Administration on Aging

Putting Data to Work for Older People

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OAA Service Users: Who Is At Risk for Becoming Medicare-Medicaid Eligible?

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Since passage of the Older Americans Act (OAA) in 1965, the Administration on Aging (AoA) has supported the delivery of services to Americans aged 60 and over and their caregivers, helping them maintain independence and remain in their own homes. Through its "Aging Services Network" including State Units on Aging (SUAs), Area Agencies on Aging (AAAs), local service providers, and tribal partners, AoA works to provide services designed to mitigate the effects of declining physical health and functioning experienced by frail adults aged 60 and over. *This brief, the seventh in a series that presents findings from AoA's National Survey of OAA Participants, explores the use of community-based services among OAA Title III program recipients at risk of becoming eligible for Medicaid.*

Summary

Individuals enrolled in both Medicare and Medicaid services are often more frail and more costly to care for than Medicaid-only enrollees. Across Title III services funded by the Older Americans Act (OAA), the percentage of adults aged 60 and over receiving both Medicare and Medicaid benefits ranges from 16 percent among people receiving congregate nutrition services to 38 percent among those receiving case management services. To learn more about this population, this brief examines OAA service recipients by program utilization and certain health and economic characteristics that may lead to adults aged 60 and over becoming eligible for Medicaid. OAA participants not currently receiving Medicaid are classified into two groups: first by income (impoverished vs. not impoverished), and second by health status (frail vs. not frail). Findings suggest that classifying OAA service recipients by income or health characteristics (the two main reasons that Medicare participants become eligible for Medicaid) may help us to better understand how the proportion of adults aged 60 and over who may be at risk of becoming eligible for Medicaid differs by OAA program participation. It also demonstrates that those who are at risk for becoming eligible for Medicaid are already receiving programs and services designed to help them stay in their homes and communities.

What Is the Aging Services Network?

The Aging Services Network (funded under Title III of the Older Americans Act) provides a range of community-based services – home-delivered and congregate nutrition services, case management, transportation, and homemaker and caregiver support to individuals age 60 and over and their caregivers. These services are intended to reach the most vulnerable older adults in greatest social and economic need. Such services enhance both the quality of life and social interaction, and minimize the impact of disability.

Background

The majority of adults aged 65 and over (93 percent) living in the community, have Medicare as their primary source of health insurance (DeNavas-Walt, Proctor, and Smith 2013). Medicare covers acute care services (inpatient hospitalizations and other short-term care) and some post-acute care (care provided in settings such as skilled nursing facilities). In 2008, Medicare paid for approximately 60 percent of the health care costs of people age 65 and over. The remaining health care costs were either paid for by supplementary health insurance policies or out of pocket by the consumer (Federal Interagency Forum on Aging-Related Statistics 2012). One source of supplementary health insurance that is being relied upon more

and more by adults aged 65 and over is Medicaid.[1] In 2011, 14 percent of people age 65 and over (6 million people) were enrolled in both Medicare and Medicaid (CMS Medicare-Medicaid Coordination Office 2013). Individuals enrolled in both Medicare-Medicaid are more likely than Medicare-only enrollees to be frail, live with chronic conditions, and have functional and/or cognitive impairments (Young et al. 2013). As a result, Medicare-Medicaid enrollees tend to use more, and more costly, medical care.

There are two main pathways for people age 65 and over to become eligible for both Medicare and Medicaid—living in poverty for an extended amount of time or becoming impoverished due to high medical expenses. Those in the first group typically become eligible for Medicaid based on income or disability status before they turn 65, and then later qualify for Medicare based on age. Those in the second group become eligible for Medicare when they turn 65, and then later become eligible for Medicaid as a result of becoming impoverished due to high medical expenses (De Nardi et al. 2011). The second group is of particular interest to the Administration on Aging, as there is potential to prevent slow declines in health and delay adults aged 60 and over from "spending down" their assets and becoming eligible for Medicaid.

An important first step in learning whether community-based long-term care can help prevent or delay adults aged 60 and over from "spending down" and becoming eligible for Medicaid, is to better understand the service utilization of those who might be at risk based on their health or socioeconomic status. Adults aged 60 and over who are frail, impoverished, and/or have serious health conditions and functional limitations are often the ones who are more likely to need institutional care. In fact, Title III of the OAA focuses on this vulnerable population in delivery of its programs and services through the Aging Services Network. Therefore, learning more about the characteristics of the "at-risk" Medicare-only population, and the types of community-based services they use, may inform future research that helps adults aged 60 and over remain independent and avoid unnecessary institutional care.

Using data from the National Survey of Older American Act Participants (NSOAAP), the study population was assessed by analyzing responses from participants in five Title III programs[2] about AoA services received. Then, within each program, the Medicare-Medicaid enrollee group was defined as respondents who reported receiving Medicaid. Medicare-only enrollees were then classified into two at-risk groups based on either income or health characteristics that may predispose them towards becoming Medicare-Medicaid enrollees. Since characteristics of service recipients vary by program, the composition of the at-risk groups also varies across programs. Because several different combinations of characteristics can result in Medicare-only OAA service recipients being more vulnerable to becoming Medicare-Medicaid enrollees, we identified two subgroups of Medicare-only enrollees who, by virtue of selected characteristics, may be potential Medicare-Medicaid enrollees.

As mentioned earlier, Medicare-Medicaid enrollees differ from Medicare-only enrollees on a variety of factors including income, health status, and demographic characteristics. Medicare-Medicaid enrollees are more likely than Medicare-only enrollees to have low incomes, poor health status, be female, and live alone or in institutions (CMS Medicare-Medicaid Coordination Office 2013; MedPAC 2013; Coughlin et al. 2012). Therefore, this brief uses two at-risk categorizations to compare service utilization of adults aged 60 and over who might be at risk of becoming Medicare-Medicaid enrollees. The **income at-risk** group consists of individuals with household incomes below the poverty threshold[3] (i.e., those more likely to qualify for Medicaid). The **health at-risk** group includes those that have difficulties with two or more Activities of Daily Living (ADLs), or three or more chronic health conditions but no income restrictions. Within each of the OAA Title III programs, the Medicare-only group is separated into these two at-risk groups to assess how these different dimensions or attributes may contribute to the type and mix of program and service use among OAA recipients.[4]

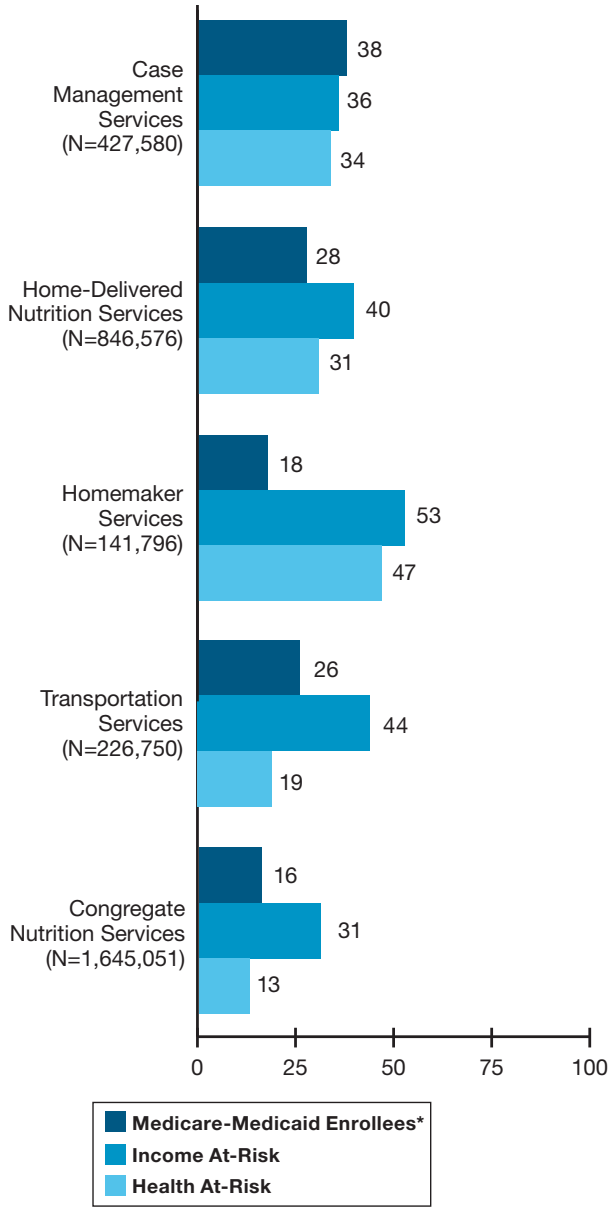
1 People who are eligible for both Medicare and Medicaid, Medicare-Medicaid enrollees, all qualify for full Medicare benefits but differ in the amount of Medicaid benefits they are eligible to receive. Full Medicare-Medicaid enrollees are beneficiaries who qualify for full benefits from Medicaid as well as from Medicare, while partial Medicare-Medicaid enrollees are beneficiaries who qualify to have Medicaid pay some of the expenses they incur under Medicare (Congressional Budget Office 2013).

2 The five Title III programs were case management, homemaker, transportation, and congregate and home-delivered nutrition services.

3 While the federal poverty guidelines for 2012 were $11,170 for a single person household and $15,130 for a two-person household, we used $15,000 as our income maximum based on available income categories in the 2012 NSOAAP.

4 Note that the two at-risk groups are not mutually exclusive. Each group includes everyone who meets the criteria for being in that particular group.

Figure 1. Proportion of OAA Recipients by Risk Group and Service Utilization, 2012



Source: Seventh National Survey of OAA Participants (2012).

*In the NSOAAP, respondents are asked if they receive Medicaid benefits. They are not asked if they receive Medicare benefits. Since nearly all Americans age 65 and over have Medicare as the primary source of health insurance coverage, we made the assumption that anyone age 65 and over who reports receiving Medicaid is a Medicare-Medicaid enrollee. Among the population ages 60–64, data from the U.S. Census Bureau tells us that only 3 percent (or slightly more than 400,000) are enrolled in both Medicare and Medicaid. The data in this report have been adjusted to reflect these estimates. (Source: AGID, Data Files, AoA Special Tabulations, *http://www.agid.acl.gov/DataFiles/ACS2011DIS/?stateabbr=AL*, 2009–2011 ACS Special Tabulation, Disability Tables, *http://www.agid.acl.gov/DataFiles/ACS2011DIS/Table/?tableid=S210DIS10&state=AL*, S210DIS10 - Health Insurance by Disability, accessed on September 19, 2014.)

Who Is At Risk?

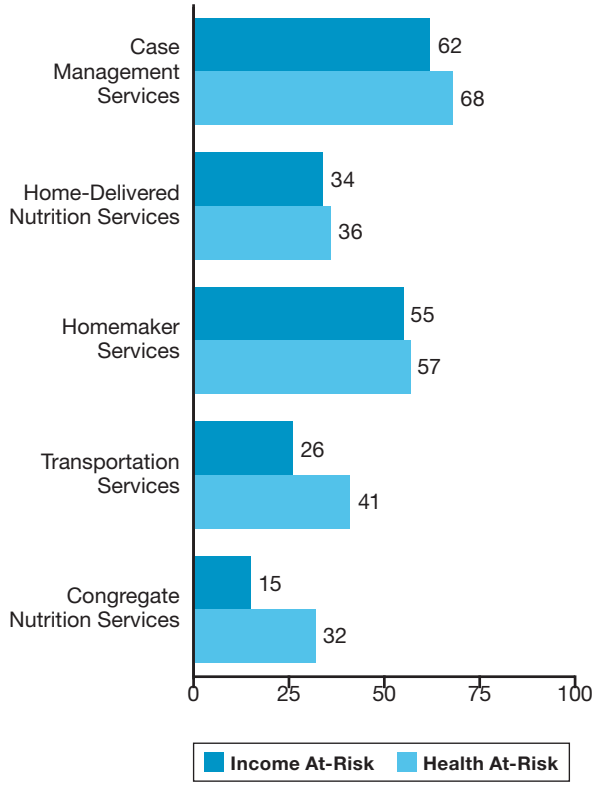
When comparing Medicare-Medicaid enrollees to Medicare-only enrollees across the different programs, in general, a disproportionate share of Medicare-Medicaid enrollees lack a high school diploma, are African American, and tend to report being in poor or fair health compared to Medicare-only enrollees (data not shown). However, while Medicare-only enrollees generally report better outcomes on certain health or socio-demographic dimensions when compared to Medicare-Medicaid enrollees, within the Medicare-only enrollees group, there is considerable heterogeneity in characteristics such as age, health status, and living arrangements.

When being at risk is defined by low income, the proportion of those at risk by each service type ranges from 31 percent among those receiving congregate nutrition services to 53 percent among those receiving homemaker services. In contrast, when defined by health status, the proportion of those at risk ranges from 13 percent among those receiving congregate nutrition services, to 47 percent among those receiving homemaker services (Figure 1).

Across all service types, recipients of homemaker services have the largest proportion of participants at risk due to income or health, while the lowest proportion of those at risk appears to be among recipients of congregate nutrition services. The variation in the proportion of at-risk OAA clients by service type could be due to the specific needs of the clients or it could be due to heterogeneity of the population. However, the transitions between the at-risk and Medicare-Medicaid enrollees categories within any of the programs are unknown due to the limitations of a point-in-time study.

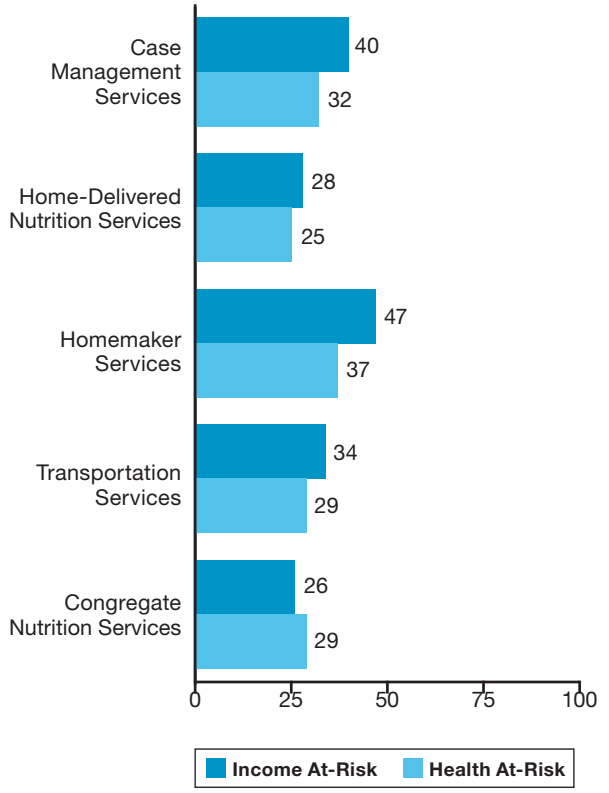
With the exception of congregate nutrition services participants classified as **income at-risk**, over one quarter of Title III program participants in each of the two at-risk groups reported receiving multiple services (Figure 2). A considerably higher proportion of case management and homemaker service recipients reported receiving multiple services compared to participants receiving home-delivered nutrition services, congregate nutrition services, or transportation services. The proportion of those receiving multiple services ranged from a low of 15 percent (congregate nutrition services—**income at-risk**) to a high of 68 percent (case management—**health at-risk**). In general, regardless of service type, **health at-risk** participants were more likely to receive multiple services compared to **income**

Figure 2. Proportion of OAA Recipients Receiving Main Service Plus Two Additional Services by Risk Group and Main Service Utilization, 2012



Source: Seventh National Survey of OAA Participants (2012).

Figure 3. Proportion of OAA Recipients Receiving SNAP, Energy, or Housing Assistance by Risk Group and Service Utilization, 2012



Source: Seventh National Survey of OAA Participants (2012).

at-risk participants. This is likely due to **health at-risk** individuals having multiple functional impairments, such as difficulties with two or more ADLs or three or more chronic conditions, and therefore needing a wider array of OAA services to remain in their homes.

Receipt of Non-Title III Services Varies by Program and Risk Group

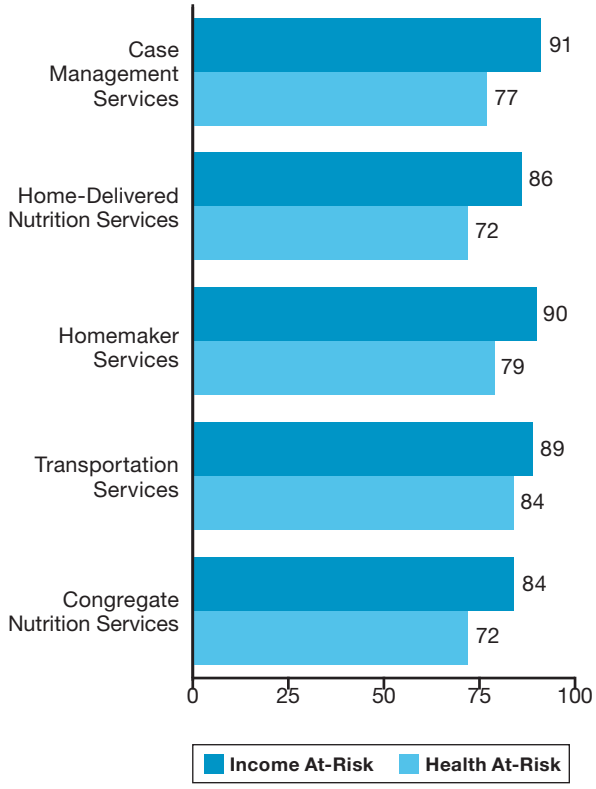
Medicare-Medicaid enrollees are a diverse population on a number of indicators (Coughlin et al. 2012). Yet most Medicare-Medicaid enrollees are living at or below the poverty level and are likely to be eligible for other federally funded services such as Supplemental Nutrition Assistance Program (SNAP), energy assistance, and/or housing subsidies.[5] To better understand if the at-risk measures in this brief are capturing those who are truly at risk of becoming Medicare-Medicaid enrollees, their participation in these federally funded services is examined. Across the various programs, a greater proportion of **income at-risk** participants reported receiving SNAP, energy, or housing assistance compared to **health at-risk** participants. The only exception was for congregate nutrition services where a greater proportion of **health at-risk** participants reported receiving these other federally funded services. The proportion of **income at-risk** participants receiving SNAP, energy, or housing assistance ranged from 26 percent (congregate nutrition services) to 47 percent (homemaker services), while the proportion of **health at-risk** participants receiving these services ranged from 25 percent (home-delivered nutrition services) to 37 percent (homemaker services) (Figure 3).

Do Services Help Those At Risk Stay in the Community?

The use of Title III services helps adults aged 60 and over live independently and remain in their homes and communities. More than 70 percent of those receiving case management, home-delivered nutrition, homemaker, transportation, or congregate nutrition services reported that this assistance allowed them to live independently (Figure 4).

5 The NSOAAP asks "Are you receiving any other types of assistance such as food stamps?" In 2008, the Food Stamp Act and Program was renamed the Supplemental Nutrition Assistance Program (SNAP).

Figure 4. Proportion of OAA Recipients Reporting that Services Allow Them To Live Independently by Risk Group and Service Utilization



Source: Seventh National Survey of OAA Participants (2012).

Across all services, a greater proportion of **income at-risk** participants reported that these services enabled them to live independently compared to **health at-risk** participants. The proportion of **income at-risk** participants reporting that these services enabled them to live independently ranged from 84 percent (congregate nutrition services) to 91 percent (case management services), while the proportion of **health at-risk** participants reporting the same ranged from 72 percent (home-delivered nutrition services and congregate nutrition services) to 84 percent (transportation services).

Possible Implications

The cost of providing health care to Medicare-Medicaid enrollees is high and the number of people eligible for both programs continues to grow. Between 2006 and 2011 the number of Medicare-Medicaid enrollees age 65 and over increased by 12.5 percent from 5.3 million to 6.0 million (CMS Medicare-Medicaid Coordination Office 2013). The federal and state outlays to pay for the care of this population topped $319 billion in 2011 (Feder et al. 2011).[6] Because many older Medicare-Medicaid enrollees are more likely than Medicare-only enrollees to have a Medicare-qualifying disability (CMS 2013), be in fair or poor health, and have mental health needs (KFF May 2011), they are also more likely to need institutional care. Home and community-based services are intended to allow many adults aged 60 and over with disabilities to remain independently in the community and delay or eliminate the need for institutional care.

While informative, this brief provides only a limited look at OAA recipients who are at risk of becoming eligible for Medicaid. Program recipients vary in their risk profiles and using other ways to assess risk would likely produce different results. However, Title III of the OAA targets its services to the most vulnerable adults aged 60 and over, those in greatest social and economic need. Therefore, many of the people receiving services through the Aging Services Network could be at risk for becoming eligible for Medicaid. For example, this analysis of OAA recipients has found that indicators of vulnerability include low income, poor health, and having limitations in functional status. OAA recipients with these characteristics exist in each population receiving services from Title III programs. Findings here suggest that it is the combination of these characteristics that play a role in determining who is vulnerable to becoming eligible for Medicaid.

Given the heterogeneity of the Medicare-only population, using any single approach to targeting services may be infeasible. By exploring the different pathways to becoming at risk for Medicare-Medicaid eligibility, and examining service utilization among these different vulnerable subgroups, it may be possible to target the different subgroups with the particular services they need. While a comprehensive analysis is beyond the scope of this brief, future research could explore methods to construct a more multi-dimensional measure of risk that would account for combinations of risk factors.

Acknowledgments

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6 This total includes a combination of federal spending ($175.7 billion from Medicare and $80.9 billion from Medicaid) and state spending ($62.7 billion from Medicaid) for Medicare-Medicaid enrollees of all ages (Feder et al. 2011).

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Data

Information on Title III participants was drawn from the Seventh National Survey of OAA Participants. Westat, Inc., conducted the telephone survey in 2012, administering it to over 5,000 people who reported receiving Title III services. This brief includes data for 4,158 recipients who were surveyed about their experiences with case management, home-delivered nutrition services, homemaker services, congregate nutrition services, and transportation services. The survey used a two-stage sample design, first selecting a sample of AAAs and then randomly sampling participants from each selected AAA by service type. The number of participants selected from each AAA was proportional to the number of participants served in that particular service by the sampled AAA. All analyses in this brief apply sample weights to account for this design. Additional data from, and more detailed documentation about, the NSOAAP and other AoA data sources are available on the AGing Interactive Database (AGID) located at *http://www.agid.acl.gov.*

About This Series

This series is funded by AoA, and presents analyses conducted by Social & Scientific Systems using data from AoA's National Survey of Older Americans Act Participants. This survey collects information from Title III recipients about their demographics, socioeconomic status, health, and functioning, as well as their service use and client-reported service impact and quality. For more information about this study, please contact Niranjana Kowlessar at Social & Scientific Systems, *NKowlessar@s-3.com*.