QMB Plus and SLMB Plus categories were created when Congress changed eligibility criteria for QMBs and SLMBs to eliminate the requirement that QMBs and SLMBs could not otherwise qualify for Medicaid. Individuals in these "Plus" categories meet QMB or SLMB eligibility requirements, but also meet the financial criteria for full Medicaid coverage in their state. These individuals DO receive full Medicaid benefits.
g) Until September 30, 2002, Medicaid paid a small part of the Medicare Part B premium for additional Qualifying Individuals (QI2s) with incomes between 135% and 175% of the FPL. Congress allowed the authority for the QI2 program to expire on that date.
h) Individuals in nursing facilities and those receiving HCBS are not eligible for Medicaid if they transferred assets in the five-year period prior to application. States, at their option, may also apply a transfer of asset penalty to other coverage groups.

Source: Kaiser Family Foundation, December 2010. Updated by The Hilltop Institute, June 2011.

Figure 1, developed by Hilltop, takes a different approach and attempts to chart pathways to Medicare-Medicaid eligibility based on age group (aged 18-64 or aged 65 and older) and precipitating condition or event (i.e., disability, low income, medically needy, or need for an institutional level of care) as discussed below. This figure does not include individuals who do not receive full Medicaid benefits or those who become eligible for Medicare through deemed status (i.e., end-stage renal disease or amyotrophic lateral sclerosis/Lou Gehrig's disease).

Figure 1. Pathways to Medicare-Medicaid Eligibility



SSI Cash Assistance	State Poverty Level	Workers with Disabilities	Medically Needy	Special Income Rule
Income payment standard is generally $674 for individuals and $1,011 for couples living alone (2009 figures).	*Up to 100% of the FPL (in 2011, $908 for individuals and $1,226 for couples). 21 states and DC participate; income limits vary.*	*Income requirements vary by state. Various eligibility pathways based on earnings.*	*35 states and DC allow persons with high medical expenses to "spend down" to Medicaid eligibility. 29 states and DC also include persons in nursing homes or HCBS waivers. Not all states have HCBS waivers for persons with disabilities aged 18-64.*	*39 states and DC apply this rule, typically 300% of SSI ($2,022 in 2009), to persons in nursing homes or assessed at an institutional level of care. 21 of these states use only the special income rules.*

Pathways to Medicare-Medicaid Eligibility for Adults with Disabilities (Aged 18-64)

Disability (SSDI) and Low Income: An individual under age 65 who qualifies for SSDI because of a disability also becomes eligible for Medicare after a two-year waiting period. The individual may also qualify for SSI cash assistance if the individual's countable income from SSDI and all other sources is less than the SSI payment standards (in 2009, $674 for individuals and $1,011 for couples living alone). With SSI eligibility comes Medicaid eligibility in most states.[7] At this point, the individual would become a Medicare-Medicaid enrollee, receiving SSDI, SSI, Medicare, and Medicaid benefits. SSDI recipients with incomes too high to qualify for SSI may qualify for state poverty level Medicaid (typically income up to 100 percent of the FPL). Some states provide Medicaid coverage to working people with disabilities who have incomes under specified levels. These are additional pathways for becoming a Medicare-Medicaid enrollee.

Disability (SSDI) and High Medical Expenses: SSDI recipients who have incomes higher than the SSI maximum but who meet state-specified asset requirements and have medical expenses that cause them to "spend down" their income to a state-specified level may be eligible for Medicaid benefits, making them Medicare-Medicaid enrollees. Some states also provide coverage under their medically needy program to persons in nursing homes as well as those participating in HCBS waivers.

The medically needy path is complex, difficult for the applicant to understand, and administratively burdensome for the state. By law, the medically needy income standard (MNIL) is low because it cannot be greater than 133 percent of the 1996 AFDC payment standard. MNILs vary significantly among states and range from a low of $92 to a high of $991. The monthly spend down is determined by subtracting the MNIL from the individual's countable income. The difference is then multiplied by the number of months in a state's spend-down period (generally six) to determine how much an individual must incur in medical expenses before becoming eligible. Since the expense must actually be incurred and not projected,[8] many individuals do not meet their spend down until they are well into the spend-down period. At that point, they become Medicaid eligible for the balance of the spend-down period. Then the individual loses eligibility and must start the spend-down process all over again. Some states allow an individual to pay his or her spend-down amount directly to the state rather than waiting to incur medical expenses. Administratively, this is much simpler as well as easier for the

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[7] There are eleven so-called 209(b) states that perform independent Medicaid eligibility determinations for SSI recipients rather than conferring automatic eligibility. If the SSI recipient is ineligible for income-related reasons, the state must allow the individual to "spend down" either to a medically needy level or, in Ohio and Indiana, to their 209(b) eligibility level.

[8] An exception is made for nursing home residents where the cost of care may be projected, thereby allowing most medically needy applicants to become eligible as of their application date.

applicant to understand. However, because spend-down amounts are usually large, this is an unaffordable option for many.

Depending on the state, the Medicaid benefits under a state's medically needy program may be more limited than those available to SSI recipients.

Disability (SSDI) and Institutional Level of Care: States may apply a special income rule—up to 300 percent of SSI—to provide Medicaid coverage to persons with disabilities who are in institutions or participate in home and community-based services (HCBS) waivers authorized under Section 1915(c) of the Social Security Act. Eligible nursing home residents must contribute most of their income to the cost of care. Some states allow HCBS participants to retain all of their income, while other states require participants to contribute a portion of their income to the cost of their care.

Persons with income *greater* than the special income standard can also qualify for Medicaid by directing income to a qualified income trust (commonly called a Miller trust), thereby reducing countable income to the state's special income limit. The money in the trust goes toward the individual's care and any funds left in the trust on the death of the individual go to the state. An SSDI recipient who meets the state's income and asset requirements and is assessed to need an institutional level of care may be eligible for Medicaid benefits, making the individual a Medicare-Medicaid enrollee.[9]

Pathways to Medicare-Medicaid Eligibility for Aged Adults (Aged 65 and Older)

Low Income: Adults aged 65 and older are entitled to Medicare and, if they meet the income requirements, may receive SSI cash assistance. Such individuals are automatically eligible for Medicaid in most states, making them Medicare-Medicaid enrollees. In addition, some states provide state poverty level Medicaid coverage to persons aged 65 and older (typically income up to 100 percent of the FPL).

High Medical Expenses: Adults aged 65 and older are entitled to Medicare and, if they meet asset requirements and spend down their income to state-specified levels because of medical expenses, may become eligible for Medicaid benefits, making them Medicare-Medicaid enrollees. Some states also provide coverage under their medically needy program to persons in nursing homes as well as to those participating in HCBS waivers. The spend-down process is the

[9] A state *must* provide coverage for Medicaid LTSS either through the special income rule or the medically needy coverage group. There are 21 states that provide LTSS coverage solely through the special income pathway. All other states offer medically needy coverage, and some of the medically needy states also offer coverage through the special income rule. In these states, persons with income greater than 300 percent of the FBR use the medically needy path and do not have to establish a Miller trust.

same as that described above for individuals with disabilities. Depending on the state, the Medicaid benefits may be more limited than those available to SSI recipients.

Institutional Level of Care: Adults aged 65 and older are entitled to Medicare and, if they meet income and asset requirements and are assessed to need an institutional level of care, may become eligible for Medicaid benefits under the special income rule, making them Medicare-Medicaid enrollees. This would include individuals in nursing facilities and other institutions, as well as individuals participating in Medicaid HCBS waivers authorized under Section 1915(c) of the Social Security Act. As with individuals with disabilities, eligible persons may be required to contribute some or most of their income toward the cost of their care.

Individuals with income greater than the special income standard can also qualify for Medicaid by directing income to a qualified income trust (commonly called a Miller trust), thereby reducing countable income to the state's special income limit. The money in the trust must be used to pay for the individual's care. Any funds remaining in the trust at the time of the individual's death must go to the state.

Another Pathway to Medicare-Medicaid Eligibility: Medicare Savings Program

Individuals participating in the Medicare Savings Program receive Medicaid assistance only for Medicare premiums and, for some, deductibles and copayments. Medicaid participants who qualify for Medicare because they have a disability or are aged 65 or older and who meet certain income guidelines are eligible to participate in the Medicare Savings Program (see Table 1 on page 9). They may qualify as Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Qualified Working Disabled Individuals (QWDI), and Qualifying Individuals (QI). Income and asset requirements and Medicaid assistance for each group are summarized in Table 1. All types receive assistance with Medicare premiums; only QMBs receive cost sharing.

Pathways to Medicare-Medicaid Eligibility Can Vary

Individuals can become Medicare-Medicaid enrollees either by first becoming eligible for Medicare and then Medicaid, or by becoming eligible for Medicaid first. For example:

- Medicare → Medicaid: A working adult under age 65 becomes disabled and qualifies for SSDI. After a two-year wait, the individual becomes eligible for Medicare. If the individual's income and assets drop low enough, then the individual could become eligible for SSI and subsequently for Medicaid.
- Medicaid → Medicare: An adult under age 65 is disabled and qualifies for SSI, which in turn qualifies the individual for Medicaid. At age 65, the individual "ages" into Medicare.

- Medicaid → Medicare: An adult over age 65 participates in the Medicaid program but did not enroll in Medicare when he/she turned 65. The state assists the individual in enrolling in Medicare.

Hilltop was unable to find scholarly literature, analyses, or case studies on the pathways individuals take to Medicare-Medicaid eligibility. Nor could we find any published data on how many Medicare-Medicaid enrollees became eligible first for Medicare and then Medicaid, or the reverse, and the precipitating conditions or events that led to Medicare-Medicaid eligibility. In order to illustrate different pathways and the human side of eligibility determination, we developed the five mini-case studies that follow.

Pathways to Dual Eligibility: Mini-Case Studies
Edward is a 79-year-old man who has been diagnosed with coronary artery disease, angina, and spinal stenosis. After several bypass operations, he has become too frail to remain alone in the community and is unable to perform several activities of daily living (ADLs). After a hospital stay, Edward was admitted to a nursing facility, relying on Medicare for his nursing home expenses. Edward had worked in a local factory for more than 40 years and had enjoyed a comfortable retirement until a few years ago when his resources were largely diminished due to the end-of-life costs for his late wife. Edward's assets now consist of the funds from the sale of his home and a small savings account. His savings rapidly eroded with the co-payments associated with his 100-day Medicare-covered nursing home stay and the subsequent expenses after his Medicare benefit was exhausted. The nursing home social worker advised him to apply for Medicaid. Between gathering the necessary documentation and application review and disposition, two and a half months elapsed before Edward was determined eligible for Medicaid, but Medicaid paid his nursing home costs retroactively to the time of application.
Olivia is a 67-year-old widow living in a rural area in a small home she and her husband purchased 35 years ago. She receives monthly Social Security payments and has Medicare coverage. A lifelong smoker, her COPD and emphysema have progressed to the need for round-the-clock oxygen support, strictly limiting her activities. Olivia also suffers from osteoarthritis in her shoulders, spine, and back, which limits her mobility and causes much pain. Her son, who lives in a neighboring state, called various community agencies to see what assistance she could obtain and was referred to an intake worker at the county office on aging. Upon reviewing her income and assets, staff determined that Olivia would not meet Medicaid financial eligibility. For about 18 months, with some financial help from her son, she managed to afford to stay in her home using her Social Security checks, taking out a loan on her house, and relying on her Medicare coverage. However, Medicare deductibles and copayments and unreimbursed prescription drugs accumulated, and what resources she had in the bank diminished. She again applied for Medicaid with the help of a county case worker and this time met the financial eligibility requirements. Olivia was enrolled in a Medicaid HCBS waiver and now receives the services and supports she needs to remain at home.
Gina is a 33-year-old woman who worked as a bartender. Her bartending job did not provide health insurance and she has no investments and limited savings. On her way home one night, she was shot in the head and sustained a traumatic brain injury. Although her prognosis for survival is good, her rehabilitation process will be extensive. Gina will not be able to return to any kind of work in the near

Pathways to Dual Eligibility: Mini-Case Studies
future. She is admitted to a nursing facility for rehabilitation. Because she has minimal income and assets and requires an institutional level of care, the nursing home assists her in applying for Medicaid. She is approved for Medicaid within three months and Medicaid covers her expenses retroactively to her date of admission. The nursing home social worker advises Gina's family that she is likely to be eligible for income support through SSDI and SSI and eventually Medicare after she is discharged from the nursing home. Her sister works with the Aging and Disability Resource Center to file applications. Gina is approved for SSDI and SSI a short time after leaving the nursing home. She receives Medicare coverage 24 months after becoming eligible for SSDI.
Tim is a 55-year-old man who abuses alcohol, has Type II diabetes, and has been diagnosed with bipolar disorder. He is alternatively homeless, living with his parents or staying with a series of friends. After his third arrest for public drunkenness, and the loss of another job, his elderly parents could no longer provide for his needs and took him to a mental health clinic, pleading for medical and financial aid. From there he was referred to the county's health department. Because Tim had worked intermittently throughout his adult life and contributed to Social Security, health department staff said he would likely be eligible for SSDI and eventually Medicare because of his disabilities. Also, his income and assets could be low enough to qualify for SSI and Medicaid. A health department caseworker assisted Tim with applications. After some months, Tim became eligible for SSDI and SSI and began receiving monthly checks. Medicaid came with SSI, which enabled Tim to obtain outpatient services for substance abuse and his mental health condition at a mental health clinic, as well as help managing his diabetes from a primary care physician. Following the 24-month waiting period, Tim received Medicare coverage and became a Medicare-Medicaid enrollee.
Kenny is a 48-year-old man with kidney disease that has progressed to the point that he requires dialysis three times a week. Now with a diagnosis of end-stage renal disease, he became eligible for Medicare via deemed disability. While on dialysis, Kenny was initially able to maintain employment. However, his disease progressed and he left his job to undergo a kidney transplant. Because of complications, he was unable to return to work. A social worker at the hospital advised Kenny that because he is unemployed, he could apply for SSDI to help offset his lost income and that he might be eligible for SSI and Medicaid. After an application process that spanned about 3 months, Kenny was enrolled in SSDI, SSI, and Medicaid, and thus became a Medicare-Medicaid enrollee.

Note: The individuals described in these case studies are fictitious, as are the events precipitating Medicare-Medicaid eligibility determination. Any resemblance to real persons, living or dead, is purely coincidental.

Coverage and Pathways Vary Across the States

In November 2009, the AARP Public Policy Institute, in partnership with the Congressional Budget Office, surveyed all 50 states and the District of Columbia to obtain up-to-date information on Medicaid financial eligibility pathways for older adults and persons with disabilities. Forty-nine states and the District of Columbia responded to the survey. AARP cross-referenced survey responses with information on state websites, in state waiver applications, and on the Kaiser Family Foundation website. Prior to this study, the last comprehensive review of

state financial eligibility standards was conducted by the Congressional Research Service in 2002 (Stone, 2002).

While most states offer both mandatory and optional pathways to Medicaid coverage, the variation across states is striking as demonstrated in the AARP report (in particular, see the state-by-state comparisons in the appendices). For example:

Welfare-Related Coverage: In 39 states and the District of Columbia, individuals who are determined eligible for SSI automatically become eligible for Medicaid. These states use federal SSI standards in determining eligibility. Eleven states (the 209(b) states) use more restrictive standards than SSI. These states had more restrictive Medicaid eligibility standards in place when SSI was enacted in 1972, and their program rules were grandfathered under Section 209(b) of the Social Security amendments.

State Poverty Level Coverage: States may opt to provide Medicaid coverage to individuals with incomes up to 100 percent of the FPL. Twenty-one states and the District of Columbia participate in this type of coverage, although five use thresholds lower than 100 percent of the FPL.

Medically Needy: Thirty-five states and the District of Columbia allow individuals with high medical expenses to "spend down" to Medicaid eligibility. Contrary to conventional wisdom, individuals do not have to be residing in a nursing home to qualify, nor must they require an institutional level of care. However, the medically needy pathway to Medicaid eligibility has been helpful for people who need institutional or waiver services. Twenty-four states and the District of Columbia extend medically needy coverage not only to institutionalized persons, but also to participants in HCBS waiver programs. In the medically needy states, there is wide variation in income and asset limits and the budget period for the spend-down computation.

Special Income Rule: This rule gives states the option to extend Medicaid coverage to individuals who require at least 30 days of nursing home care and whose income is too high to qualify for Medicaid. States may set income eligibility up to 300 percent of the SSI benefit amount. Thirty-nine states and DC apply a special income limit for older adults and individuals with disabilities in nursing homes and an additional four states apply a special income limit only for people participating in HCBS waiver programs.

Characteristics of Pre-Medicare-Medicaid Enrollees

A search of the literature found no definitions or studies specifically targeting pre-Medicare-Medicaid enrollees. However, examining the characteristics of SSDI and SSI recipients, Medicare participants under age 65, medically needy Medicaid beneficiaries, and aged Medicaid beneficiaries assessed to require an institutional level of care provides some insight into what this

population might look like. Similarly, the characteristics of current Medicare-Medicaid enrollees can be informative.

SSDI Recipients

The number of individuals receiving SSDI cash assistance increased by 50 percent from 2000 to 2009: from just over 5.9 million to 8.9 million. Workers with disabilities accounted for 87 percent of total recipients. Total monthly benefits for workers with disabilities increased by 39 percent from 2000 to 2009: from slightly more than $3.9 billion to $8.3 billion (Table 2). There were just under one million adult children SSDI recipients[10] in 2009. Total monthly benefits paid to adult children increased by 65 percent from 2000 to 2009, from $378 million to $623 million.

Table 2. SSDI Recipients and Payments, 2000 and 2009

	2000	2009	Percent Change
Number of Recipients	5,972,468	8,945,376	50%
Workers	5,042,333	7,788,013	54%
Widow(er)s	201,446	236,480	17%
Adult Children	728,689	920,883	26%
Total Monthly Benefits ($ Millions)			
Workers	$3,965	$8,289	39%
Widow(er)s	$105	$161	55%
Adult Children	$378	$623	65%
Average Monthly Benefit			
Workers	$796.40	$1,064.30	34%
Widow(er)s	$519.70	$682.70	32%
Adult Children	$518.30	$676.30	30%

Source: Social Security Administration. Annual Statistical Report on the Social Security Disability Insurance Program, 2009.

Among all SSDI recipients in 2009, the most common impairment was "Mental Disorders—Other" (27.5 percent), followed by "Musculoskeletal System and Connective Tissue" (24.9 percent). For adult children, the most frequent condition was "Mental Disorders—Retardation" (46.7 percent) and "Mental Disorders—Other" (19.8 percent) (Table 3).

[10] An adult disabled before age 22 may be eligible for child's benefits if a parent is deceased or starts receiving retirement or disability benefits. The "adult child" must be unmarried, age 18 or older, and have a disability that started before age 22.

Table 3. Top Seven Diagnostic Groups for SSDI Beneficiaries, 2009

Diagnostic Group	Total Recipients		Workers		Widow(er)s		Adult Children	
	Rank	% of Total	Rank	% of Total	Rank	% of Total	Rank	% of Total
Mental Disorders—Other	1	27.5%	1	28.5%	1	25.2%	2	19.8%
Musculoskeletal System and Connective Tissue	2	24.9%	2	27.6%	2	31.2%	7	0.8%
Nervous System and Sense Organs	3	9.4%	3	9.4%	4	7.3%	4	10.1%
Mental Disorders—Retardation	4	8.9%	5	4.6%	6	4.2%	1	46.7%
Circulatory System	5	7.9%	4	8.8%	3	8.7%	8	0.5%
Injuries	6	3.9%	6	4.2%	8	2.6%	5	1.6%
Endocrine, Nutritional, and Metabolic Diseases	7	3.3%	7	3.6%	5	7.0%	9	0.4%

Source: Social Security Administration. Annual Statistical Report on the Social Security Disability Insurance Program, 2009.

A Congressional Budget Office issue brief examines trends in SSDI participation and expenditures and suggests explanations for the growth in the number of SSDI recipients. The aging of the workforce and the increase in the number of women working have resulted in an increase in the number of people receiving SSDI benefits. The issue brief concludes that it is unclear how the effects of changes in the general health of the population have affected the number of SSDI beneficiaries. The easing of the eligibility criteria in the Disability Benefits Reform Act of 1984 has interacted with the workforce's changing demographics to increase the average time spent in the program. The brief also discusses trends in applications when employment opportunities are scarce (applications increase) and explains that the availability of health insurance probably affects application to the program (Congressional Budget Office, 2010).

Mathematica Policy Research, Inc. linked and analyzed data from the National Center for Health Statistics population-based surveys and SSA and Medicare administrative records to study SSDI beneficiaries during the six-year window surrounding SSDI entitlement. The study focused on recipient characteristics, insurance status, and health care access. SSDI participants were significantly older than the general population aged 18 to 64, less likely to have education beyond high school, and more likely to be widowed, divorced, or separated. SSDI recipients were less likely to be insured than the general working-age population, health care access problems were frequently reported, and poverty rates increased post-SSDI entitlement, suggesting significant gaps in the safety net before, during, and after SSDI enrollment (Livermore, Stapleton, & Claypool, 2010).

In another report, Mathematica Policy Research, Inc. reports on the characteristics of SSDI and SSI recipients. The authors conclude that beneficiaries have very limited or no ability to work for the following reasons: poor or deteriorating health (43 percent of SSDI beneficiaries; 41 percent of SSI beneficiaries); difficulty getting around outside the home (46 percent), concentrating (55 percent), and dealing with stress (58 percent); been enrolled for 10 years or longer and therefore

have lost attachment to the labor force (53 percent); have less than a high school education (42 percent); and live in poverty (49 percent) (Livermore, 2008).

SSI Recipients

The total number of SSI recipients increased from 6.6 million in 2000 to 7.7 million in 2009, or by 16.3 percent. This growth was fueled by a 22.7 percent increase in the number of recipients with disabilities: from 5.2 million in 2000 to 6.4 million in 2009. During the same period, the number of recipients who were blind or aged 65 and older decreased by 11.7 percent and 8.0 percent, respectively (Table 4). In 2009, individuals with disabilities accounted for 84 percent of all SSI recipients, up from 79 percent of total SSI recipients in 2000.

Federally administered SSI payments increased by 51.9 percent from 2000 to 2009, led by a 57.7 percent increase in payments to recipients with disabilities. Average monthly federally administered payments increased by 31.7 percent, with average monthly payments to recipients aged 65 and older increasing at the most rapid rate (33.2 percent).

Table 4. SSI Recipients and Payments, 2000 and 2009

	2000	2009	Percent Change
Number of Recipients of Federally Administered Payments	6,601,686	7,676,686	16.3%
Aged 65 and Older	1,289,339	1,185,959	-8.0%
Blind	78,511	69,302	-11.7%
With Disabilities	5,233,836	6,421,425	22.7%
Total Federally Administered Payments ($ Millions)	$30,672	$46,592	51.9%
Aged 65 and Older	$4,540	$5,569	22.7%
Blind	$386	$426	10.4%
With Disabilities	$25,746	$40,597	57.7%
Average Monthly Federally Administered Payment	$378.82	$498.75	31.7%
Aged 65 and Older	$299.69	$399.14	33.2%
Blind	$413.22	$520.30	25.9%
With Disabilities	$397.92	$516.93	29.9%

Source: Social Security Administration. Annual Statistical Supplement, 2010.

As Table 5 shows, the most common impairments for SSI recipients in 2009 were “Mental Disorders—Other” (38.1 percent) and “Mental Disorders—Retardation” (20.7 percent). Mental disorders were followed by “Musculoskeletal System and Connective Tissue” impairments (11.3 percent).

Table 5. Top Eight Diagnostic Groups for SSI Beneficiaries Aged 18-64, 2009

Diagnostic Group	Rank	% of Total
Mental Disorders—Other	1	38.1%
Mental Disorders—Retardation	2	20.7%
Musculoskeletal System and Connective Tissue	3	11.3%
Nervous System and Sense Organs	4	7.8%
Circulatory System	5	4.2%
Unknown	6	3.8%
Endocrine, Nutritional, and Metabolic Diseases	7	3.0%
Injuries	8	2.6%

Source: Social Security Administration. Annual Statistical Report on the Supplemental Security Income Program, 2009.

A Kentucky study provides an interesting snapshot of SSI recipients in rural Kentucky. In 2004, RTI International surveyed 1,329 Medicaid/SSI recipients aged 18 to 64 in 39 rural counties in southern and eastern Kentucky to compare access to care by type of disability. Medicaid claims were used to validate survey responses. Among those surveyed, 39.3 percent were eligible for SSI because of a physical disability, 31.2 percent because of mental illness, and 29.5 percent because of a developmental disability. Respondents with physical disabilities and mental illness were more likely to be female (60.9 percent and 72.0 percent, respectively). Respondents with physical and mental disabilities were more likely than those with developmental disabilities to report poor health status. Respondents with physical disabilities reported more limitations with activities of daily living (ADLs), while those with mental illness and developmental disabilities reported a greater number of limitations in instrumental activities of daily living (IADLs) (Mitchell, Hoover, & Bir, 2004).

A 2000 study of the experience of community-residing SSI recipients aged 19 to 64 in the Oregon Health Plan (a Medicaid managed care plan authorized under an 1115 waiver) found that the Medicare-Medicaid enrollees in the study population were younger, more often single, and had higher household incomes than the non-Medicare-Medicaid enrollees. Also among the Medicare-Medicaid enrollees, there was a higher proportion of individuals who had disabilities due to mental illness (Walsh & Khatutsky, 2000).

A CMS survey of Medicaid beneficiaries with disabilities in New York City was the data source for an examination of access to and use of care among subgroups of the population with disabilities—adults with physical disabilities, mental illness, and developmental disabilities. Long, Coughlin, and Kendall (2002) concluded that those with mental illness and those with greater health and functional limitations faced more difficulties in obtaining medical care.

Medicare Participants

The number of Medicare enrollees with disabilities (these individuals are under age 65) increased from 5.3 million in 2000 to 7.7 million in 2009, or by 44.3 percent. This compares to an increase of only 13.1 percent for enrollees aged 65 and older. The number of enrollees with disabilities who had end-stage renal disease totaled 203,939, or 2.6 percent of total enrollees with disabilities. In 2009, average per person payments for enrollees with disabilities were $10,484, 6.4 percent higher than average payments for enrollees aged 65 and older (Table 6).

Table 6. Medicare Enrollment and Payments, 2000 and 2009

	2000	2009	Percent Change
Number Enrolled (Thousands)	39,632	46,521	17.4%
With Disabilities	5,371	7,755	44.3%
Aged 65 and Older	34,261	38,766	13.1%
Number with End-Stage Renal Disease	338,992	423,533	24.9%
With Disabilities		203,939	
Aged 65 and Older		194,893	
End-Stage Renal Disease Only		24,701	
Total Program Payments ($ Millions)	$174,261	$318,009	82.5%
With Disabilities	$25,773	$59,462	130.7%
Aged 65 and Older	$148,488	$258,546	74.1%
Program Payments Per Person Served	$5,323	$9,962	87.2%
With Disabilities	$5,252	$10,484	99.6%
Aged 65 and Older	$5,335	$9,849	84.6%

Source: Medicare and Medicaid Statistical Supplement, 2002 and 2010 Editions

Medicare-Medicaid Enrollees

By examining the current population of Medicare-Medicaid enrollees, it is possible to shed light on which pre-Medicare-Medicaid enrollees are likely to progress to full Medicare-Medicaid eligibility. The demographic characteristics, service utilization patterns, and impairments of current Medicare-Medicaid enrollees might be used to develop criteria for identifying the most vulnerable pre-Medicare-Medicaid enrollees and providing them with services and supports that could be most helpful in preventing a decline in functional status and/or enabling the individual to continue workforce participation.

Historical data on the number of Medicare-Medicaid enrollees, their characteristics, and their utilization and expenditures were not found in the published literature or in government reports. The Kaiser Family Foundation has published annual estimates for the past five or six years based on analyses by the Urban Institute using data from the Medicaid Statistical Information System (MSIS). However, there is no compilation of historical trend data on Medicare-Medicaid enrollees such as that available for Medicare and Medicaid beneficiaries and SSDI and SSI recipients.

The Urban Institute most recently estimated that there were 10.3 million Medicare-Medicaid enrollees in federal fiscal year (FFY) 2010. Medicare spending by this population totaled $180.6 billion and Medicaid spending totaled $167.5 billion (Holahan, 2010).

A MedPAC analysis of the Medicare Current Beneficiary Survey Cost and Use file from 2006 was the most comprehensive analysis of Medicare-Medicaid enrollees identified in the literature review. The analysis found that, when compared to other Medicare beneficiaries, Medicare-Medicaid enrollees were more likely to be young and have a disability, be a member of a minority group, and report poor health status. Physical and cognitive impairments varied considerably for Medicare-Medicaid enrollees who were aged 65 and older compared to those who were under age 65 and had disabilities. As shown in Table 7, 44 percent of the Medicare-Medicaid enrollees with a disability and 26 percent of the Medicare-Medicaid enrollees aged 65 and older had a mental illness. Among those with a disability, 18 percent had a developmental disability (Table 7).

Table 7. Physical and Cognitive Impairments Among Medicare-Medicaid Enrollees

Impairment	Enrollees Aged 65+	Enrollees with Disabilities
Mental Illness	26%	44%
Dementia	16%	3%
Developmental Disability	2%	18%
One or No Physical Impairments	54%	33%
Two or More Physical Impairments	3%	3%

Source: MedPAC

As shown in Table 8, chronic conditions varied for Medicare-Medicaid enrollees aged 65 and older and those with disabilities. This analysis was conducted by Mathematica Policy Research, Inc. for MedPAC and used the CMS merged Medicaid (MAX) and Medicare summary spending files for 2005. Most prevalent among the Medicare-Medicaid enrollees aged 65 and older were ischemic heart disease (43 percent) and diabetes (36 percent); 30 percent had Alzheimer's disease and related conditions. Among the Medicare-Medicaid enrollees with disabilities, depression was most prevalent (28 percent), followed by diabetes (23 percent).

Table 8. Most Frequent Chronic Conditions Among Medicare-Medicaid Enrollees

Chronic Condition	Enrollees Aged 65+	Enrollees with Disabilities
Alzheimer's and Related Conditions	30%	5%
Chronic Obstructive Pulmonary Disease	18%	10%
Depression	18%	28%
Diabetes	36%	23%
Heart Failure	33%	11%
Ischemic Heart Disease	43%	17%
Rheumatoid Arthritis/Osteoarthritis	31%	13%

Source: MedPAC

Medically Needy Medicaid Beneficiaries

"Medically needy" is an optional Medicaid eligibility category that can apply to individuals aged 65 and older, as well as younger people with disabilities. By deducting the cost of medical care from their income, certain individuals can "spend down" to qualify for Medicaid. This is a path to Medicare-Medicaid eligibility for individuals under age 65 who qualify for SSDI/Medicare, as well as for adults aged 65 and older who are entitled to Medicare. Individuals qualify if their countable income—after deducting medical and/or long-term services and supports (LTSS) expenses—is no more than the state's income limit for the medically needy program (AARP, 2010). Table 9 shows Medicaid enrollment and spending by the medically needy population in FY 2009.

Table 9. Medicaid Medically Needy Enrollees and Spending, United States, FY 2009

	Enrollment	Total Spending ($ Millions)	Per Enrollee Spending
All Populations	2,419,425	$30,074.1	$12,430.3
Aged 65 and Older	596,994	$14,072.1	$23,571.6
Persons with Disabilities	448,086	$12,728.0	$28,405.2
Adults Under Age 65	714,721	$2,092.4	$2,927.5
Children	659,624	$1,181.6	$1,791.4

Source: MSIS data, Centers for Medicare and Medicaid Services.

A search for studies on the characteristics of medically needy Medicaid beneficiaries and circumstances surrounding spend down to Medicaid eligibility uncovered a series of journal articles in the early 1990s focusing on spend down by nursing home residents. No recent literature was found. The literature from the early 1990s examined how many people were experiencing catastrophic nursing home expenses, the extent to which middle-class elderly people were exercising asset transfers to hasten Medicaid eligibility for nursing home coverage, the experience with nursing home residents transitioning from private-pay to Medicaid coverage, and characteristics of individuals in nursing homes who spent down to Medicaid coverage. Some of these studies are described below.

- Wealth and income data from two different samples of older adults in nursing homes were used to predict the time until spend down to Medicaid eligibility. "Welfare aversion" was found to be a significant factor, and elderly persons in the study appeared to receive asset transfers in order to avoid Medicaid eligibility (Norton, 1995).
- An analysis of the discharged resident survey of the 1985 National Nursing Home Survey found that only 10 percent of nursing home patients who entered as private-pay patients were discharged as Medicaid patients (Spence & Wiener, 1990).
- Among Medicaid nursing home clients in Michigan in 1984, 27.2 percent of elderly clients were "spend downers," with utilization similar to other nursing home clients but

lower Medicaid claims because they contributed more to the cost of their care (Burwell, Adams, & Meiners, 1990).

- A review of two different measures for how elderly people are affected by catastrophic nursing home expenses found that national studies underestimated the extent of spend down due to data limitations. Also, state studies only reflect state data sets and state-specific circumstances. The authors recommended more state studies and a better understanding of asset transfer (Adams, Meiners, & Burwell, 1993).

Special Income Rule for Individuals Requiring an Institutional Level of Care

Hilltop was unable to find studies on the characteristics of individuals qualifying for Medicaid based on the special income rule.

Potential Triggers for Medicare-Medicaid Eligibility

Hilltop researched the literature on factors that might hasten a descent into functional decline or economic insecurity among the population under age 65 with disabilities and those aged 65 and older.

Admission to a nursing home is a widely acknowledged signal of functional decline. Conditions and impairments that are predictors of a nursing home admission could be informative in identifying vulnerable pre-Medicare-Medicaid enrollees. A 2007 meta-analysis studied sociodemographic, functional, cognitive, service use, and informal support indicators for predicting nursing home admission among older adults in the United States. The strongest predictors were dependencies in three or more ADLs, cognitive impairment, and prior nursing home use (Gaugler, Duval, Anderson, & Kane, 2007). A 12-year epidemiological study of a community-based cohort of 1,147 older adults in southwestern Pennsylvania found that dementia and number of prescription medications measured at baseline were the strongest predictors of nursing home admission (Bharucha, Pandav, Shen, Dodge, & Ganguli, 2004).

Other predictors of functional decline in older adults could inform interventions for pre-Medicare-Medicaid enrollees. Cornette and colleagues (2005) identified five factors that are predictors of functional decline during a hospitalization and after discharge: age, pre-morbid IADL, low Mini Mental State score, a fall in the previous year, and poor self-perceived health. Kleinpell Fletcher, and Jennings (2008) present an overview of research and evidence-based practices for elderly care during hospitalization to prevent functional decline. Stuck et al. (1999) reviewed the literature published between 1985 and 1997 that reported statistical associations between individual baseline risk factors and subsequent functional status (defined as disability or physical function limitation) in community-based older persons. The strongest evidence for an increased risk in functional decline was for (in alphabetical order): cognitive impairment, depression, disease burden (co-morbidity), increased or decreased body mass index, lower extremity functional limitation, low frequency of social contacts, low level of physical activity,

no alcohol use compared to moderate use, poor self-perceived health, smoking, and vision impairment (Stuck et al., 1999). Muramatsu, Yin, and Hedeker (2010) examined the mental health effects of living in a society supportive of HCBS for individuals aged 70 and older. They found that low and declining functions in daily living and cognition constituted significant stressors among seniors and their spouses, and that informal support from non-spouse family and friends helped lower depression. In addition, in states with more supportive HCBS, there tended to be lower levels of depression, especially among those with no informal supports (Muramatsu et al., 2010).

Loss of employment (or the inability to work) and poverty in the post-retirement years are likely to thrust an individual into Medicare-Medicaid eligibility. The Urban Institute reviewed and synthesized the literature on the dynamics of poverty. Results were consistent regarding the events associated with entries and exits from poverty: labor supply and earnings are most significant, but changes in household composition (e.g., changes to or from female-headed household) are also important. Blacks, young adults, and female-headed households are especially vulnerable to poverty entry, low exit rates, and long durations. Employment, marriage, and education are also important factors (Cellini, McKernan, & Ratcliffe, 2008). The National Council on Aging analyzed data from the 2009 Current Population Survey Annual Social and Economic Supplement, the 2008 American Community Survey, and other sources to develop profiles of older adults in poverty. The analysis concluded that women, individuals aged 75 and older, and people from racial and ethnic minority groups are the most vulnerable to poverty. The report also shows geographic variations (Johnson & Wilson, 2010). AARP examined poverty among older adults and provides data on those spending more than 20 percent of their income on health care, by income level. The report also provides data on self-reported health status by family income level, which suggest that older adults with lower incomes are in poorer health (O'Brien, Wu, & Baer, 2010).

Loss of a spouse or caregiver can be a precursor to functional decline. Lee and Carr (2007) found that widowed persons whose spouses had serious ongoing health problems prior to death reported more limitations in performing daily activities; in addition, those who were not with their spouses before they died had greater functional limitations. In a study of a large population of married persons aged 35 to 84 in Finland, Martikainen and Valkonen (2007) found that excess mortality among surviving spouses was high from accidental, violent, and alcohol-related causes and moderate for chronic ischemic heart disease and lung cancer. Martikainen and Valkonen (2007) also found that bereaved women fared better than bereaved men. In another Finnish study, Nihtilä and Martikainen (2008) found that the risk of institutionalization is particularly high immediately after the death of a spouse.

Potential Interventions for Pre-Medicare-Medicaid Enrollees

Appendix 2 describes a number of federal and state programs that either target pre-Medicare-Medicaid enrollees or could potentially target this population. When available, evaluation

findings are discussed. Included are suggested “intervention opportunities” for pre-Medicare-Medicaid enrollees.

Final Thoughts

The many pathways to Medicare-Medicaid eligibility are dependent on a complex interplay of age, health, disability, and socioeconomic status, as well as an intricate web of eligibility requirements, application procedures, and waiting periods.

The literature puts forth a number of recommendations for policy change related to SSDI, including eliminating the 24-month Medicare waiting period, strengthening incentives for SSDI recipients to work, providing incentives for employers to offer additional supports for people with disabilities, and “unbundling” SSDI from Medicare benefits. All of these could significantly alter the number of Medicare-Medicaid enrollees.

Under the ACA, individuals aged 18 to 64 with incomes up to 133 percent of the FPL will be eligible for Medicaid benefits. This will likely increase the number of Medicare-Medicaid enrollees. However, it is difficult to predict how the ACA will affect SSDI applications. Applications may decline if people can more easily obtain health insurance without applying for SSDI in order to obtain Medicare coverage.

Analytical studies are needed to learn more about how existing Medicare-Medicaid enrollees came to be eligible for both programs. What are their demographic and socioeconomic characteristics, functional and health status, medical conditions and diagnoses, patterns of service use, and life circumstances, both before and after becoming Medicare-Medicaid enrollees? Are there sub-populations within the broader population? Among individuals over age 65, how are those who became Medicare-Medicaid enrollees before age 65 different from those who became Medicare-Medicaid enrollees after age 65? How did they find their way through the eligibility determination process and what kind of help did they get along the way from health care providers and social services agencies?

In order to develop effective interventions for pre-Medicare-Medicaid enrollees, it is important to have criteria for identifying those at greatest risk. The analytical studies described above, as well as programs such as the Community Living Program (see Appendix 2), can point to possible targeting criteria.

Mental health conditions are the most prevalent conditions across the entire spectrum of pre-Medicare-Medicaid enrollees and those who are eligible for Medicare-Medicaid. Many under age 65 with mental health conditions can participate in the workforce and lead productive lives with proper treatment. For those aged 65 and older, better management of mental health conditions can help prevent functional decline and improve quality of life. Developing and rigorously evaluating interventions to address mental health issues is exceedingly important.

Finally, the programs described in Appendix 2 offer a variety of intervention approaches. It will be important to finance sound evaluations that measure the extent to which functional decline can be forestalled or minimized and economic security can be assured during periods of disability and in the post-retirement years.

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Appendix 1. Framework for Literature Review on Pathways to Medicare-Medicaid Eligibility

Topics to Investigate		Data Sources	Pathways to Medicare-Medicaid Eligibility		
			<65 w/ Disability*	65+ w/ Low Income	65+ in NF Spend Down
1. Map pathway to Medicare-Medicaid eligibility (i.e., age, functional, and financial eligibility requirements; processes; timeframes)		Published literature			
2. Any estimates or descriptions in the literature on pre-Medicare-Medicaid enrollees: number, service utilization, costs		Published literature Internet research State analyses			
3. Types of events that trigger Medicare-Medicaid eligibility and could be the focus of interventions:	Clinical triggers for a rapid descent into functional decline—e.g., an event (fall, broken hip) or a chronic disease that is not managed well	Published literature Internet research State reports			
	Life events that can trigger a rapid descent into functional decline (e.g., loss of spouse, move from home, loss of health insurance)	Published literature Internet research State reports			
	Income maintenance/financial factors that can trigger a rapid decline in income/assets (e.g., disability classification, long-term unemployment, loss of pension, death of spouse)	Published literature Internet research State reports			
4. Barriers to Medicare-Medicaid eligibility determination along the pathway (e.g., 2-year wait for <65 with disability group)		Published literature Internet research State reports Interviews with key informants (SSA, CMS, states)			

Topics to Investigate	Data Sources	Pathways to Medicare-Medicaid Eligibility		
		<65 w/ Disability*	65+ w/ Low Income	65+ in NF Spend Down
5. Examples of federal programs to help states assist pre-Medicare-Medicaid enrollees, by type (i.e., diversion, transition, Info/referral). Provide information on program descriptions, participating states, number of people served, expenditures, etc. (to the extent such information is available)	Published literature Federal websites/reports Interviews with key federal informants (CMS, AoA)			
6. Provisions in the Affordable Care Act that are likely to affect the current pathways to Medicare-Medicaid eligibility	ACA Published literature Federal websites/reports			
7. Examples of innovative state programs to assist pre-Medicare-Medicaid enrollees, by type (i.e., diversion, transition, info/referral). Provide state, program description, number of people served, expenditures, etc. (to the extent such information is available)	Published literature State websites/reports Interviews with key state informants			
8. Perceived gaps in federal/state programs for averting/delaying Medicare-Medicaid eligibility	Published literature State websites/reports Interviews with key federal/state informants			
9. Any potential new strategies/options for averting/delaying Medicare-Medicaid eligibility	Published literature State websites/reports Interviews with key federal/state informants			

* Includes both individuals with disabilities and those with deemed status (e.g., end-stage renal disease or amyotrophic lateral sclerosis).

Appendix 2. Potential Interventions for Pre-Medicare-Medicaid Enrollees

Below are descriptions and evaluation findings (when available) of a number of federal and state programs that either target pre-Medicare-Medicaid enrollees (typically without mentioning this population, but as part of a larger, diverse population) or could potentially target this population. The programs have been organized into seven categories: subsidized LTSS for pre-Medicare-Medicaid enrollees, immediate access to services for medically needy clients, programs to support caregivers, health insurance for pre-Medicare-Medicaid enrollees, supported employment to encourage workforce participation, medical homes for a continuum of coordinated services and supports, and new settings for serving pre-Medicare-Medicaid enrollees. Following the program descriptions within each category are suggested "intervention opportunities" for pre-Medicare-Medicaid enrollees.

Subsidized LTSS for Pre-Medicare-Medicaid Enrollees

Community Living Program

The Community Living Program is sponsored by AoA. The stated purpose of the program is to assist individuals whose incomes are too high to qualify for Medicaid but who are at risk of nursing home placement and spend down to Medicaid to continue to live in their communities. Grants were awarded to 12 states in 2007, 14 states in 2008, and 16 states in 2009. Prior to 2009, the program was called the Nursing Home Diversion Modernization program. The programs were to develop targeting criteria to ensure that the target population was served, use flexible dollars so that services could be tailored to the individual consumer, offer the option of a Cash & Counseling model, and complement and support family caregivers. In addition, each state was to carry out a program evaluation. In most states, the programs are still in progress and evaluations are not yet available. AoA has not commissioned a national evaluation.

Hilltop requested program information and evaluation reports from all of the Community Living Program states. Evaluation reports were received from Michigan and New York. While these reports provide useful information on program implementation, they do not provide conclusive findings on program outcomes—e.g., whether the program was successful in diverting participants from nursing homes. To do so would entail a larger-scale study with a control group. A review of targeting criteria used by states for identifying individuals at risk of nursing home placement, as well as service packages provided to program participants, could inform future interventions. For example, Michigan developed a screening tool based on functional criteria, financial indicators, and major life events, such as loss of a caregiver, a hospital or nursing home discharge, or an allegation of abuse.

Oregon Project Independence

Established in 1975, Oregon Project Independence serves older adults who have too many assets to qualify for Medicaid but can remain in their own homes if they receive appropriate services. The stated goals are to promote quality of life and independent living; provide preventive and long-term services and supports to reduce the risk for institutionalization and promote self-determination; provide services to frail and vulnerable older adults who have limited access to LTSS; and to optimize personal and community support resources. The program is funded with state general fund revenue and client fees using a sliding scale based on income after deducting out-of-pocket medical expenses. The state provides "pass-through" funding to the area agencies on aging (AAAs) to implement the program locally, so program design can vary across the state. Services include case management, home care, personal care, assisted transportation, adult day care, respite care, nursing services, chore services, and home-delivered meals.

A November 2004 review of Oregon Project Independence found that the program served 2,213 clients and collected $136,642 in client fees from July 2003 to June 2004. The monthly cost per client averaged $109.00. Thirty-two percent of clients were determined to need assistance with mobility, cognition, or eating. The program review concludes, "Without these services provided through the OPI program, these clients would require admission to a nursing facility to meet ADL needs" (Oregon Department of Human Services, 2004). However, the review lacks evidence to adequately support this conclusion.

Florida Community Care for the Elderly

The Community Care for the Elderly Act, passed in 1973 and amended in 1976, authorized funding for demonstration projects to test cost-effective ways of keeping older adults in their homes and preventing institutional placement. The Act was amended again in 1980 to expand the program statewide. Community Care for the Elderly provides community-based services to homebound adults aged 60 and older at risk of nursing home placement to remain in their homes or in the home of a caregiver. All clients are charged fees on a sliding scale based on income. The program is funded by the state and administered by the Department of Elder Affairs. AAAs are responsible for administering the funds and operating the program at the local level. A case manager is assigned to each client. Services include adult day care, home health aide, homemaker services, counseling, home repair, medical therapeutic care, home nursing, emergency alert response, and others.

Connecticut Home Care Program for Elders

The Connecticut Home Care Program for Elders (CHCPE) serves adults aged 65 and older who are at risk of institutionalization or at risk of staying in an institution unless home care services are available. Individuals must qualify for one of three service levels. Category 1 is "at risk of hospitalization or short-term nursing home care" and the care plan limit is "no more than 25 percent of nursing home costs." Category 2 is "in need of short or long-term nursing home care"

and the care plan limit is "no more than 50 percent of nursing home costs." For Categories 1 and 2, there is a limit on assets, but there is no limit on income. Category 3 is a Medicaid waiver for clients who are assessed to need a nursing home level of care and who are eligible for Medicaid. Services for clients in Categories 1 and 2 are funded mostly with state funds; enrollment is dependent on availability of funds. Nurses and social workers provide care management, conduct in-home assessments, and establish and monitor plans of care. Services include adult day care, homemaker services, companion and chore services, home-delivered meals, emergency response systems, home health services, mental health counseling, home health aides, adult foster care, and nursing and therapist services.

A 2010 study by Robinson et al. examined unmet needs and service gaps for CHCPE clients using administrative data for a retrospective cohort of CHCPE clients, care manager notes, and focus groups with care managers to learn about system gaps leading to nursing home admission. Forty-nine percent of CHCPE clients who left the program entered nursing homes. Identified service gaps included a lack of home care providers available on nights and weekends, limits on covered services, and the need for an intermediate type of homecare worker who could provide a wide range of care, from hands-on care to homemaker services. The study also found an increasing presence of substance abuse and mental health needs and a lack of appropriate housing. The study makes a number of recommendations for redesigning CHCPE based on these findings (Robinson et al., 2010).

Jersey Assistance for Community Caregiving (JACC)

JACC is a New Jersey state-funded program that provides services to individuals aged 60 and older who are at risk of nursing home placement but have incomes too high to be eligible for Medicaid. JACC services are limited to a maximum of $600 per month, or $7,200 annually. Clients may be required to make a co-payment based on a sliding scale. Services are based on an assessment, a plan of care, and availability of funding. Services include respite care, homemaker services, environmental accessibility adaptations, personal emergency response systems, home-delivered meals, adult day care, special medical equipment and supplies, transportation, chore services, attendant care, and home-based supportive care.

Subsidized LTSS for Pre-Medicare-Medicaid Enrollees

Intervention Opportunities: Many states have state-funded programs similar to the programs described above that provide subsidized LTSS to older adults. With funding, these programs could be expanded to serve younger people with disabilities. Before expanding such programs, however, research is needed on how to effectively target pre-Medicare-Medicaid enrollees who are most vulnerable using health status, functional status, and financial measures, as well as information on life circumstances that affect wellbeing. A demonstration with a rigorous evaluation that tests some of the most promising targeting models used in Community Living Program states could inform program expansion.

Immediate Access to Services for Medically Needy Clients

For individuals receiving HCBS and seeking to spend down to Medicaid eligibility, states typically determine the monthly amount that an individual must "spend down" in order to qualify, and the individual will often accumulate unpaid HCBS claims for several months while eligibility is being determined. In some cases, providers discontinue services because of the unpaid claims, putting the individual at risk of nursing home placement.

Hawaii implemented the Quest Expanded Access (QExA) managed long-term care program in 2009 under an 1115 waiver. When individuals are expected to spend down to Medicaid eligibility within several months, they may pay an enrollment fee equal to their monthly spend-down amount to a QExA health plan in order to enroll in QExA immediately. This helps prevent service disruption during the eligibility determination process (Engquist, Johnson, & Johnson, 2010).

Immediate Access to Services for Medically Needy Clients

Intervention Opportunities: Other states with managed care programs could negotiate similar arrangements with health plans. States with fee-for-service LTSS programs could use retroactive eligibility.

Programs to Support Caregivers

Connecticut Choices at Home

Choices at Home provides caregivers who qualify for the Connecticut Statewide Respite Program or the National Family Caregiver Program with up to $3,500 per year to hire family, friends, or someone else to provide personal care, general housekeeping, and companionship. The program also provides up to $4,000 per family for home modifications. This program is funded with a grant from AoA.

Florida Home Care for the Elderly

Home Care for the Elderly is another state-funded program that targets individuals at risk of nursing home placement. This program provides subsidy payments to help caregivers assist older adults with low incomes in their own home or the home of the caregiver. The payments to caregivers are for support and health maintenance and to assist with specialized health needs.

Programs to Support Caregivers

Intervention Opportunities: These are relatively low-cost programs that could encourage informal caregivers to continue to care for their loved one. States could be encouraged to implement such programs, perhaps with Older Americans Act funding.

Health Insurance for Pre-Medicare-Medicaid Enrollees

Medicaid Buy-In Program

The Medicaid Buy-In program was authorized by the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket to Work). The program allows states to expand Medicaid coverage to workers with disabilities whose incomes and assets would otherwise make them ineligible for Medicaid. To participate, an individual must have a disability as defined by the SSA and earned income. Currently, 42 states have Medicaid buy-in programs under BBA, Ticket to Work, or 1115 waivers. States have flexibility in establishing financial eligibility requirements, premiums, and co-payments. Providing Medicaid coverage to individuals with disabilities who have incomes too high to qualify for SSDI/Medicare can help keep these individuals healthy and working—and deter them from resorting to SSDI and Medicare.

At least one in three Medicaid Buy-In participants has a diagnosis of a disabling mental health condition. In their study, Liu and Croake (2010) found that, compared to other Medicaid Buy-In participants, those with serious mental illness (SMI) had lower medical expenses, were more likely to be employed, and were more likely to increase their earnings over time.

States with Medicaid Buy-In programs authorized under Ticket to Work have the option to include populations with conditions that have improved to the point where they no longer qualify under the SSA's definition of disability. Demonstrations involving individuals with SMI would be useful to assess whether they could stay healthy and gradually increase their earnings.

Accelerated Benefits Demonstration

The SSA designed and funded the Accelerated Benefits Demonstration in 2006. This demonstration is currently underway. Individuals qualifying for SSDI benefits must complete a 5-month waiting period before receiving cash benefits; then they must wait an additional 24 months to entitlement to Medicare. SSDI beneficiaries with serious health care needs may not have health insurance during this period. The random assignment evaluation of the Accelerated Benefits Demonstration has two intervention groups: one group receives coverage under a private health insurance plan and the second group receives benefits under the health insurance plan, plus additional services by telephone. The evaluation is examining health, use of medical

care, functioning, employment, and payment of SSDI benefits (Wittenburg, Warren, Peikes, & Freedman, 2010).

Health Insurance for Pre-Medicare-Medicaid Enrollees

Intervention Opportunities: Launch a federal demonstration with a rigorous evaluation to encourage states to enroll individuals with SMI in their Medicaid Buy-In programs to determine the effects on SSDI and SSI participation and employment. If the evaluation of the Accelerated Benefits Program indicates positive outcomes, provide incentives to states to implement the program more broadly.

Supported Employment to Encourage Workforce Participation

Demonstration to Maintain Independence and Employment (DMIE)

DMIE was authorized by Ticket to Work. DMIE is intended to determine whether workers with potentially disabling conditions who receive a comprehensive package of health care services and employment supports are successful in postponing or avoiding the need for disability benefits.

Four states have DMIE demonstrations—Minnesota, Kansas, Texas, and Hawaii. Minnesota's program and evaluation results are described immediately below. Evaluation results are not yet available for the other three programs. The Kansas program targets working individuals in the state's high-risk insurance pool who have pre-existing health conditions. Hawaii is targeting employed adults with diabetes. The Texas demonstration is providing enhanced services to employed adults with SMI or a behavioral diagnosis co-occurring with a physical diagnosis.

Minnesota Stay Well, Stay Working: The Stay Well, Stay Working (SWSW) DMIE demonstration offered working persons with SMI a comprehensive set of health, behavioral health, and employment support services. The demonstration employed an experimental design in which participants were randomly assigned to either the intervention group (1,494 individuals) or control group (300 individuals). The demonstration was implemented in two regions in Minnesota from January 2007 to September 2009. Wellness and Employment Support Navigators assessed enrollees' health, behavioral health, and employment support needs; developed a Wellness and Employment Success Plan; and educated, supported, and empowered enrollees to manage health, behavioral health, and employment issues and effectively use available services. The evaluator found a number of positive outcomes—the most important being that access to comprehensive health and behavioral health coverage and employment support services affected the likelihood of applying for SSDI. Fourteen percent of the control group applied for SSDI within one year of enrollment, while only 4 percent of the intervention group applied.

Supported Employment for Individuals with Mental Health Conditions

Drake, Skinner, Bond, and Goldman (2009) reported that providing mental health services along with evidence-based supported employment—a rigorously tested service model that helps people with mental health disabilities succeed in a competitive employment environment—to the population with mental health-related disabilities could reduce growth in rates of disability and enable those who have been determined to have a psychiatric disability to work and contribute to their own welfare. The authors also make a number of recommendations to encourage individuals with mental health conditions to work: delinking health insurance from disability status in order to encourage people with disabilities to work; linking supported employment services to mental health services; creating more incentives for individuals who qualify for SSDI or SSI to move back into the workforce as rapidly as possible; and, for people in the early stages of mental illness, intervening early to provide supported employment and mental health services.

Senior Community Service Employment Program (SCSEP)

SCSEP is a community service and training program for adults who are at least 55 years old, unemployed, and have a family income of no more than 125 percent of the FPL. The program is authorized under Title V of the Older Americans Act (OAA). Administered by the U.S. Department of Labor, it is the only OAA program not administered by AoA. Fiscal year 2011 funding is approximately $571.9 million; 22 percent of funds are allocated among states and territories and 78 percent of funds are used for competitive grants. There are currently 74 grantees: 18 national organizations and 56 units of state and territorial governments. SCSEP provides eligible participants with job training and other employment supports and subsidizes wages and fringe benefits.

President Obama's proposed FY 2012 budget calls for reducing funding for SCSEP by 45 percent and transferring responsibility for the program to AoA "to consolidate senior services and provide them more effectively" (Executive Office of the President, 2011).

Supported Employment to Encourage Workforce Participation

Intervention Opportunities: With its encouraging evaluation findings, Minnesota's Stay Well, Stay Working program could be continued and replicated in other states. The other three DMIE programs should be monitored to see if the evaluations warrant program replication. Demonstrations linking supported employment with mental health services for people with mental health disabilities could be carried out to test various models. Finally, if SCSEP were moved from the Department of Labor to AoA, this program could be re-examined, fine-tuned, and linked to health services and LTSS so that it could serve pre-Medicare-Medicaid enrollees. This could be done in the context of reviewing all OAA programs, as the OAA is due for reauthorization this year, effective in FY 2012.

Medical Homes for a Continuum of Coordinated Services and Supports

Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration

MAPCP uses advanced primary care (APC) practices, or "medical homes," to provide patient-centered care using a team approach. APC practices emphasize prevention, health information technology, care coordination, and shared decision making among patients and providers in order to improve the quality and coordination of health services. This is a medical model; services do not extend to LTSS.

In the MAPCP demonstration, Medicare is joining with Medicaid and private health plans to provide a monthly care management fee for beneficiaries receiving primary care from APC practices. The care management fee covers care coordination, improved access, patient education, and other services to support patients with chronic illness. Participating states are expected to monitor utilization patterns for Medicare patients and work to improve the efficiency and effectiveness of care for Medicare beneficiaries and Medicare-Medicaid enrollees.

In November 2010, CMS selected eight states to participate in the three-year MAPCP demonstration: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota. These states previously operated APC programs involving just Medicaid and private health plans, so they will now extend the programs to Medicare beneficiaries and Medicare-Medicaid enrollees. Programs in two of the MAPCP states are worth noting and described below.

- **Vermont Blueprint for Health:** This statewide public/private partnership was launched by Vermont in 2006 to transform health care delivery in the state. Vermont uses medical homes supported by community health teams as its foundation, and the state is moving toward a system of universal coverage that would include medical homes for all residents. Vermont's community health teams provide a link between primary care and LTSS and connect patients to social and economic support services (Hsiao, 2011; Bielaszka-DuVernay, 2011b).
- **Community Care of North Carolina (CCNC):** Established in 1998, CCNC provides Medicaid beneficiaries with a medical home, care coordination, and disease management, although it does not integrate LTSS. Medical homes are provided through local nonprofit community networks composed of physicians, hospitals, social service agencies, and county health departments. Enrollment is mandatory for most children and parents, as well as for elderly individuals and persons with disabilities who are not Medicare-Medicaid enrollees. In 2009, CMS approved a waiver of §646 under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to allow the state to expand CCNC to include Medicare-Medicaid enrollees, although their participation is voluntary because of Medicare's "freedom of choice" requirement. Medicare fee-for-

service payments are unchanged and any cost savings are shared by the state and CMS (Engquist et al., 2010).

Geriatric Resources for Assessment and Care of Elders (GRACE)

GRACE was developed by Wishard Health Services in Indianapolis. GRACE is an integrated care model that targets older adults with low incomes—many of whom are Medicare-Medicaid enrollees and have chronic conditions. GRACE uses nurse-social worker teams to assess clients; develop individualized plans of care; and coordinate medical, behavioral health, and social services using a web-based tracking system. Evaluations have demonstrated cost savings and shown dramatic improvements in indicators of quality health care and geriatric-specific care. The developers of GRACE believe there is further potential for cost savings if the model were used to prevent or delay nursing home placement and if incentives were better aligned across Medicare and Medicaid through a shared savings model (Engquist et al., 2010; Bielaszka-DuVernay, 2011a).

Medicaid Health Homes

Section 2703 of the ACA permits states to provide a "health home" to Medicaid beneficiaries with at least two chronic conditions under a new state plan option. The health home provider will be responsible for coordinating all of the individual's care, including physical health, mental health, and substance abuse prevention and treatment services. This new option became available to states on January 1, 2011. The Federal Medical Assistance Percentage (FMAP) for health home services will be 90 percent for the first two years that the state plan amendment is in effect.

The ACA defines chronic conditions to include asthma, diabetes, heart disease, a mental health condition, a substance use disorder, and being overweight with a body mass index of over 25. States can target populations based on the number of chronic conditions, a specified combination of chronic conditions, or the severity of the chronic conditions. Six core health home services specified in the ACA are reimbursed at the 90 percent FMAP. All other services provided to the specified population are reimbursed at the state's regular FMAP. States may *not* exclude Medicare-Medicaid enrollees because participation cannot be limited by eligibility category.

Medical Homes for a Continuum of Coordinated Services and Supports

Intervention Opportunities: All of the medical and health home models discussed above could be extended to include coordination of LTSS to help manage chronic conditions and prevent functional decline and further disability. In reaching beyond Medicare and Medicaid beneficiaries to the broader population, these programs will naturally include pre-Medicare-Medicaid enrollees. If aging and disability resource centers (ADRCs) were to be expanded to provide information, referrals, and application assistance for income support and supported work programs as well as health services and LTSS, care coordinators could refer pre-Medicare-Medicaid enrollees to the ADRCs for a full range of services. A demonstration with a randomly

selected control group that targets pre-Medicare-Medicaid enrollees for enrollment in a health home that provides a full continuum of services and supports could examine the extent to which a health home can prevent or delay Medicare-Medicaid eligibility and help this population to stay healthy and in the workforce.

New Settings for Serving Pre-Medicare-Medicaid Enrollees

Federal Qualified Health Centers (FQHCs)

There are about 1,200 FQHCs in the United States, as well as many FQHC look-alikes. FQHCs are intended to provide primary and preventive health care services to low-income, medically underserved, and vulnerable populations who have limited access to affordable care.

Naturally Occurring Retirement Communities (NORCs)

NORCs are housing developments, apartment buildings, and neighborhoods with high concentrations of older residents. There are about 300 self-identified NORCs in the United States. NORC Supportive Services Programs (NORC-SSP) have implemented health and social services programs designed to support "aging in place" and prevent or delay institutionalization. Eligibility is based on age and residence, not functional status or income, although the programs use publicly funded programs to weave together supportive services for residents. NORC-SSPs typically provide case management/assistance and social work services; health promotion and disease prevention assistance; education, socialization, and recreational activities; and volunteer opportunities for members and others. Funding typically comes from a variety of sources—government, philanthropies, housing corporations, and participant fees (Engquist et al., 2010).

New Settings for Serving Pre-Medicare-Medicaid Enrollees

Intervention Opportunities: NORCs and FQHCs are potentially an untapped resource for targeting and serving pre-Medicare-Medicaid enrollees. This population could be given greater access to NORCs by receiving subsidies for rent and annual membership fees. FQHCs, which are probably already serving large groups of pre-Medicare-Medicaid enrollees, could function as health homes for this population, coordinating a full range of services. Financial incentives could be provided to FQHCs to establish these health homes.

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