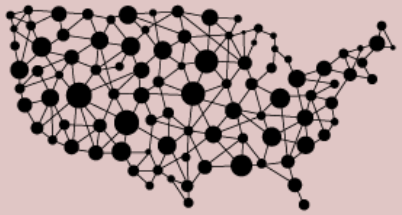

ATI Advisory
State Resource Center

State Opportunity: Understanding the Medicare-Only Population and Approaches to Address Unmet Needs

December 2023

ABOUT THIS TOOL

→ Background and Purpose

There is value in states understanding the needs and characteristics of the subset of Medicare-only individuals who are at risk of becoming eligible for Medicaid. Supporting this "near dual" eligible population can prevent worsening health outcomes, improve individual-level experiences, and protect the state Medicaid budget.

This deck quantifies key aspects of the Medicare-only, near dual eligible population and provides states with example approaches to support this population.

Navigate directly to a section of this tool:

WHY STATES SHOULD PAY ATTENTION TO MEDICARE-ONLY TRENDS

Medicare-only individuals may face significant unmet LTSS or related needs but without the supports from Medicaid

Medicare-only individuals may have similar social and functional needs as dual eligible populations

Medicare-only individuals can quickly become dual eligible as a result of asset spend-down

Medicare-only individuals can be supported through various approaches at the state-level

Understanding the Medicare-Only Population & Pathways to Dual Eligibility

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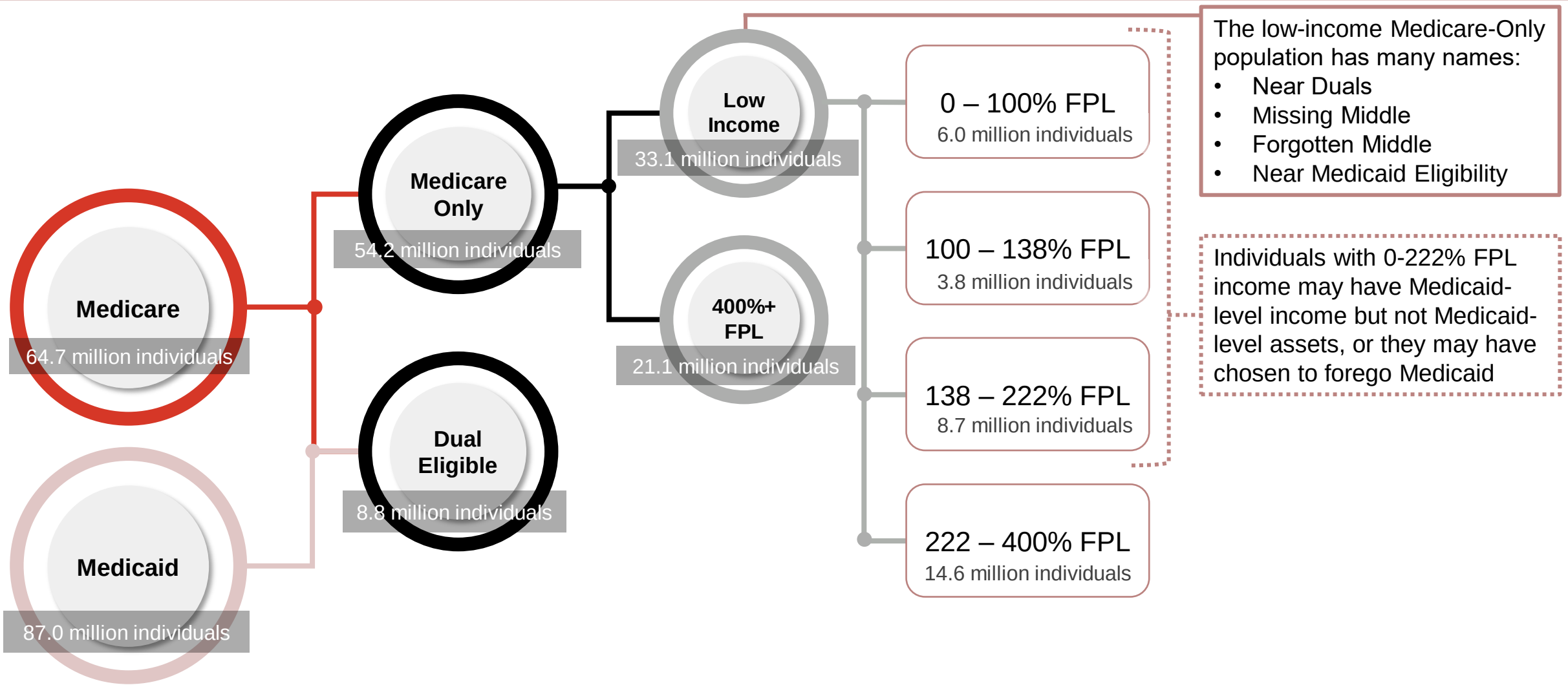
BECAUSE MEDICAID ELIGIBILITY VARIES ACROSS STATES, THERE IS NO ONE DEFINITION OF THE LOW-INCOME MEDICARE-ONLY POPULATION



FPL: Federal Poverty Level

Source: ATI Advisory analysis of Medicare Master Beneficiary Summary File for December 2022 (Medicare, Medicare Only, and Dual Eligible). ATI Advisory analysis of State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data for May 2023. ATI Advisory analysis of the American Community Survey, IPUMS USA, for 2021 (all other). FPL is the Health Insurance Unit FPL calculated by SHADAC.

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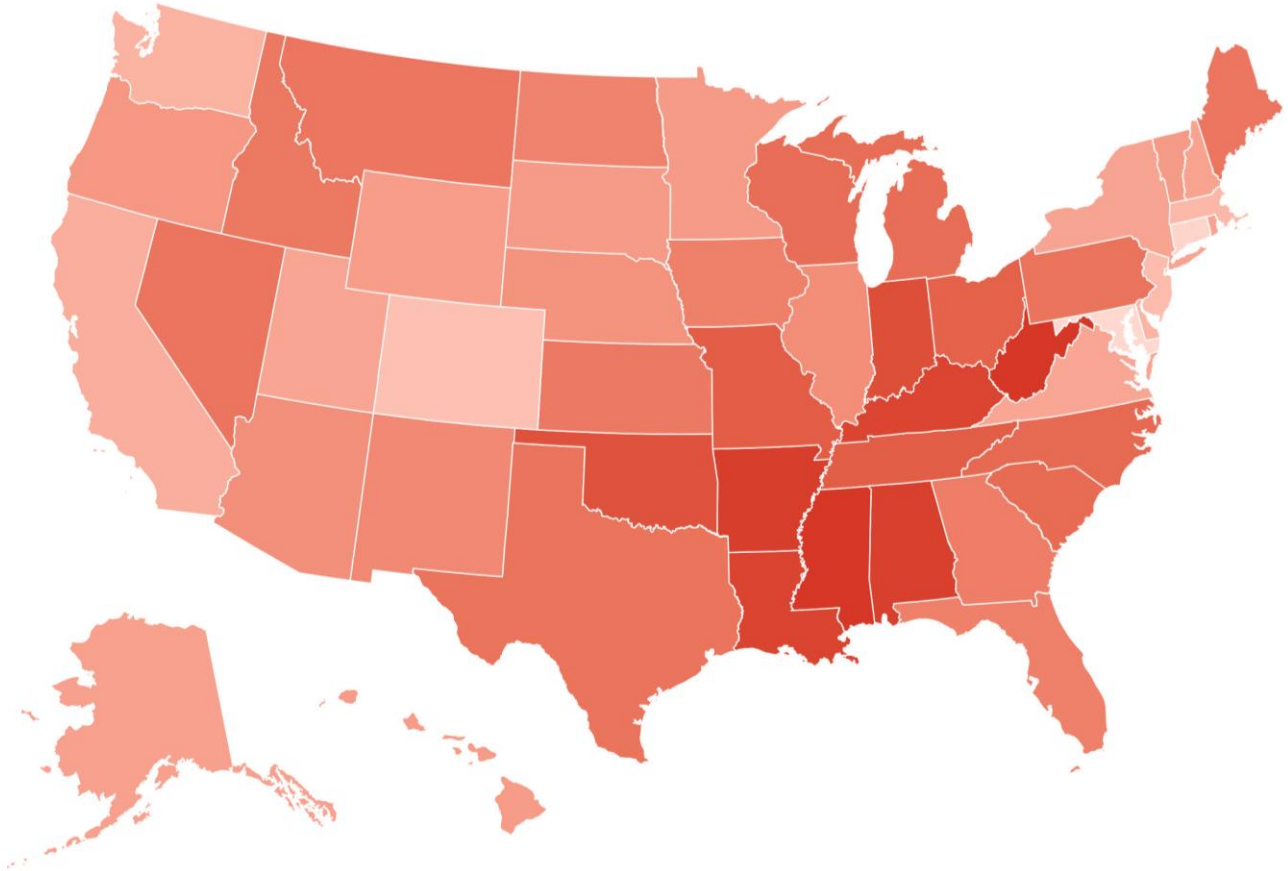
HOW PREVALENT ARE LOW-INCOME MEDICARE-ONLY INDIVIDUALS ACROSS THE U.S.?

→ Individuals with Incomes <400% FPL as a Percent of Medicare-Only Individuals by State, 2021



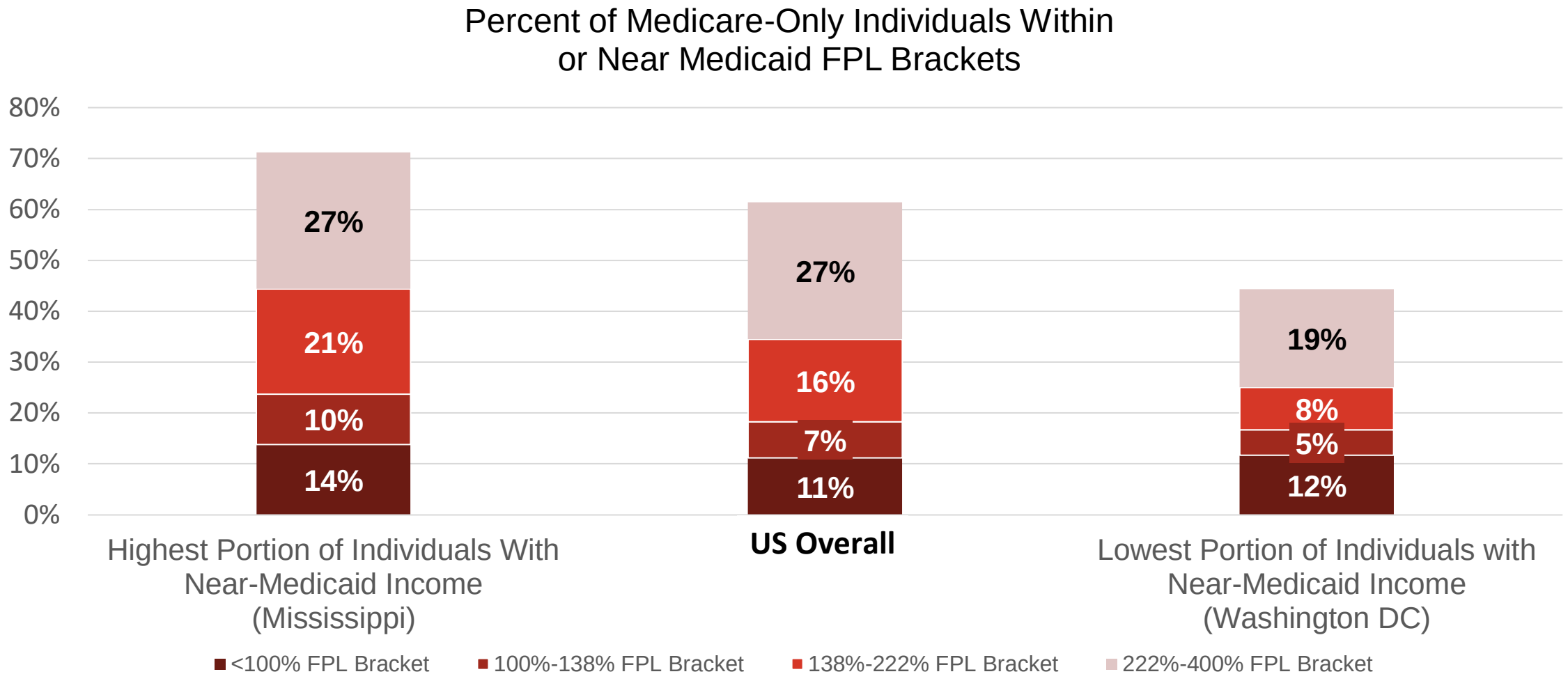
Medicare-Only Individuals With Incomes <400% FPL

71%
65%
60%
55%
50%
44%

7 in 10 Medicare-Only Individuals Have Incomes <400% FPL (Mississippi)

4 in 10 Medicare-Only Individuals Have Incomes <400% FPL (Washington, DC)

A HIGH NUMBER OF MEDICARE-ONLY INDIVIDUALS HAVE INCOMES UNDER OR NEAR COMMON MEDICAID ELIGIBILITY THRESHOLDS



ATI Advisory analysis of the American Community Survey, IPUMS USA, for 2021. FPL is the Health Insurance Unit FPL calculated by SHADAC.

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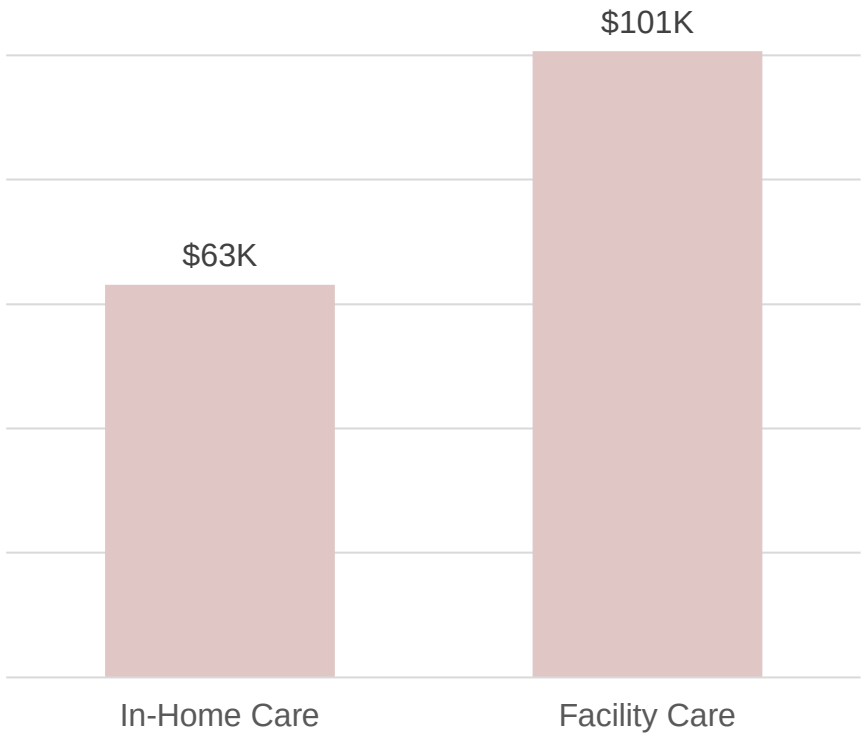
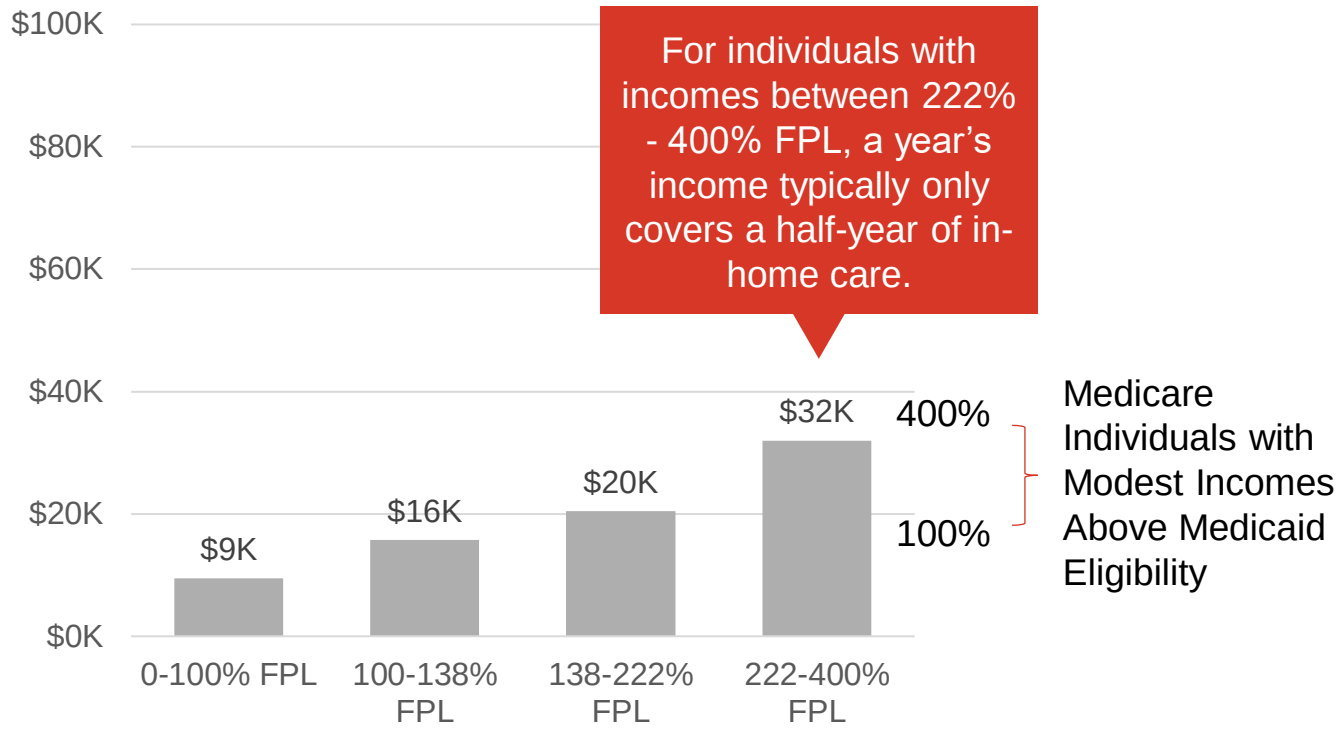
MEDICARE-ONLY INDIVIDUALS WITH LOW INCOMES (< 400% FPL) WOULD HAVE DIFFICULTY AFFORDING A YEAR OF SELF-PAID LTSS

Annual Cost of Homemaking Services and Semi-Private Nursing Facility, 2023



Median Per-Person Income by FPL Bracket



Source: ATI Advisory analysis of the American Community Survey, IPUMS USA, for 2021. FPL is the Health Insurance Unit FPL calculated by SHADAC, and inflated. Genworth Cost of Care Survey, 2021 Edition, with cost of care inflation-adjusted to 2023 assuming a 3% inflation rate. In-Home Care reflects 44 hours of homemaking services; Facility Care reflects a semi-private nursing facility room.

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Why Should States Focus on the Needs of Medicare-Only Individuals?

MEDICARE-ONLY INDIVIDUALS WITH LOW INCOMES (< 400% FPL) HAVE A SIMILAR PROFILE TO DUAL ELIGIBLE INDIVIDUALS AND THEREFORE NEED SIMILAR SUPPORTS

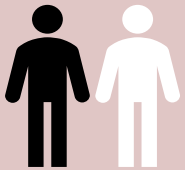
Compared to Medicare-only individuals with higher incomes, Medicare-only individuals with low incomes:

Report high rates of food insecurity and are less likely to report living with others who could provide informal supports

Are more likely to report needing help with functional or cognitive needs

Are more likely to report having mental health needs

Are more likely to be Black or Latinx



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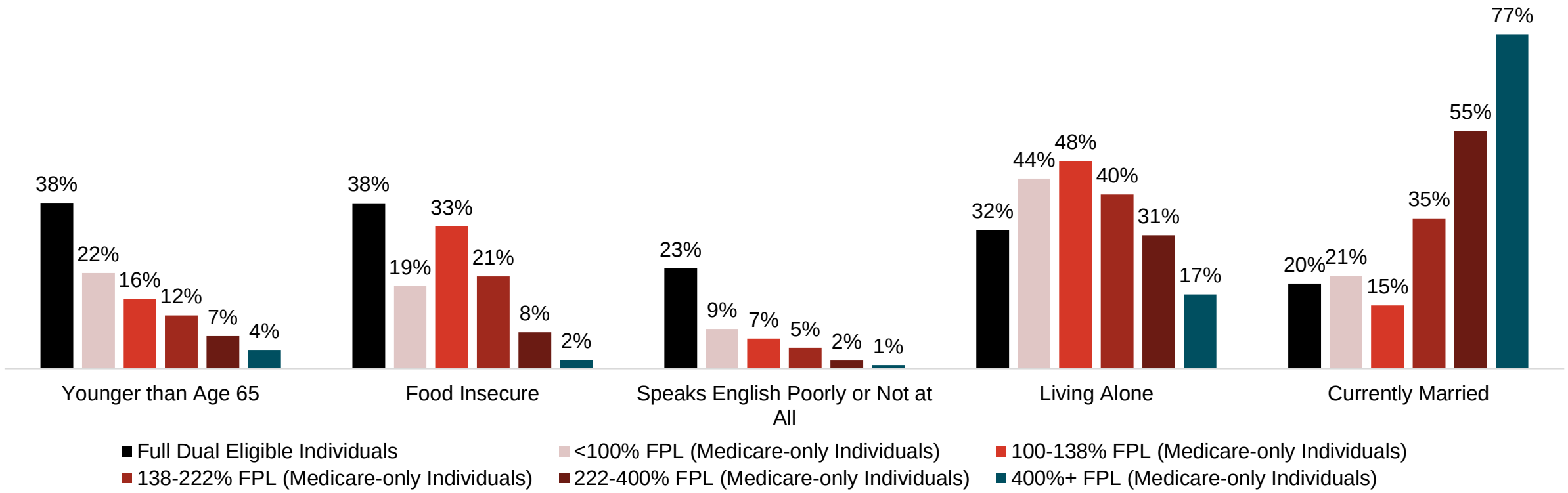
MEDICARE-ONLY INDIVIDUALS WITH LOW INCOMES (< 400% FPL) REPORT HIGHER RATES OF FOOD INSECURITY AND ARE LESS LIKELY TO HAVE SOCIAL SUPPORTS COMPARED TO INDIVIDUALS WITH 400%+ FPL

Reported Demographics and Social Supports of Medicare Individuals by Income Eligibility for Medicaid



Data Source: 2020 Medicare Current Beneficiary Survey.

Note, Food Insecurity, English Ability, Living Alone variables are limited to community-dwelling Medicare individuals.

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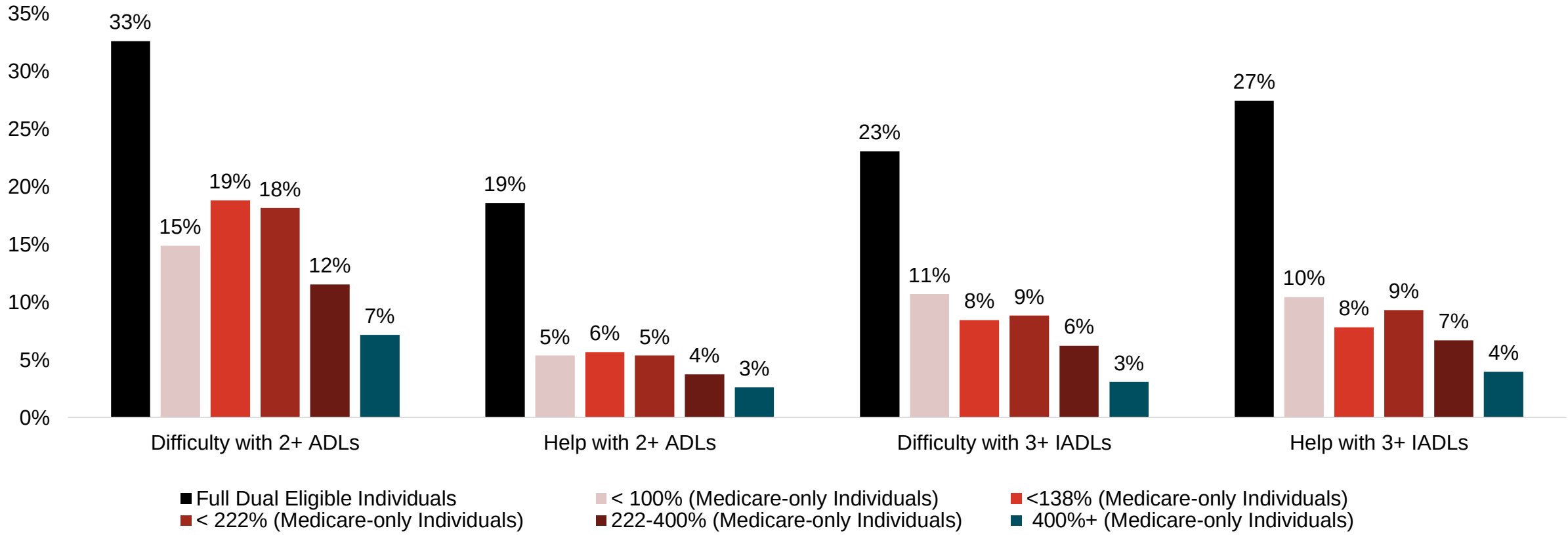
MEDICARE-ONLY INDIVIDUALS WITH LOW INCOMES (< 400% FPL) REPORT HAVING SIGNIFICANT UNMET FUNCTIONAL AND COGNITIVE NEEDS

Number of Functional and Cognitive Needs that Medicare Individuals Report Needing Help with, by Income



Data Source: 2020 Medicare Current Beneficiary Survey, Community only
Difficulty with IADLs – the individual reports that they have difficulty with the IADL or they report that they do not do it because of their health.
Help with IADLs – the individual reports receiving help with the IADL, but they may receive help because they hire individuals to do chores, not only because they have difficulty

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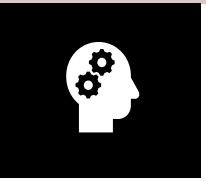
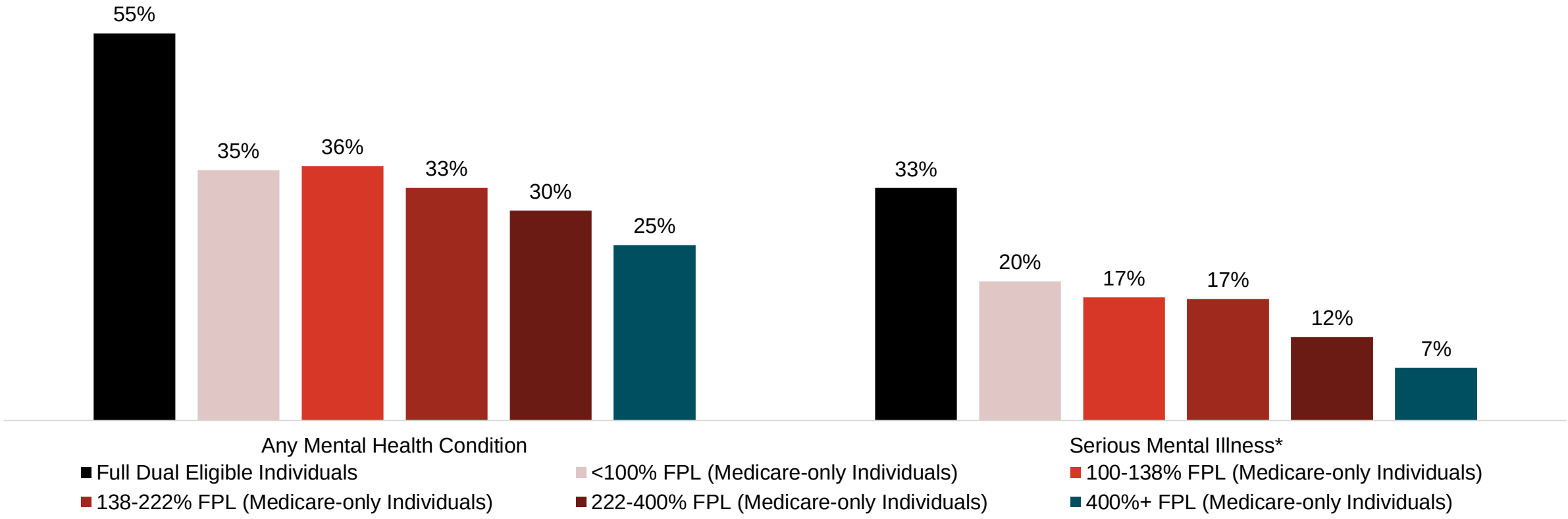
MEDICARE-ONLY INDIVIDUALS WITH LOW INCOMES (< 400% FPL) ARE MORE LIKELY TO REPORT HAVING MENTAL HEALTH NEEDS COMPARED TO INDIVIDUALS WITH HIGHER INCOMES (400%+ FPL)



Reported Mental Health Needs of Medicare Individuals by Income



Data Source: 2020 Medicare Current Beneficiary Survey, Community only

Note: mental health conditions are based on self-reported data.

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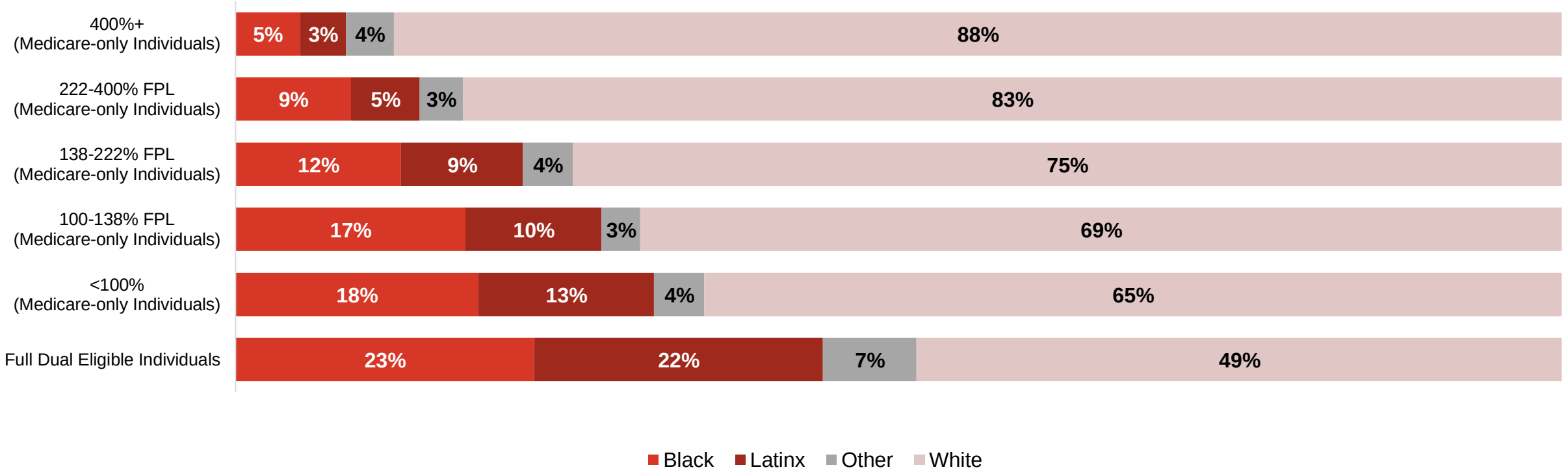
MEDICARE-ONLY INDIVIDUALS WITH LOW INCOMES (< 400% FPL) ARE A DIVERSE POPULATION, AND UNMET LTSS OR RELATED NEEDS DRIVE STATE HEALTH INEQUITIES

Race and Ethnicity of Medicare Individuals by Income



Data Source: 2020 Medicare Current Beneficiary Survey

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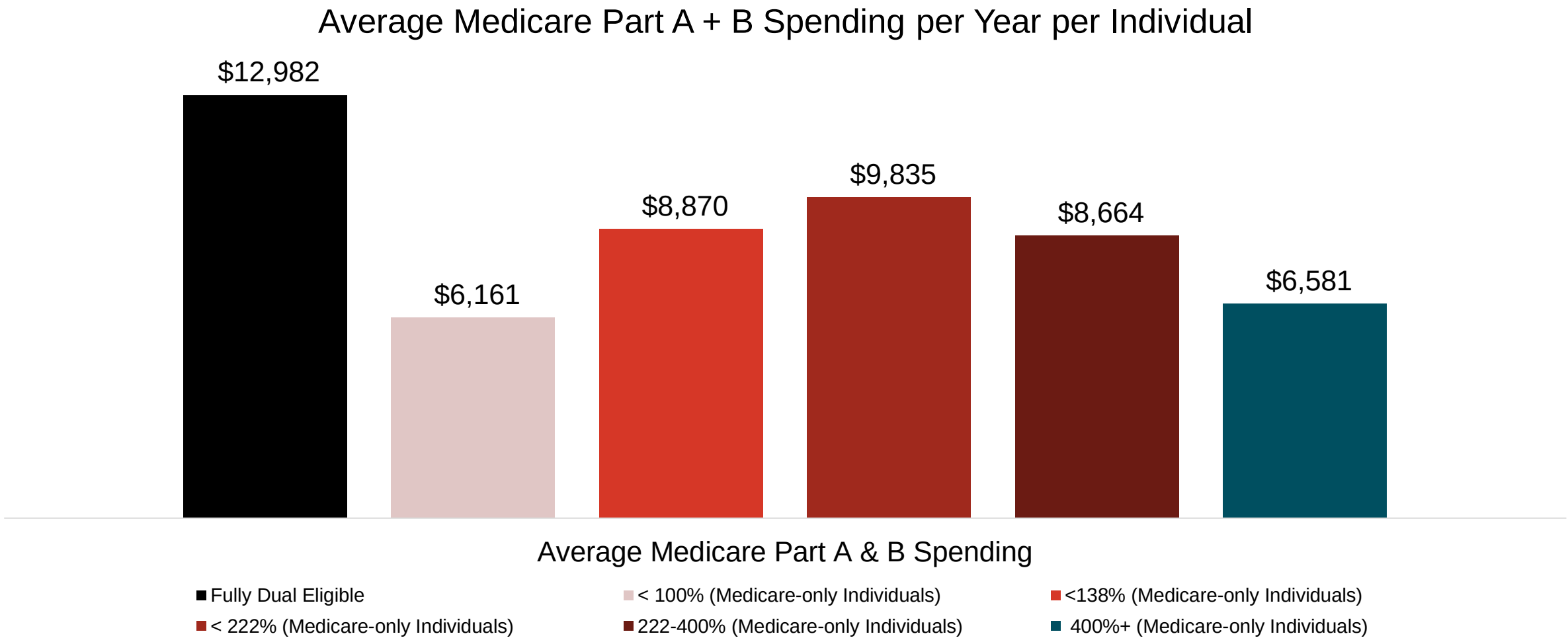
MEDICARE SPENDS MORE ON LOW-INCOME MEDICARE-ONLY INDIVIDUALS (< 400% FPL) THAN THOSE WITH INCOMES OVER 400% FPL



Data Source: 2020 Medicare Current Beneficiary Survey, Community only

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PROFILE: CINDY – MAKING DO WITH LONG-TERM NEEDS, NO EMPLOYMENT, AND NO COVERAGE

ADL and IADL Dependent - Needs help anytime she gets in and out of her wheelchair, including to dress and to use her bed, bath, or toilet

Manages to get by with about 6 hours of in-home aide per day by taking unsafe risks to perform self-care, and by using diapers

Lives alone and can no longer participate in workforce

Inherited $50,000 on January 1st and put it in savings
Earns yearly SSDI payments of $11,558
Will pay $179/day or $65,538/year for (I)ADL help

At age 55, Cindy has faced decades of disability after a short career making an income at 200% of the FPL.

ADLs are Activities of Daily Living, such as dressing, bathing, and toileting. IADLs are Instrumental ADLs, such as managing money, shopping, and cooking.
Source: Genworth Cost of Care Survey, 2021 Edition, with cost of care reflecting 44 hours per week of home health aide services, inflation-adjusted to 2023 assuming a 3% inflation rate. SSDI income estimated with DisabilityQualification.com using the 2023 200% FPL as Cindy's average 10-year taxed income from her working years.

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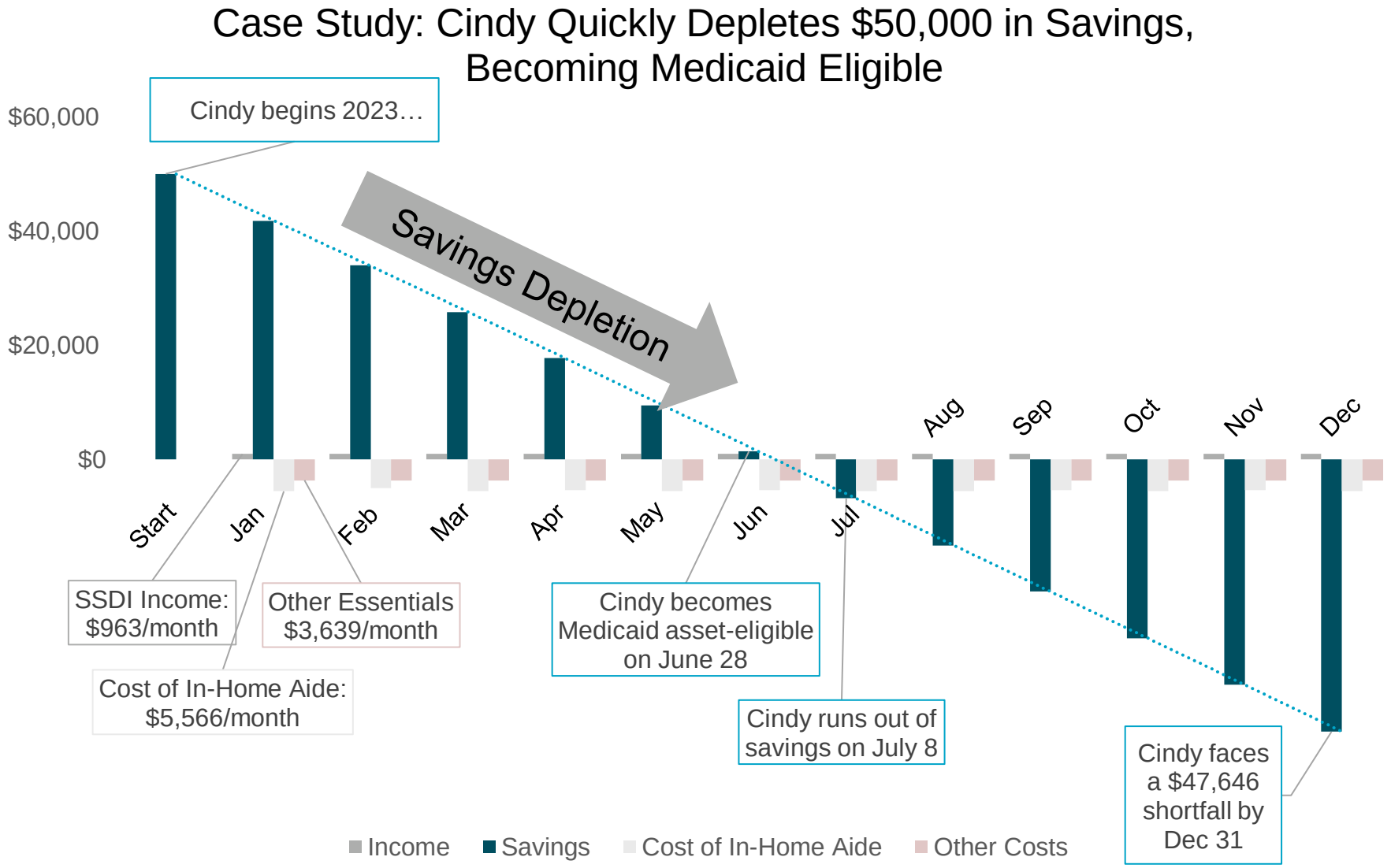
PROFILE: CINDY – SAVINGS DEPLETION AND BECOMING MEDICAID ELIGIBLE



Even with $50,000 of inherited savings and her SSDI benefit payments, Cindy runs out of savings by July.

→ Assumptions: Cindy has modest spending on essentials plus rent, while paying $5.4K for medical care annually.

ATI Advisory simulation of personal finances at the end of each month for an individual using 6.25 hours of home health aide services per day, has $50,000 in savings, earns SSDI based on having 10 years' taxed income equal to 200% FPL, and spends 100% of income on aide services.
Source: Genworth Cost of Care Survey, 2021 Edition, inflated to 2023. HUD FMR for 2023 Abilene TX MSA (1 BR). EPI modest budget for 1 adult in Abilene TX MSA. Transportation from ASPE Breakdown of Mean Household Expenditures for <400% FPL older adults.

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Opportunities for States to Address Unmet LTSS or Related Needs

STATES HAVE DIFFERENT LEVERS TO ADDRESS UNMET LTSS OR RELATED NEEDS

Data analysis to understand the Medicare-only population should inform state approaches to support this population who do not have access to Medicaid

States Have Policy Levers

- Expand Medicaid eligibility supported by state dollars (e.g., via a federal demonstration waiver)
- Expand access to Aging and Disability network services for Medicare-only individuals with unmet LTSS or related needs
- Use state Medicaid agency levers (Medicaid requests for proposals, Medicaid managed care contracts, and State Medicaid Agency Contracts) to partner with Medicaid managed care organizations and D-SNPs to invest in the near dual eligible population
- Use other state levers (through the Department of Insurance) to influence Medicare Advantage plan strategies

States Can Deploy Programs

- Partner with Older Americans Act programs (including Area Agencies on Aging [AAAs] and State Health Insurance Assistance Programs [SHIPs])
- Establish an office dedicated to Medicare
- Implement CAPABLE (Community Aging in Place – Advancing Better Living for Elders)

States Can Engage and Educate

- Leverage Master/ Multisector Plan on Aging activities
- Engage Medicare-only individuals to understand what they need
- Educate and share tools for Medicare providers
- Collaborate with Medicare Advantage plans
- Bolster enrollment in Medicare Savings Program (MSP) through outreach
- Explore partnerships with U.S. Department of Housing and Urban Development
- Collaborate with the state agency managing behavioral health

POLICY EXAMPLES: STATES CAN PURSUE MEDICAID WAIVERS TO SUPPORT THE LTSS NEEDS OF LOW-INCOME MEDICARE-ONLY INDIVIDUALS

State	Medicaid Waiver / Demonstration Authority	Implementation Date	Benefit	Eligible Population	Notes & Outcomes
VT	Section 1115(a)	Waiver first approved by CMS on October 1, 2010 • Currently authorized through December 31, 2027	1. Full Medicaid State Plan and HCBS benefits 2. Limited HCBS benefits, including Adult Day Services, Case Management, and Flexible Funds	1. Individuals ages 65+ or ages 18+ with a disability, and who are not Medicaid-eligible and have "highest" or "high" clinical need for HCBS 2. Individuals with "moderate" clinical need for HCBS up to 300% of SSI Federal Benefit Rate, if at risk for institutionalization	• Demonstration intended to delay or prevent need for more costly LTSS or institutionalization • Cost savings to be reinvested into HCBS if >1% of state spend • Demonstration shows a significant increase in share of enrollees receiving care outside of nursing facilities year-over-year
WA	Section 1115(a)	Waiver first approved by CMS on January 9, 2017 • Currently authorized through June 30, 2028	Tailored Supports for Older Adults (TSOA): • A limited HCBS benefit package that supports unpaid family caregivers, including training, respite, and support groups	Individuals "at risk" of future Medicaid LTSS needs, who do not currently meet Medicaid financial eligibility criteria • Individuals ages 55+, not currently Medicaid eligible, meet functional needs eligibility assessment, income up to 400% of SSI Federal Benefit Rate	• Analysis of WA's TSOA pilot showed a reduction in utilization of traditional Medicaid LTSS compared to baseline • ¼ of TSOA participants enrolled in Medicaid within 6 months, but were less likely to use MLTSS • About 1,600 beneficiaries enrolled between 2017 - 2019

HCBS – Home- and Community-Based Services, SSI – Supplemental Security Income, LTSS – Long Term Services and Supports

Source: VT 2010 Waiver Approval; VT 2022 1115 Waiver Approval; VT Interim Evaluation Report; WA 2017 Waiver Approval; WA 2023 1115 Waiver Approval; WA Interim Evaluation Report; Long-Term Services and Supports Rebalancing Toolkit

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PROGRAM EXAMPLES: STATES CAN DEPLOY PROGRAMS TO MEET THE LTSS NEEDS OF LOW-INCOME MEDICARE-ONLY INDIVIDUALS

State	Funding Source	Implementation Date	Benefit	Eligible Population	Notes & Outcomes
CT	State budget appropriations: **Public Act No. 15-5**	July 1, 2015	*Connecticut Home Care Program for Elders (CHCPE):* • Provides assistance to adults with **ADL difficulty** to help avoid institutionalization • Covers services including adult day care, home-delivered meals, home health aides, case management	Eligible individuals must have a functional need for services, **demonstrating difficulty performing ADLs** • State-funded CHCPE services have **no income limit** and an **asset limit of $36,270**	• State funded CHCPE beneficiaries must pay a 9% copay on all services • CT also offers similar CHCPE services to **Medicaid-eligible beneficiaries** under 1915(c) and 1915(i) authority, with an income restriction and asset limit • As of FY 2018, **16,000** residents served • CT estimates **cost savings of nearly $400M annually** due to nursing facility diversion
MN	Funded by State-directed **Older Americans Act** Area Agencies on Aging funds	2010	*Return to Community Initiative (RTCI):* • A statewide benefit that facilitates **transitions from institutional to home- or community-based care** • **Case management,** including establishing a community living plan and connections to Medicaid and Social Services, and **post-discharge follow-up visits** for up to 5 years	Individuals at risk of becoming **long-stay nursing facility residents** • Not Medicaid eligible upon nursing facility admission, admitted to nursing facility for 45+ days, desire to return to the community, documented health and functional criteria	• State goal is to achieve cost savings by delaying or avoiding consumer spend down to Medicaid • At one-year follow-up, **only 8.2% of RTCI clients had converted to Medicaid**; **76% remained alive and in the community** • Assisting an **average of 90-100 members/month** as of 2016

ADL – Activity of Daily Living

Source: Long-Term Services and Supports Rebalancing Toolkit; A Statewide Model for Assisting Nursing Home Residents to Transition Successfully to the Community; CHCPE Request for Referral; CT Public Act No. 15-5; Connecticut Home Care Program for Elders (CHCPE); CT 2018 CHCPE Evaluation

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ENGAGE AND EDUCATE EXAMPLES: STATES CAN LEVERAGE RESOURCES TO EDUCATE MEDICARE-ONLY INDIVIDUALS AT RISK OF BECOMING DUAL ELIGIBLE

Opportunity	Engagement Effort
Create State Medicare Office	Establish an office dedicated to analyzing, understanding, and addressing the needs of Medicare individuals within the state, inclusive of dual eligible and non-dual eligible individuals with unmet LTSS or related needs. The California Office of Medicare Innovation and Integration (OMII) is an example of a state effort to address this issue.
Engage Providers	Bring Medicare providers together in moderate income areas to discuss the gaps and needs of the individuals they serve. Develop materials to share in provider offices about OAA and other benefits and SHIP counseling.
Leverage Plans	Engage Medicare Advantage plans to identify state-specific opportunities for low-income Medicare individuals who are not Medicaid eligible. Plans can be a key connection point for individuals to services and supports in the community so resources can be developed to facilitate these connections and shared with plans. Provide care managers to high-risk patients (often Medicare-only individuals at risk of becoming a dual eligible individual) through Medicare Advantage plans to connect beneficiaries with resources.
Engage Organizations	Educate Aging and Disability Resource Centers (ADRCs), Centers for Independent Living (CIL), and SHIPs to help individuals make informed choices. ADRCs help connect older adults and people with disabilities with supportive services and eldercare resources to continue living as they choose in their community. CILs provide independent living services for people with disabilities. SHIPs can help low-income Medicare-only individuals identify likely eligibility and refer them to programs to help financially.

Contact us for more data and actionable opportunities specific to your state

Visit the State Resource Center →

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