



**U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy**

LOSS OF MEDICARE-MEDICAID DUAL ELIGIBLE STATUS:

FREQUENCY, CONTRIBUTING FACTORS AND IMPLICATIONS

POLICY BRIEF

May 2019

Office of the Assistant Secretary for Planning and Evaluation

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This report was prepared under contract #HHSP2332016000211 between HHS's ASPE/DALTCP and the Research Triangle Institute. For additional information about this subject, you can visit the DALTCP home page at <https://aspe.hhs.gov/office-disability-aging-and-long-term-care-policy-daltcp> or contact the ASPE Project Officer, Jhamirah Howard, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. Her e-mail address is: Jhamirah.Howard@hhs.gov.

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Loss of Medicare-Medicaid Dual-Eligible Status: Frequency, Contributing Factors and Implications

Policy Brief

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ACRONYMS

The following acronyms are mentioned in this report and/or appendix.

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
DI	Disability Insurance
D-SNP	Dual Eligible Special Needs Plan
ESRD	End-Stage Renal Disease
FFS	Fee-For-Service
HCBS	Home and Community-Based Services
LCL	Lower Confidence Limit
LTSS	Long-Term Services and Supports
MACPAC	Medicaid and CHIP Payment and Access Commission
MedPAC	Medicare Payment Advisory Commission
MMLEADS	Medicare-Medicaid Linked Enrollee Analytic Data Source
OASI	Old Age and Survivor's Insurance
RTI	Research Triangle Institute
SSA	U.S. Social Security Administration
SSI	Supplemental Security Income
UCL	Upper Confidence Limit

EXECUTIVE SUMMARY

ES.1. Background

Dual eligible beneficiaries constitute an important subset of the Medicare and Medicaid populations because these individuals are low income and have a high prevalence of chronic conditions and disabilities, substantial care needs, and disproportionately high Medicaid and Medicare expenditures. While stability in Medicare coverage is expected for all those enrolled, Medicaid coverage can be more volatile due to fluctuations in income, eligibility, and renewal requirements. Past research has not specifically considered stability of enrollment among *new*, full-benefit dual eligible beneficiaries following their initial transition to full-dual eligibility, and little is known about loss of Medicaid coverage for dual eligible beneficiaries.

For dual eligible beneficiaries, the loss of full-benefit Medicaid coverage is of concern because most of them do not have an alternative source of health insurance for the services covered by full-benefit Medicaid. For providers involved in the care of dual eligible beneficiaries, discontinuity in full-benefit Medicaid coverage may lead to disruption in care and adverse health outcomes. This policy brief seeks to document the frequency of Medicaid coverage loss among full-benefit dual eligible beneficiaries and identify potential causes for coverage loss.

ES.2. Methods

We used both quantitative and qualitative methods to gather information on the loss of Medicaid coverage among full-benefit dual eligible beneficiaries and possible causes. We conducted semi-structured, key informant interviews with ten subject matter experts who are knowledgeable about the dual eligible population and state Medicaid eligibility, enrollment, and redetermination procedures. These qualitative interviews were used to provide context for the interpretation of the results from quantitative data analysis.

The quantitative analysis used the national Medicare-Medicaid Linked Enrollee Analytic Data Source for 2006-2010. We focused on *new* dual eligible beneficiaries with full Medicaid and Medicare benefits. We then identified new, full-duals losing full-benefit dual status in the 12 months following their initial transition to that status, both with any break in coverage and a break in coverage lasting longer than 3 months. We conducted descriptive and multivariate analyses to examine the effects of beneficiary characteristics and state Medicaid eligibility policies on the risk of coverage loss.

ES.3. Qualitative Results

- Experts interviewed noted that the most common reason for a full-benefit dual eligible beneficiary to lose coverage would be failure to comply with certain administrative requirements, and less common reasons were changes in eligibility due to changes in income, assets, or functional status.
- Respondents indicated that both a lack of awareness of Medicaid program recertification requirements and the administrative burden of these requirements would contribute to coverage loss. They thought that individuals who were new to Medicaid could be especially vulnerable because of their lack of knowledge of Medicaid processes and procedures.

ES.4. Quantitative Results

- Among 2,580,078 individuals who newly transitioned to full-benefit dual eligible status during 2007-2009 and were followed for 12 months after the transition, 750,243 (or 29.1%) lost coverage for at least 1 month, and 543,659 (or 21.1%) lost coverage for more than 3 months, during these 12 months of follow-up.
- Compared to beneficiaries who were eligible for Medicaid based on receiving Supplemental Security Income (SSI) cash benefits, those who were eligible based on medically needy status, poverty-level coverage, Section 1115 Waivers, or other eligibility category had significantly higher risk of losing full-benefit Medicaid coverage.
- Compared to beneficiaries who were originally eligible for Medicare due to age (turning 65), those who were eligible because of disability or end-stage renal disease had 50% and 65% greater risk of losing coverage, respectively.
- Individuals who became Medicaid-eligible first before gaining Medicare eligibility had a 37% lower risk of losing coverage compared to those who started with Medicare coverage and transitioned to full-benefit Medicaid eligibility.
- Individuals in 209(b) states had a 32% higher risk of losing coverage, and those in states that apply the special income rule had 71% higher risk of losing coverage, compared to those in other states. Individuals in states that offer poverty-level coverage had a 38% lower risk of losing coverage. The individual-level risk of coverage loss did not differ significantly in states with the medically needy option and in other states without such an option.

ES.5. Discussion and Conclusion

Contrary to expectations, a substantial number--nearly 30%--of new full-benefit dual eligible beneficiaries lose coverage for at least 1 month during the 12 months immediately following their initial transition to full-dual eligible status. This frequency of coverage loss among *new*, full-benefit dual eligibles is notably higher than reported in previous studies that typically included a cross-section of dual eligibles, most of whom were not new duals. In addition, nearly 30% of those who lost coverage had short coverage breaks for 1-3 months, likely for reasons that are administrative in nature. These findings suggest that new dual eligible beneficiaries may be more unstable, as compared to other, more “established” duals. According to subject matter experts, this coverage instability may be due in part to unfamiliarity with Medicaid policies and eligibility verification procedures.

This analysis also sheds light on how Medicaid eligibility is associated with loss of Medicaid coverage at the individual level. Those who qualified for Medicaid coverage by receipt of SSI-cash benefits were the most stable group and those in the medically needy eligibility category were among the least stable. These findings are consistent with subject matter experts’ expectations.

There is wide variation in the rates of full-benefit Medicaid coverage loss across states, driven in part by state Medicaid eligibility policies. New full-duals in 209(b) states, or in states that apply the special income rule were more likely to lose coverage than those in states without such policies, while individuals in states that provide poverty-level coverage had lower risk of losing coverage. Findings suggest that states with relatively more inclusive Medicaid eligibility coverage policies (which may also have less stringent or more streamlined recertification and other procedural requirements) tend to decrease coverage loss than states with relatively more restrictive Medicaid coverage.

High “churning” in dual eligible status is problematic for both individual beneficiaries and providers. For dual eligible beneficiaries, the loss of full-benefit Medicaid coverage is of concern because most of them do not have an alternative source of health insurance for the services covered by full-benefit Medicaid. Without Medicaid support, many of these low income individuals may have difficulty paying for cost-sharing of Medicare services and may be unable to access services that are not covered by Medicare (such as long-term services and supports). For providers involved in the care of dual eligible beneficiaries, discontinuity in full-benefit Medicaid coverage may lead to financial losses.

1. BACKGROUND

More than 11 million people are dually eligible for Medicare and Medicaid services, and this population continues to grow (CMS, 2016). Dual eligible beneficiaries constitute an important subset of the Medicare and Medicaid populations because these individuals are low income and have a high prevalence of chronic conditions and disabilities, substantial care needs, and disproportionately high Medicaid and Medicare expenditures (Young et al., 2013). Individuals who are dually eligible can receive either partial or full Medicaid benefits depending on state Medicaid eligibility criteria. Partial-benefit dual eligible beneficiaries receive limited Medicaid support for Medicare premiums and sometimes cost-sharing; full-benefit dual eligible beneficiaries receive the full range of Medicaid benefits, including coverage of long-term services and supports (LTSS), in addition to assistance with Medicare premiums and cost-sharing (MedPAC & MACPAC, 2017). Generally, full-benefit dual eligibles are expected to have relatively stable Medicaid enrollment due to their low income and high health care and LTSS needs, especially among older people and people with disabilities, whose income and assets are expected to be stable (Ku & Steinmetz, 2013).

Since dual eligible beneficiaries represent a vulnerable population, gaps in insurance coverage can compromise access to care and result in increased costs and decreased quality of care, further increasing an individual's risk for adverse health outcomes (CMS, 2015). A prior study found that a substantial proportion, approximately 30%, of new, full-benefit dual eligible beneficiaries identified during 2007-2010 lost full-benefit coverage for at least 1 month in the 12 months following their transition to full-benefit dual status (Feng et al., 2017). Another study found among all dual eligibles, 15.6% lost Medicaid benefits in the 2009-2011 period. Dual eligibles younger than 65 had a higher rate of coverage loss, 21.4%, compared with those age 65 and older (Riley, Zhao, & Tilahun, 2014). Among all Medicaid enrollees in 2010-2011, individuals were enrolled for about 80% of the year (Ku & Steinmetz, 2013). Older people and persons with disabilities are enrolled for a greater portion of the year than other adults. As months of enrollment increased and continuity of Medicaid coverage improved, the average monthly cost of Medicaid coverage decreased (Ku & Steinmetz, 2013).

This policy brief aims to identify potential causes for the loss of Medicaid coverage among full-benefit dual eligible beneficiaries. While stability in Medicare coverage is expected because of eligibility due to age and the very low rate of exit from either Supplemental Security Income (SSI) or Social Security Disability Insurance, Medicaid coverage can be more volatile due to fluctuations in income, eligibility and renewal requirements (Riley et al., 2014). This analysis focuses on full-benefit dual eligible beneficiaries, as opposed to partial duals, as they constitute the majority of all dual eligibles and are among the highest cost and most vulnerable enrollees. In addition, the contribution of Medicaid toward health care use and spending is more modest for partial duals than for full-duals. We aim to better understand the relationship between states' Medicaid eligibility and enrollment policies and reasons for loss of Medicaid coverage among full-benefit dual eligible beneficiaries. Understanding the factors associated with gaps in dual coverage is the first step toward creating policies to mitigate loss of coverage and improve health outcomes for this population.

1.1. Medicaid Coverage Among Full-Benefit Dual Eligible Beneficiaries

Federal law requires states to provide Medicaid coverage to older people and individuals with disabilities who meet certain income, asset, and functional criteria. A categorization of key state Medicaid eligibility policies for older people and persons with disabilities is detailed in **Appendix Table A-1**). The most common pathways to Medicaid eligibility for older people and persons with disabilities are SSI and the Special Income Limit (Accius, Flowers, & Flinn, 2017).

In 39 states,¹ individuals receiving SSI benefits are eligible to receive Medicaid benefits. Among these SSI states, where receipt of SSI benefits is the same as meeting Medicaid *eligibility* standards, a further subset, known as “1634 States,” automatically *enroll* individuals receiving SSI in Medicaid and do not require a separate application for Medicaid (SSA, 2014).

States in which receipt of SSI is not sufficient for determining Medicaid eligibility are referred to as “209(b) States” after the section of the Social Security Act that authorizes this policy. The 209(b) states establish standards for Medicaid eligibility that are more restrictive than the SSI criteria with regard to either the level of income or the way that income and medical expenses are counted toward Medicaid eligibility. All 209(b) states are required to allow older people and people with disabilities to spend down to the state’s income and asset levels. States also have the option of providing coverage to older people and people with disabilities with incomes up to 100% of the federal poverty level (Stone, 2011).

States also have the option of extending Medicaid benefits to individuals through the Special Income Rule. Individuals receiving Medicaid benefits through the Special Income Rule must require an institutional level of care for at least 30 consecutive days, meet a designated resource threshold and have income below a specified level. States that choose to use the Special Income Rule but do not allow the medically needy option must allow individuals to place excess income into a Miller Trust. Miller Trusts allow individuals with incomes above the state-specified limit for the Special Income Rule to assign excess income to the Miller Trust, allowing them to qualify for Medicaid through the Special Income Rule.

Additionally, states may provide coverage to individuals if they are “medically needy.” Individuals are considered medically needy if their income minus out-of-pocket medical expenses places them below a state-established income and asset level during a specified period, known as the budget period. Both the amount of medical expenses and budget period are state specific.

Individuals may also receive benefits through Section 1115 research and demonstration waivers. States must apply to the Centers for Medicare & Medicaid Services (CMS) to waive certain provisions of the Medicaid statute in order to demonstrate innovative approaches to increase access to Medicaid for individuals, provided they do so in a way that is budget neutral to

¹ This refers to 2006-2010, the period for data analysis reported in this brief. In 2014, Indiana became a 209(b) State. Currently, 40 states use SSI criteria to determine Medicaid eligibility.

the Federal Government. In applying for Section 1115 Waivers, the state must demonstrate that the demonstration will increase coverage and access to Medicaid, improve health outcomes, and increase the quality of care for the low income population served by Medicaid. Most often this is accomplished through delivery system reform. Eligibility and benefits received under Section 1115 Waivers vary by state (CMS, 2017).

1.2. Limited Understanding of Medicaid Coverage Loss among Full-Benefit Dual Eligible Beneficiaries

Past research has not specifically considered stability of enrollment among *new*, full-benefit dual eligible beneficiaries following their initial transition to full-dual eligibility. However, there are a few studies examining the loss of Medicaid coverage for full-benefit dual eligible beneficiaries. A 2014 study found that among a 5% sample of all full-benefit dual eligible beneficiaries nationally, 15.6% lost Medicaid benefits in the 36-month study period, January 2009-December 2011 (Riley et al, 2014). Among those losing benefits, almost one-third (28.8%) lost benefits for only 1-3 months and just over one-half (51.3%) eventually regained benefits. The authors also find that a higher probability of maintaining Medicaid coverage is associated with higher Medicaid fee-for-service (FFS) expenses (among those not enrolled in Medicaid prepaid plans) and with enrollment in a Dual Eligible Special Needs Plan (D-SNP). Those enrolled in Medicare Advantage plans were more likely to lose Medicaid coverage.

A recent study considered the continuity of Medicaid coverage through the creation of Medicaid enrollment “continuity ratio,” which calculates the length of Medicaid enrollment in a year by dividing the average monthly number of Medicaid enrollees during a fiscal year by the number of unduplicated individuals enrolled in Medicaid at any time during the year (Ku & Steinmetz, 2013). In the 2010-2011 period, the overall continuity ratio was 81%; the ratio was 86% in the aged population, 90% in the blind/disabled population, 83% among children, and 72% among nondisabled adults.

A study completed by the Kaiser Family Foundation in 2006 examined the stability of Medicaid coverage (regardless of partial-benefit or full-benefit status) among those who had Medicare coverage in the 1997-2000 time frame. Over the 4 years examined, among all Medicare beneficiaries in the sample, 20.6% were dually eligible for Medicaid and Medicare, 12.5% had continuous Medicaid enrollment and 8.1% had noncontinuous Medicaid enrollment (Stuart & Singhal, 2006). Those with continuous Medicaid enrollment do not differ substantially in age from those with noncontinuous enrollment.

2. METHODS

We used a combination of methods to gather information on the loss of Medicaid coverage among full-benefit dual eligible beneficiaries and possible causes, including interviews with subject matter experts and quantitative data analysis. The information from the subject matter expert interviews was used to provide context for the interpretation of the results from quantitative data analysis.

2.1. Subject Matter Expert Interviews

We conducted semi-structured, key informant interviews with ten subject matter experts who are knowledgeable about the dual eligible population and state Medicaid eligibility, enrollment, and redetermination procedures. Seven of these interviews were with national experts and three were with state Medicaid officials. These interviews occurred from May-June 2017, and each lasted about 45 minutes. The goal of these interviews was to identify Medicaid policies regarding eligibility and enrollment procedures that are possibly related to the loss of full Medicaid benefits among dual eligible beneficiaries. Interviews were conducted according to standard qualitative data collection and evaluation practice, guaranteeing respondent anonymity and confidentiality.

2.2. Quantitative Analysis

2.2.1. Data Source

We used the national Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) for 2006-2010, the most recent years of this data available at the time of our research. MMLEADS contains data on demographics (age, sex, race/ethnicity, date of birth, date of death), program eligibility (Medicare-Medicaid coverage initial start date, original reason for Medicare eligibility and current reason for Medicare-Medicaid eligibility, dual status indicator, FFS vs. managed care enrollment), utilization, and spending for all Medicare-Medicaid enrollees (Buccaneer, 2015). Monthly data for most of these variables (e.g., flags for dual status, Medicaid Analytic eXtract uniform eligibility codes, Medicare-Medicaid service utilization and spending) are available in MMLEADS.

2.2.2. Study Population: New, Full-Benefit Dual Eligible Beneficiaries

In this study, we focused on *new* dual eligible beneficiaries with full Medicaid and Medicare benefits. Full-benefit dual eligibles constitute the majority of all dual eligible beneficiaries. New, full-benefit dual eligibles were defined as individuals who experienced their initial transition to full-benefit dual status at some point from January 2007 through December 2010, but had never been a full-benefit dual in calendar year 2006. This approach allows a look-

back period of at least 1 year for every person prior to their initial transition to full-benefit dual status.

Full-dual status was identified using the monthly dual status code with values of either 02 (Qualified Medicare Beneficiaries plus full Medicaid), 04 (Specified Low Income Medicare Beneficiaries plus full Medicaid), or 08 (other full-benefit duals). The original data source for this code is the Medicare Modernization Act State File (Buccaneer, 2015). The first month and year in which an individual was identified as a full-dual was considered their initial point of transition to full-dual status. Using these criteria, we identified a total of 3,881,656 new full-dual eligibles during 2007-2010. For the analysis presented in this brief, we used a subset of 2,580,092 new full-dual eligibles who survived for at least 12 months after their initial transition to full-dual status and had the monthly dual status code available for all those months. In effect, this limited the analysis to those whose initial transition to full-dual eligibility occurred at some point during January 2007-December 2009. This approach allowed us to track all individuals for 12 months after their initial transition to full-dual status, ensuring a comparable follow-up period for assessing the risk of coverage loss.²

2.2.3. Measuring Coverage Loss

Among the 2,580,092 new, full-duals identified above who transitioned during 2007-2009, we created two measures of loss of full-benefit dual eligible status in the 12 months following their initial transition to that status. In the first measure, we identified individuals who did not maintain full-benefit dual status for all the 12 months following this transition--in other words, those who lost full-dual coverage for at least 1 month. In the second measure of coverage loss, we identified beneficiaries who had a break in full-dual coverage for more than 3 months out of the 12-month follow-up period (the break may or may not be for consecutive months). Individuals identified by the second measure are a subset of those identified by the first measure. Loss of coverage for 3 or fewer months is likely due to an administrative issue, rather than a change in eligibility, whereas the second measure identifies people for whom the loss of coverage is longer lasting and, therefore, perhaps more consequential to the individual. We focus mainly on the first measure but also present descriptive results for the second measure for comparison purposes.

This analysis measures the loss of full-benefit dual eligible status. Specifically, beneficiaries who lost full Medicaid benefits, either completely or by moving to partial Medicaid benefits, or who lost Medicare benefits would be considered to have lost full-benefit dual eligible status. However, as noted earlier, we expect that very few Medicare beneficiaries would lose Medicare coverage. Thus, in this analysis, while we refer to loss of full-benefit Medicaid eligibility, we recognize the possibility that loss of full-benefit dual eligible status could also result from loss of Medicare coverage.

² A potential bias of this approach for the results is that individuals who died in the 12 months following their transition (excluded from our analysis) may have higher medical expenses and therefore less likely to lose Medicaid eligibility due to high need.

2.2.4. Statistical Analysis

We first conducted descriptive data analysis to examine the associations of loss of full-benefit dual coverage with beneficiary characteristics: age (at time of transition to full-dual status), sex, race/ethnicity, original reason for Medicare eligibility, reason for Medicaid eligibility (at time of transition to full-dual status), temporal pathway to full-benefit dual eligible status (Medicare-to-Medicaid, Medicaid-to-Medicare, or simultaneous transition to eligibility for both programs), and with selected state Medicaid policies. Additional details regarding these variables and the study population are provided in **Appendix Table A-2**.

We then examined the independent effects of the above individual-level and state-level policy variables on predicting the likelihood of losing full-benefit Medicaid coverage, using multivariate analysis. We used two different regression modeling techniques. Our main results are based on “time-to-event,” or “survival” analysis. This technique compares individuals on their time to coverage loss and measures the effect of each of the variables on the risk of coverage loss, using a Cox proportional-hazards model, with the outcome of any loss of coverage (including 3 or fewer months). Individuals who did not lose coverage over the 12-month follow-up were considered censored as of the end of the 12 months. The model adjusted the standard errors for the clustering of observations within states.

Additionally, as a sensitivity analysis we viewed the loss of full-benefit Medicaid coverage over the course of the 12-month follow-up period as a dichotomous (yes/no) variable, and we performed logistic regression to obtain the independent effect of each of the individual-level and policy-level variables on the probability of coverage loss. The outcome again was any loss of coverage (including 3 or fewer months). To account for the clustering of observations within states, we used state random effects. We expected these two techniques to provide similar results. We present the survival analysis results in the main body of this brief and the logistic model results in the appendix.

3. RESULTS

3.1. Reasons for Loss of Medicaid Coverage, According to Subject Matter Experts

To receive Medicaid benefits, generally an individual must apply to the program in the state in which they reside, and be certified as eligible at least annually, depending on state-specific criteria. Changes in income, assets, or medical need may result in an individual losing Medicaid benefits. Individuals may also lose Medicaid coverage if they fail to meet the administrative requirements, such as attending an in-person interview to renew their Medicaid benefits or providing documentation of income and assets to demonstrate their continued eligibility. Specific policies and renewal processes vary by state.

In general, experts we interviewed expected that the full-dual population would have relatively stable income and assets over time and were likely to sustain Medicaid coverage. However, they noted several reasons that a full-benefit dual eligible beneficiary might lose coverage. They thought the most common reason would be failure to comply with certain administrative requirements; less common reasons were changes in eligibility due to changes in income, functional status, or assets.

Respondents believed that full-benefit dual eligible beneficiaries would be most likely to lose coverage because of a failure to complete the Medicaid eligibility renewal process. Medicaid eligibility recertification is required at least annually, but this varies by state and eligibility group. Specific administrative issues that may lead to a loss of Medicaid coverage include a state's Medicaid renewal period (the period of time in which an individual must provide proof to the state of their continued eligibility for Medicaid), recertification procedures and requirements, and method of income and asset verification. State Medicaid officials participating in the study noted that in their respective states, beneficiaries were provided with two mailed notices prior to renewal and could respond by mail, online, telephone, or fax. However, recertification procedures vary across states, ranging from passive renewals where prepopulated forms are provided and beneficiaries need to respond only if there has been a change, to requiring in-person applications. Furthermore, some states allow a grace period if an individual fails to recertify using the correct documents or in a timely manner, while others do not. Additionally, some states verify income by sharing information across state agencies, electronic or otherwise, or allow individuals to self-report, while other states require individuals to obtain and provide documentation. Lastly, the verification of assets varies across states.

Respondents indicated that both a lack of awareness of Medicaid program recertification requirements and the administrative burden of these requirements could contribute to individuals losing coverage. Respondents thought that individuals who were new to Medicaid could be especially at risk because of their lack of knowledge of Medicaid processes and procedures. Lack of awareness of annual renewal processes, for example what documents are required and how current those documents need to be, can lead to a denial of coverage. Experts also indicated that they would expect the managed care population, especially D-SNP enrollees, individuals

enrolled in state demonstrations under the Financial Alignment Initiative, and those in nursing facilities, to have higher rates of stability in full-dual status because these providers and plans are financially motivated to keep individuals enrolled and may provide aid with recertification. In addition, respondents felt that new Medicaid enrollees might not understand or recall that new information, such as change of address, must be reported. This could leave new, full-duals vulnerable to losing coverage because the state can no longer find them. This is an especially formidable barrier for transient populations who lack access to affordable housing and personal telephone or Internet connections.

Instability of full-dual status may vary by Medicaid eligibility category. Experts expected the greatest amount of instability to be among those eligible for Medicaid through the medically needy/spenddown pathway because of variation in medical and LTSS expenses.

Beneficiaries eligible for Medicaid because of SSI benefits were expected to have relatively less instability; however, respondents noted they expected differences between three types of states. In 1634 States, where individuals are automatically enrolled in Medicaid when they receive SSI benefits, it was hypothesized that SSI beneficiaries in these states would be the most stable. Among SSI states where individuals must separately apply to Medicaid and submit paperwork for recertification each year despite receipt of SSI benefits, more volatility in coverage was expected. In 209(b) states, SSI beneficiaries must also apply for Medicaid separately, and as noted above, these states may have more restrictive criteria for Medicaid eligibility than they have for SSI; therefore, higher volatility in coverage was expected for these states.

Individuals eligible for Medicaid because of the Special Income Rule were expected to be relatively stable. However, experts noted that individuals could lose eligibility by being discharged from a nursing home or because of a slight increase in income (if they did not have a Miller Trust).

Respondents also noted that LTSS providers have the financial incentive to help their beneficiaries remain enrolled using authorized representatives, which may include social workers. The same was thought for those eligible for Medicaid via Section 1115 Waivers or receiving LTSS in the community; these individuals likely receive support from case managers through the re-enrollment process.

Additional reasons proposed for why full-benefit dual eligible beneficiaries might lose Medicaid eligibility included having presumptive eligibility taken away, if it was originally, incorrectly granted; experiencing changes in eligibility due to income, which could result, for example, from a spouse passing away, resulting in higher SSI payments and life insurance payments for the widowed spouse; and moving from one state to another may result in disenrollment because states have differing eligibility pathways.

Respondents also noted that beneficiaries may choose to opt out of receiving full Medicaid benefits. Experts felt that beneficiaries might choose this option if they were at risk for losing their provider network if their providers did not participate in Medicaid (because they were enrolled in an Medicare Advantage plan and that plan did not also have a Medicaid managed

care plan) or upon learning of the estate recovery requirements after enrolling in full-benefit Medicaid. Federal law requires states to recover Medicaid expenses from an individual's estate. States are required to recover the cost of LTSS, but they may also recover additional Medicaid expenses (Administration on Aging, 2017). Some experts also suggested that for individuals who may not use many Medicaid benefits, the hassle of renewal may not be worth the additional benefit; however, others felt that this was unlikely.

When asked specifically about full-benefit duals becoming partial-benefit duals, experts noted that the most prevalent reason for switching from full-dual to partial-dual status would be an increase in income or assets, as the asset requirements for full-benefit dual eligible beneficiaries is generally more stringent than for partial-benefit duals.

3.2. Quantitative Analysis

Overall, among individuals who became dually eligible for full Medicare and Medicaid benefits for the first time during 2007-2009 and were followed for 12 months after the transition, 750,243 out of 2,580,078 (29.1%) lost coverage for at least 1 month during a 12-month follow-up (**Exhibit 1**). There was substantial variation across states in the likelihood of losing full-benefit Medicaid coverage.³ Rates of coverage loss ranged from 15.3% in New Jersey, 16.9% in Colorado, and 17.2% in Oklahoma, to 43.8% in Ohio, 52.1% in Indiana, and 67.9% in Georgia. The average rate of coverage loss across all the states was 28.9%, and the median was 26%.

EXHIBIT 1. Percentage of New Full-Duals with Loss of Full-Benefit Medicaid Coverage over 12 Months Following Initial Transition to Full-Dual Status, 2007-2009, by State							
State	Beneficiaries with 12 Months of Follow-up	No Loss of Coverage		Loss of Coverage: At Least 1 Month		Loss of Coverage: More than 3 Months	
	N	#	%	#	%	#	%
AK	4,364	3,557	81.5	807	18.5	403	9.2
AL	28,151	20,832	74.0	7,319	26.0	3,816	13.6
AR	28,428	20,620	72.5	7,808	27.5	6,207	21.8
AZ	48,760	35,998	73.8	12,762	26.2	9,390	19.3
CA	340,118	266,614	78.4	73,504	21.6	45,760	13.5
CO	24,348	20,228	83.1	4,120	16.9	2,925	12.0
CT	31,606	23,576	74.6	8,030	25.4	5,758	18.2
DC	7,524	5,467	72.7	2,057	27.3	1,133	15.1
DE	5,170	3,354	64.9	1,816	35.1	1,526	29.5
FL	153,194	93,783	61.2	59,411	38.8	50,386	32.9
GA	75,228	24,139	32.1	51,089	67.9	41,544	55.2
HI	10,475	7,935	75.8	2,540	24.2	1,410	13.5
IA	24,718	20,267	82.0	4,451	18.0	2,998	12.1
ID	8,789	6,746	76.8	2,043	23.2	1,122	12.8
IL	122,262	83,215	68.1	39,047	31.9	29,527	24.2
IN	59,637	28,586	47.9	31,051	52.1	24,469	41.0
KS	19,660	12,546	63.8	7,114	36.2	4,841	24.6
KY	36,918	24,946	67.6	11,972	32.4	9,415	25.5

³ This analysis measures the loss of full-benefit dual eligible status including the loss of Medicaid and Medicare benefits. We expect a negligible number of Medicare beneficiaries to lose Medicare coverage. Thus, we refer to the loss of full-benefit Medicaid coverage throughout this section to aid interpretation and understanding of these results.

EXHIBIT 1 (continued)							
State	Beneficiaries with 12 Months of Follow-up	No Loss of Coverage		Loss of Coverage: At Least 1 Month		Loss of Coverage: More than 3 Months	
		N	#	%	#	%	#
LA	39,961	30,414	76.1	9,547	23.9	8,050	20.1
MA	86,585	68,506	79.1	18,079	20.9	12,627	14.6
MD	30,117	22,412	74.4	7,705	25.6	5,498	18.3
ME	19,575	14,645	74.8	4,930	25.2	3,511	17.9
MI	94,693	67,523	71.3	27,170	28.7	19,962	21.1
MN	43,298	32,780	75.7	10,518	24.3	7,224	16.7
MO	57,200	36,509	63.8	20,691	36.2	16,188	28.3
MS	29,853	18,950	63.5	10,903	36.5	8,672	29.0
MT	6,937	4,067	58.6	2,870	41.4	2,318	33.4
NC	83,996	58,705	69.9	25,291	30.1	19,070	22.7
ND	5,017	3,104	61.9	1,913	38.1	1,517	30.2
NE	12,615	9,156	72.6	3,459	27.4	1,934	15.3
NH	10,059	5,750	57.2	4,309	42.8	3,318	33.0
NJ	60,517	51,261	84.7	9,256	15.3	5,553	9.2
NM	13,161	9,807	74.5	3,354	25.5	2,707	20.6
NV	8,681	5,543	63.9	3,138	36.1	2,002	23.1
NY	215,228	168,658	78.4	46,570	21.6	28,950	13.5
OH	118,619	66,664	56.2	51,955	43.8	42,494	35.8
OK	35,577	29,450	82.8	6,127	17.2	3,785	10.6
OR	23,625	18,081	76.5	5,544	23.5	4,058	17.2
PA	133,647	105,186	78.7	28,461	21.3	21,023	15.7
RI	11,144	8,849	79.4	2,295	20.6	1,721	15.4
SC	39,207	31,972	81.5	7,235	18.5	5,266	13.4
SD	4,787	3,915	81.8	872	18.2	643	13.4
TN	53,429	43,366	81.2	10,063	18.8	6,982	13.1
TX	125,992	84,271	66.9	41,721	33.1	22,914	18.2
UT	11,746	7,125	60.7	4,621	39.3	3,359	28.6
VA	43,608	33,242	76.2	10,366	23.8	7,661	17.6
VT	7,484	5,742	76.7	1,742	23.3	1,228	16.4
WA	52,804	34,827	66.0	17,977	34.0	13,922	26.4
WI	48,934	32,096	65.6	16,838	34.4	10,632	21.7
WV	19,914	12,614	63.3	7,300	36.7	5,883	29.5
WY	2,718	2,236	82.3	482	17.7	357	13.1
Total	2,580,078	1,829,835	70.9	750,243	29.1	543,659	21.1

SOURCE: RTI Analysis of MMLEADS Data.

The percentage of new full-dual beneficiaries losing full-benefit Medicaid coverage varied substantially by the individual’s Medicaid eligibility pathway to full-dual eligibility and by original reason for Medicare eligibility (**Exhibit 2**). Individuals who were eligible for Medicaid based on receiving SSI-cash benefits were the least likely to lose coverage (19.3%), while those who were eligible based on a Section 1115 Waiver, which was the smallest eligibility group, were the most likely to lose coverage (55.9%). Beneficiaries who were Medicaid-eligible because of medically needy status also had a high likelihood (39.2%) of losing coverage. Those who were Medicare eligible based on Old Age and Survivor’s Insurance (OASI) were less likely to lose Medicaid coverage than those who were eligible based on disability insurance (22.1% vs. 35.6%) or end-stage renal disease status (ESRD) (40.2%). Also important was the temporal pathway to dual eligibility. Those who first attained Medicaid eligibility followed by Medicare eligibility were less likely to lose coverage than those who followed the reverse order (21.7% vs. 32.3%).

EXHIBIT 2. Loss of Full-Benefit Medicaid Coverage over 12 Months Following Initial Transition to Full-Dual Status, 2007-2009, by Beneficiary Characteristics							
Characteristic	Total	No Loss of Coverage		Loss of Coverage: At Least 1 Month		Loss of Coverage: More than 3 Months	
	N	#	%	#	%	#	%
Age							
<65	1,178,424	758,186	64.3	420,238	35.7	318,368	27.0
≥65	1,401,668	1,071,653	76.5	330,015	23.5	225,295	16.1
Sex							
Female	1,540,324	1,131,472	73.5	408,852	26.5	291,384	18.9
Male	1,039,739	698,366	67.2	341,373	32.8	252,251	24.3
Race							
White, nonHispanic	1,530,691	1,071,997	70.0	458,694	30.0	340,382	22.2
African American	494,616	337,400	68.2	157,216	31.8	115,887	23.4
Asian/Pacific Islander	153,825	124,768	81.1	29,057	18.9	17,566	11.4
Hispanic	362,857	269,583	74.3	93,274	25.7	61,019	16.8
American Indian/Alaskan Native	23,581	17,323	73.5	6,258	26.5	4,348	18.4
Medicaid Eligibility							
SSI	877,279	707,777	80.7	169,502	19.3	113,039	12.9
Medically needy	459,828	279,625	60.8	180,203	39.2	136,698	29.7
Poverty	433,852	279,081	64.3	154,771	35.7	114,920	26.5
Other ^a	691,868	503,738	72.8	188,130	27.2	132,866	19.2
Section 1115 Waiver	63,141	27,827	44.1	35,314	55.9	29,090	46.1
Medicare Eligibility							
OASI	1,270,410	989,426	77.9	280,984	22.1	187,299	14.7
DI	1,255,442	807,958	64.4	447,484	35.6	340,078	27.1
ESRD	54,240	32,455	59.8	21,785	40.2	16,286	30.0
Temporal Pathway							
Medicare-to-Medicaid	1,702,880	1,153,168	67.7	549,712	32.3	399,636	23.5
Medicaid-to-Medicare	730,608	572,404	78.3	158,204	21.7	115,723	15.8
Simultaneous	127,647	91,430	71.6	36,217	28.4	24,375	19.1
SOURCE: RTI analysis of MMLEADS data.							
NOTE:							
a. The "Other" Medicaid eligibility category includes individuals who qualify for Medicaid due to the Special Income Rule and those who meet state eligibility criteria for Medicaid based on income or other eligibility requirements but are not categorized in the four alternate categories.							

Demographic factors also appear to play a role in the likelihood of losing Medicaid coverage. Females (26.5%) and beneficiaries aged 65 and older at the time of initial transition to full-dual status (23.5%) were less likely to lose coverage than males (32.8%) and those younger than age 65 (35.7%), respectively. Among racial and ethnic groups, Asians (18.9%) were the least likely to lose coverage, and African Americans (31.8%) were the most likely to lose coverage.

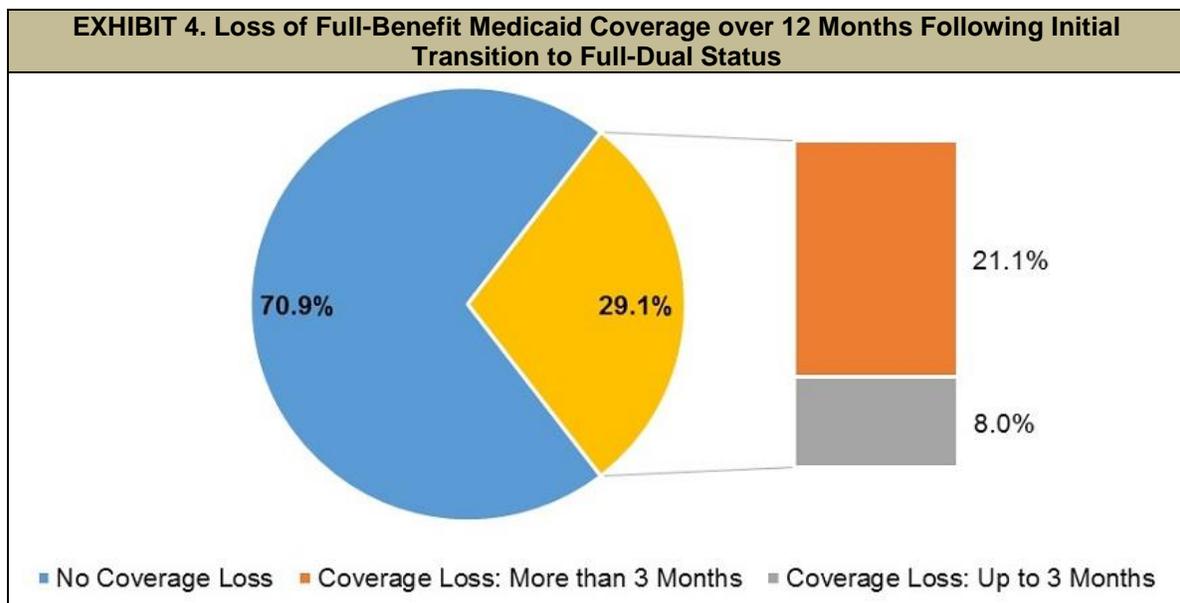
In addition to these individual-level factors, state-level Medicaid coverage policies appear to play an important role in influencing whether individuals lose Medicaid coverage (**Exhibit 3**). Beneficiaries in states that offer poverty-level coverage had lower rates of coverage loss than beneficiaries in states that do not (26.0% vs. 33.0%). Similarly, beneficiaries in states that provide medically needy coverage had lower rates of coverage loss than beneficiaries in other states that do not (28.0% vs. 32.1%). In contrast, beneficiaries residing in 209(b) states (34.7%) or states that employ the Special Income Rule (29.6%) had higher rates of coverage loss

compared to beneficiaries in states that do not allow such policies (27.6% and 26.7%, respectively).

EXHIBIT 3. Loss of Full-Benefit Medicaid Coverage over 12 Months Following Initial Transition to Full-Dual Status, 2007-2009, by State Medicaid Eligibility Policies							
State Policy	Total	No Loss of Coverage		Loss of Coverage: At Least 1 Month		Loss of Coverage: More than 3 Months	
	N	#	%	#	%	#	%
Poverty Coverage							
Yes	1,451,653	1,074,283	74.0	377,370	26.0	273,925	18.9
No	1,128,425	755,552	67.0	372,873	33.0	269,734	23.9
209(b) State							
Yes	537,358	350,811	65.3	186,547	34.7	143,351	26.7
No	2,042,720	1,479,024	72.4	563,696	27.6	400,308	19.6
Medically Needy Coverage							
Yes	1,888,010	1,359,770	72.0	528,240	28.0	383,940	20.3
No	692,068	470,065	67.9	222,003	32.1	159,719	23.1
Special Income Rule							
Yes	2,123,548	1,494,995	70.4	628,553	29.6	458,933	21.6
No	456,530	334,840	73.3	121,690	26.7	84,726	18.6
Miller Trust							
Yes	953,354	617,311	64.8	336,043	35.2	254,081	26.7
No	1,626,724	1,212,524	74.5	414,200	25.5	289,578	17.8

SOURCE: RTI Analysis of MMLEADS Data.

The results reported above are based on any loss of full-benefit Medicaid coverage for at least 1 month during the 12-month follow-up period. When examining the rates of coverage loss lasting longer than 3 months (whether consecutive or not), the rates of coverage loss decrease, although they remain substantial: While 29.1% of new full-duals ever experienced any loss of coverage during 12 months of follow-up, only 21.1% lost coverage for more than 3 months (**Exhibit 4**). The relationships of the coverage loss rates for more than 3 months with the individual and policy characteristics follow a similar pattern to those observed for the rates of any coverage loss.



These descriptive, bivariate relationships are confirmed with multivariate regression results. Presented in **Exhibit 5** and summarized below are results from the multivariate survival model predicting the time to loss of full-benefit Medicaid coverage since the initial transition to full-dual status. Hazard ratios are reported, which describe the relative risk of losing full-benefit Medicaid coverage. These results are consistent with those obtained from the logistic regression model (included in **Appendix Table A-3**).

EXHIBIT 5. Predicting Loss of Full-Benefit Medicaid Coverage over 12 Months Following Initial Transition to Full-Dual Status, 2007-2009, Multivariate Survival Analysis				
	Hazard Ratio	p-value	95% Confidence Level	
Individual Level Characteristics				
Medicaid Eligibility				
Low Income SSI-Cash (reference)				
Medically Needy	3.18	<0.0001	2.66	3.80
Low Income Poverty	2.52	<0.0001	1.79	3.54
Other ^a	1.34	0.0122	1.07	1.68
Section 1115 Waiver	3.89	<0.0001	2.79	5.42
Temporal Pathway				
Medicare-to-Medicaid (reference)				
Medicaid-to-Medicare	0.63	<0.0001	0.56	0.72
Simultaneous	1.08	0.4843	0.87	1.35
Original Reason for Medicare Eligibility				
OASI (reference)				
DI	1.50	<0.0001	1.33	1.70
ESRD	1.65	<0.0001	1.40	1.94
Age				
65+ (reference)				
<65	1.32	0.0039	1.09	1.60
Sex				
Female (reference)				
Male	1.17	<0.0001	1.14	1.20
Race and Ethnicity				
White, nonHispanic (reference)				
Black	1.10	0.1488	0.97	1.26
Hispanic	1.00	0.9610	0.90	1.10
Asian/Pacific Islander	0.79	0.0003	0.70	0.90
American Indian/Alaskan Native	0.95	0.0554	0.90	1.00
State Policies				
209(b) State	1.32	0.0287	1.03	1.70
Poverty Coverage	0.62	0.0315	0.40	0.96
Medically Needy	0.92	0.6531	0.64	1.33
Special Income Rule	1.71	0.0155	1.11	2.65
SOURCE: RTI analysis of MMLEADS data.				
NOTE: N=2,511,737.				
a. The "Other" Medicaid eligibility category includes individuals who qualify for Medicaid due to the Special Income Rule and those who meet state eligibility criteria for Medicaid based on income or other eligibility requirements but are not categorized in the four alternate categories.				

Compared to beneficiaries who were eligible for Medicaid based on receiving SSI-cash benefits, those who were eligible based on medically needy status, poverty-level coverage, other eligibility category, or Section 1115 Waivers had significantly ($p \leq 0.01$) higher risk of losing full-benefit Medicaid coverage. Such risk appears to be the highest for beneficiaries who were eligible based on Section 1115 Waivers or medically needy status, with hazard ratios indicating

over three times the risk of losing coverage for those eligible for Medicaid based on receiving SSI-cash benefits. Compared to beneficiaries who were originally eligible for Medicare based on OASI, those who were eligible based on disability insurance or ESRD had 50% and 65% greater risk of losing coverage, respectively ($p<0.01$). Individuals who became Medicaid-eligible first before gaining Medicare eligibility had a 37% lower risk of losing coverage compared to those who started with Medicare coverage and transitioned to full-benefit Medicaid eligibility ($p<0.01$). Multivariate results also confirmed the demographic patterns involving gender, race, and age that were noted in the descriptive results above, although many of the differences between racial and ethnic categories were not statistically significant.

Individuals in 209(b) states had a 32% higher risk of losing coverage, and those in states that apply the Special Income Rule had 71% higher risk of losing coverage, compared to those in other states ($p<0.05$). Beneficiaries in states that offer poverty-level coverage had a 38% lower risk of losing coverage ($p<0.05$). The individual-level risk of losing full-benefit Medicaid coverage did not differ significantly among states that had the medically needy policy and in other states without such policy.

4. DISCUSSION AND CONCLUSION

4.1. Discussion

Contrary to expectations, a substantial number--nearly 30%--of new full-benefit dual eligible beneficiaries lose coverage for at least 1 month during the 12 months immediately following their initial transition to full-dual eligible status. This frequency of coverage loss is notably higher than reported in several previous studies (Ku et al., 2009; Ku & Steinmetz, 2013; Riley et al., 2014). This discrepancy may be attributable to differences in both the populations studied and measures of coverage loss used. The population of interest in this analysis included individuals who newly became dually eligible beneficiaries, while other studies included a cross-section of dual eligibles, most of whom were not new duals. Eligibility for new duals may be more unstable, especially in the initial months following their transition to dual eligible status, as compared to other, more “established” dual eligibles. In addition, this analysis considered moving from full-benefit to partial-benefit Medicaid coverage to be coverage loss, while in other studies this distinction was rarely made.

Our analysis indicates wide variation in the rates of full-benefit Medicaid coverage loss across states, and this variation seems to be driven in part by state-specific Medicaid eligibility policies. In particular, we found that new full-duals residing in 209(b) states, which tend to have more restrictive eligibility criteria, or in states that apply the Special Income Rule, were more likely to lose full-benefit Medicaid coverage than those in other states without such policies. On the other hand, individuals in states that provide poverty-level coverage or the medically needy option had lower risk of losing coverage. These findings seem to suggest that states with relatively more inclusive Medicaid eligibility coverage policies (which may also have less stringent or more streamlined recertification and other procedural requirements) tend to decrease coverage loss than states with relatively more restrictive Medicaid coverage.

Findings from this analysis also shed light on important individual characteristics associated with loss of full-benefit Medicaid coverage. Particularly, new full-duals who qualified for Medicaid coverage by receipt of SSI had the highest stability in maintaining full-dual eligibility, or lowest risk of experiencing coverage loss in the 12-month period following their initial transition to full-dual status. This may be because some individuals reside in 1634 States, which automatically enroll individuals in Medicaid when they receive SSI benefits. Therefore, these individuals may re-enroll in SSI and not consciously re-enroll in Medicaid, whereas individuals eligible for Medicaid through other pathways need to consciously re-enroll in Medicaid. Individuals who followed any other, nonSSI-cash Medicaid eligibility pathway, such as Medically Needy, Low Income Poverty, and Section 1115 Waiver, were more likely to lose full-benefit Medicaid coverage. For individuals in the medically needy eligibility category, our data analysis finding echoes experts interviewed in this study who would expect coverage loss to be most likely among this group because their eligibility is contingent on continually incurring high medical expenses. For those eligible for Medicaid coverage under Section 1115 Waivers, the data analysis shows results contrary to the expectations of experts, who would anticipate less coverage loss in this group because beneficiaries in this group are likely to be assisted by case

managers for re-enrollment to receive LTSS in the community. It is possible that the higher rates of coverage loss in these eligibility groups are due to more onerous recertification and renewal processes, as compared to those in the SSI-cash category.

Nationally, our data analysis also reveals a substantial difference in the number of people who have any loss of coverage for 1 month or more (29.1%), compared to those who lose coverage for longer than 3 months (21.1%). The difference between these two numbers suggests that 8% of all new full-duals experienced a short break in full-dual coverage, less than 3 months, over the 12-month period following their initial transition to full-dual status. It is likely that a substantial portion of the observed coverage loss is temporary and administrative in nature, which could be resolved by improving application and recertification procedures.⁴ Some of the coverage loss may also be due to income or asset fluctuation. However, even among people who qualified for Medicaid by receiving SSI-cash benefits, the group with the greatest stability in maintaining continuous dual eligibility coverage, there still is a substantial short-term coverage loss. Although not able to quantify it, subject matter experts interviewed in this study thought that coverage loss was more likely related to administrative requirements, which vary by state. Due to data constraints, we were unable to document state-specific administrative requirements, which should be further explored in future research.

Our research considers data from the period prior to the Affordable Care Act (ACA). The ACA modified Medicaid eligibility criteria (in expansion states), the requirements for eligibility redetermination, and eased the Medicaid enrollment process for individuals. These changes included requiring a single point of entry for Medicaid and Exchange enrollment in addition to the utilization of electronic data sources to verify an individual's eligibility (Kaiser Family Foundation, 2013). Experts interviewed had mixed opinions about the potential impacts of the enrollment and eligibility provisions of the ACA on the dually eligible population. A few experts noted that the creation of the Medicare-Medicaid Coordination Office within CMS, as well as the push to better align care for the dual eligible population through activities including the Financial Alignment Initiatives, might impact the stability of an individual's full-dual status. Some respondents believed that the changes in enrollment and recertification processes would not impact this population due to specific enrollment requirements including the look-back period. This is because the electronic verification systems would be unable to verify an individual's assets. However, others noted that spillover from policies targeted at the nonaged, blind, and disabled population could occur and states may make the redetermination process less burdensome for dual eligible beneficiaries. In fact, state Medicaid officials interviewed in this study shared that changes in renewal procedures because of spillover from the ACA had impacted older people and persons with disabilities. These included providing all individuals with prepopulated renewal forms to ease the burden on beneficiaries and extending the 90-day grace period to older people and persons with disabilities.

⁴ In a recent story run by the *Georgia Health News*, a group of individuals with disabilities in Georgia sued the state for having failed to help them maintain Medicaid eligibility (available at: <http://www.georgiahealthnews.com/2017/04/georgians-disabilities-required-renew-benefits-suit/>). Of note, Georgia happened to be one of the states with the highest rate of Medicaid coverage loss in our study.

4.2. Conclusion

High “churning” in dual eligible status is problematic for both individual beneficiaries and providers. For dual eligible beneficiaries, the loss of full-benefit Medicaid coverage is of concern because most of them do not have an alternative source of health insurance for the services covered by full-benefit Medicaid (Ku & Steinmetz, 2013; Riley et al., 2014). Without Medicaid support, many of these low income individuals may have difficulty paying for cost-sharing of Medicare services and may be unable to access services that are not covered by Medicare (such as LTSS). For providers involved in the care of dual eligible beneficiaries, discontinuity in full-benefit Medicaid coverage may lead to financial losses.

This policy brief documented the frequency of Medicaid coverage loss among full-benefit dual eligible beneficiaries and identified potential causes for coverage loss using a mixed methods approach. Almost one-third of new, full-duals lost their full-dual status within 12 months of initial transition to that status. Nearly one-third of those who lost coverage did so for 3 months or less, which may represent temporary coverage loss that is due to administrative requirements. Our analysis further found wide variation in the rates of full-benefit Medicaid coverage loss across states, and this variation seems to be driven in part by state-specific Medicaid eligibility policies. Our results suggest that states with more inclusive Medicaid eligibility coverage policies tend to have less coverage loss among new, full-duals than states with more restrictive Medicaid coverage. Future research should be done to identify state-specific administrative requirements for enrollment and renewal procedures among older persons and individuals with disabilities that may adversely affect maintenance of their eligibility.

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APPENDIX A. ADDITIONAL TABLES

TABLE A-1. State Medicaid Eligibility Policies for Older People and Individuals with Disabilities, 2009						
State	209(b)	Special Income Limit	Miller Trust	Medically Needy Coverage	Medically Needy Coverage, Including HCBS	Poverty-Level Coverage
AK	No	Yes	Yes	No	NA	No
AL	No	Yes	Yes	No	NA	No
AR	No	Yes	Yes	Yes	No	Yes
AZ	No	Yes	Yes	No	NA	Yes
CA	No	Yes	No	Yes	Yes	Yes
CO	No	Yes	Yes	No	NA	No
CT	Yes	Yes	No	Yes	Yes	No
DC	No	Yes	No	Yes	Yes	Yes
DE	No	Yes	Yes	No	NA	No
FL	No	Yes	Yes	Yes	No	Yes
GA	No	Yes	Yes	Yes	No	No
HI	Yes	No	NA	Yes	Yes	Yes
IA	No	Yes	Yes	Yes	No	No
ID	No	Yes	Yes	No	NA	No
IL	Yes	No	NA	Yes	Yes	Yes
IN	Yes	Yes	Yes	No	No	No
KS	No	Yes	No	Yes	Yes	No
KY	No	Yes	Yes	Yes	Yes	No
LA	No	Yes	No	Yes	Yes	No
MA	No	Yes	No	Yes	Yes	Yes
MD	No	Yes	No	Yes	Yes	No
ME	No	Yes	No	Yes	Yes	Yes
MI	No	Yes	No	Yes	Yes	Yes
MN	Yes	Yes	No	Yes	Yes	Yes
MO	Yes	Yes	No	No	No	Yes
MS	No	Yes	Yes	No	NA	No
MT	No	No	NA	Yes	Yes	No
NC	No	No	NA	Yes	Yes	Yes
ND	Yes	No	NA	Yes	Yes	No
NE	No	No	NA	Yes	Yes	Yes
NH	Yes	Yes	No	Yes	Yes	No
NJ	No	Yes	No	Yes	No	Yes
NM	No	Yes	Yes	No	NA	No
NV	No	Yes	Yes	No	NA	No
NY	No	No	NA	Yes	Yes	No
OH	Yes	Yes	Yes	No	No	No
OK	Yes	Yes	Yes	No	No	Yes
OR	No	Yes	Yes	No	NA	No
PA	No	Yes	No	Yes	Yes	Yes
RI	No	Yes	No	Yes	Yes	Yes
SC	No	Yes	Yes	No	NA	Yes
SD	No	Yes	Yes	No	NA	No
TN	No	Yes	Yes	No	NA	No
TX	No	Yes	Yes	No	NA	No
UT	No	Yes	No	Yes	Yes	Yes
VA	Yes	Yes	No	Yes	Yes	Yes
VT	No	Yes	No	Yes	Yes	Yes
WA	No	Yes	No	Yes	Yes	No
WI	No	Yes	No	Yes	Yes	No
WV	No	Yes	No	Yes	No	No
WY	No	Yes	Yes	No	NA	No

SOURCE: Walker and Accius, 2010.

NOTE: States are only able to establish a Miller Trust if they have established Special Income Limit as an eligibility category. In data analysis, Not Applicable (NA) is coded as No.

TABLE A-2. Variables and Descriptive Statistics of Study Sample			
Variable	Description	Number	Percent
TOTAL		2,580,092	100.0
Age			
	<65	1,178,424	45.7
	≥65	1,401,668	54.3
Sex			
	Female	1,540,324	59.7
	Male	1,039,739	40.3
Race			
	White, nonHispanic	1,530,691	59.3
	Black	494,616	19.2
	Hispanic	362,857	14.1
	Asian/Pacific Islander	153,825	6.0
	American Indian/Alaskan Native	23,581	0.9
Medicaid Eligibility			
	SSI	877,279	34.0
	Medically Needy	459,828	17.8
	Poverty	433,852	16.8
	Other ^a	691,868	26.8
	Section 1115 Waiver	63,141	2.4
Medicare Eligibility			
	OASI	1,270,410	49.2
	DI	1,255,442	48.7
	ESRD	54,240	2.1
Temporal Pathway			
	Medicare-to-Medicaid	1,702,880	66.0
	Medicaid-to-Medicare	730,608	28.3
	Simultaneous	127,647	4.9
State Medicaid Eligibility Policies			
<i>Poverty Coverage</i>	Yes	1,451,653	56.3
	No	1,128,425	43.7
<i>209(b)</i>	Yes	537,358	20.8
	No	2,042,720	79.2
<i>Medically Needy Coverage</i>	Yes	1,888,010	73.2
	No	692,068	26.8
<i>Special Income Rule</i>	Yes	2,123,548	82.3
	No	456,530	17.7
<i>Miller Trust</i>	Yes	953,354	37.0
	No	1,626,724	63.0
SOURCE: RTI Analysis of MMLEADS Data.			
NOTE: Percentages may not sum to 100 due to rounding and exclusion of unknown and missing data.			
a. The “Other” Medicaid eligibility category includes individuals who qualify for Medicaid due to the Special Income Rule and those who meet state eligibility criteria for Medicaid based on income or other eligibility requirements but are not categorized in the four alternate categories.			

TABLE A-3. Predicting Loss of Full-Benefit Medicaid Coverage over 12 Months Following Initial Transition to Full-Dual Status, 2007-2009, Multivariate Logistic Regression Results				
	Odds Ratio	p-value	95% Confidence Interval	
			LCL	UCL
Individual-Level Characteristics				
Medicaid Eligibility				
Low Income SSI-Cash (reference)				
Medically Needy	5.19	<0.0001	5.13	5.24
Low Income Poverty	3.04	<0.0001	3.01	3.07
Other ^a	1.28	<0.0001	1.27	1.29
Section 1115 Waiver	6.63	<0.0001	6.51	6.76
Temporal Pathway				
Medicare-to-Medicaid (reference)				
Medicaid-to-Medicare	0.60	<0.0001	0.60	0.61
Simultaneous	1.14	<0.0001	1.12	1.16
Original Reason for Medicare Eligibility				
OASI (reference)				
DI	1.49	<0.0001	1.47	1.51
ESRD	1.64	<0.0001	1.61	1.68
Age				
65+ (reference)				
<65	1.64	<0.0001	1.62	1.66
Sex				
Female (reference)				
Male	1.25	<0.0001	1.25	1.26
Race & Ethnicity				
White, nonHispanic (reference)				
Black	1.03	<0.0001	1.02	1.04
Hispanic	1.02	0.0018	1.01	1.03
Asian/Pacific Islander	0.86	<0.0001	0.85	0.88
American Indian/Alaskan Native	1.02	0.2077	0.99	1.05
State Policies				
209(b)	1.22	0.2291	0.88	1.69
Poverty Coverage	0.58	0.0001	0.44	0.77
Medically Needy	0.92	0.5699	0.68	1.24
Special Income Rule	1.44	0.0763	0.96	2.16
SOURCE: RTI Analysis of MMLEADS Data.				
NOTE: N = 2,511,737.				
a. The "Other" Medicaid eligibility category includes individuals who qualify for Medicaid due to the Special Income Rule and those who meet state eligibility criteria for Medicaid based on income or other eligibility requirements but are not categorized in the four alternate categories.				

DUAL ELIGIBLE RESEARCH

Reports Available

Loss of Medicare-Medicaid Dual Eligible Status: Frequency, Contributing Factors and Implications

HTML <https://aspe.hhs.gov/basic-report/loss-medicare-medicaid-dual-eligible-status-frequency-contributing-factors-and-implications>

PDF <https://aspe.hhs.gov/pdf-report/loss-medicare-medicaid-dual-eligible-status-frequency-contributing-factors-and-implications>

Analysis of Pathways to Dual Eligible Status: Final Report

HTML <https://aspe.hhs.gov/basic-report/analysis-pathways-dual-eligible-status-final-report>

PDF <https://aspe.hhs.gov/pdf-report/analysis-pathways-dual-eligible-status-final-report>