The Medical Improvement Group: Issues and Options

Background

Federal law allows states the option to provide Medicaid coverage to individuals with disabilities who work. The programs, called Medicaid Buy-ins, are authorized by both the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). By the end of 2007, thirty-seven states had implemented a Medicaid Buy-in program.

The Medical Improvement Group

There are currently three separate Medicaid Buy-in programs authorized by federal law. Two of these groups, one authorized by the BBA and the other by TWWIIA, require enrolled individuals to have a disability that meets the standards of the Social Security Administration (SSA), except that their income is too high. The third program is called the "Medical Improvement Group." The medical improvement group differs from the other two programs, known as the "Basic Coverage Groups," because the individual does not have to have a condition that currently meets SSA's disability standards.

The Medical Improvement Group provides continuing coverage to people who were previously on the TWWIIA Basic Coverage Group, but who received a determination of "Medical Improvement" from either the SSA or the state disability determination team. To date, in states with both Basic and Medical Improvement groups, the benefits packages available and the income/asset requirements are the same for both the Basic Coverage Group and the Medical Improvement Group.

Without a Medical Improvement Group, an individual who receives a Medical Improvement determination loses eligibility for Medicaid. Loss of health coverage can potentially lead to a worsening of the individual's condition that forces them to reapply for SSA benefits and/or Medicaid. Implementing the Medical Improvement Group gives states an opportunity to mitigate the potential deterioration of health and to support individuals in sustained employment.

Medical Improvement Policies

In TWWIIA, there are certain requirements placed on the Medical Improvement Group. These requirements include:

- A state may only implement a Medical Improvement Group if it offers the TWWIIA Basic Coverage Group;
- A state must define a minimal work requirement for those in the Medical Improvement Group. The federal statute includes employment of 40 hours a month earning at least minimum wage, but states are given limited flexibility to craft their own work requirements;
- Individuals must be at least 16 years old, but no older than 64;
- Individuals can only enroll in the Medical Improvement Group if they were eligible and enrolled in the Basic Coverage Group and lost eligibility due to Medical Improvement;

- Individuals must continue to have a medically determinable impairment after the medical improvement determination.

Key Issues

DEFINING MEDICAL IMPROVEMENT

A determination of medical improvement does not mean that the person's condition no longer exists. In fact, for the purpose of the Medical Improvement Group, there must be documentation of an ongoing impairment after the medical improvement determination. For individuals with a SSA disability determination, Medical Improvement is evaluated during a continuing disability review (CDR). During a CDR review, SSA looks for a decrease in the severity of the disability that the benefit approval was based on; if improvement is found, SSA then evaluates the individual's ability to perform Substantial Gainful Activity (SGA).[1] If SSA finds that the person can engage in SGA then the disability benefits, including Medicaid, are terminated.[2]

For individuals with a state determination, the state disability review team is expected to use the same standards as SSA to determine eligibility. However, for the purposes of Medicaid Buy-in programs, the ability to engage in SGA is not evaluated. This creates some difficulty when determining medical improvement, since the improvement of the condition (and not the ability to earn SGA) is the only criteria available to base the determination on. Initial observations of enrollees in the Medical Improvement Group indicate that it is more likely for individuals with state disability determinations to receive subsequent medical improvement determinations than it is for individuals with SSA determinations. However, in both cases, the prevalence is very low.

IDENTIFYING AN ONGOING IMPAIRMENT

Individuals losing eligibility due to medical improvement are required to have an ongoing medically determinable impairment in order to be eligible for the Medical Improvement Group. States have generally utilized statutory language to define ongoing impairment, and offered guidance to eligibility staff on how to document the ongoing medical impairment. The two most common methods of identifying ongoing impairments are:

- The agency that documents medical improvement simultaneously documents an ongoing impairment and eligibility for the Medical Improvement Group; or
- Once medical improvement is identified, a qualified medical provider, such as a doctor, registered nurse or psychiatrist, must document an ongoing medical condition.

Some common types of disabilities in existing Medical Improvement Groups include:

- Individuals with renal disease who have had a successful transplant; and
- Individuals with a mental illness.

PROVIDING EFFECTIVE OUTREACH AND TRAINING

The complexities surrounding both Medicaid Buy-in policies as well as SSA medical improvement policies create unique challenges in effectively advertising programs to staff and con-

[1] SGA is defined by a monetary amount that automatically indexes each year. In 2008, performing SGA entails earning $940 a month. Certain other provisions may apply for self-employed individuals.

[2] The CDR process is complicated and involves multiple steps. For more information, visit *www.ssa.gov*.

sumers. Enrolling a person in the Medical Improvement Group requires an understanding of both the policies around disability determinations as well as the policies of the Medicaid Buy-in. Some states believe that individuals might not have enrolled in the Medical Improvement Group because staff and/or consumers did not know that the person was eligible.

UNDERSTANDING THE POPULATION

To date, only eight states[3] have implemented a Medical Improvement category, and none of the programs has grown substantially. The lack of enrollees and the lack of information about the people on the program create difficulty regarding effective ways to target potential beneficiaries. Furthermore, the requirement that individuals first be enrolled in the Medicaid Buy-in program prior to Medical Improvement creates a further reduction of an already limited applicant pool.

[3] Arizona, Connecticut, Kansas, Missouri, New York, Pennsylvania, Washington, and West Virginia.