2008 MEDWorks Evaluation Data Supplement
Observations and Remaining Questions

Data Observations
The following observations refer to accompanying tables as referenced: the "A" tables to the workbook “A Compendium.xls” and the “B” tables to the workbook “B Semi-Annual Continuity.xls”.

Enrollment & Turnover
1. MEDWorks peaked at 5.7% of all Medicaid working-age disabled (the MEDWorks penetration rate) in December 2004, and peaked in total number enrolled in January 2005, while the total number of working-age Medicaid disabled has continued to grow, so that the MEDWorks penetration rate had fallen one quarter by June 2007, to 4.3%. (Table A1) The annual penetration rate being higher than the monthly, due to churn on and off MEDWorks, the program peaked in FY05 at 6.0% of all working-age disabled who were enrolled in MEDWorks for the majority of their Medicaid enrollment period, and fell to 4.6% by FY08. (Table A30)
2. MEDWorks has been populated primarily from existing long-term Medicaid disabled, with less than 20% beginning their Medicaid as MEDWorks members and another 4% coming back after earlier Medicaid. Of those with previous Medicaid, 75% came specifically from the Medicaid Disabled aid category (D) and another 4% came from Medicaid aid categories that indicated Federal disability. Over 65% had been on Medicaid continuously for a year or more. (Tables A2 & A3)
3. MEDWorks members as a whole are more likely than other Medicaid disabled to be long-term disabled, averaging 74.6 months of Medicaid disability through from January 1994 through June 2007, while other Medicaid disabled averaged only 60.5 months. More specifically, however, MEDWorks members are relatively more likely to be lower medium term (2 to 6 years) and long term (over 10 years), while other Medicaid disabled are more likely to be short-term (under two years) or higher medium term (6 to 10 years). (Table A5)
4. In spite of being populated by long-term disabled, MEDWorks has had a high turnover rate. By July of 2007, after five years of the MEDWorks program, 71% of those who had been MEDWorks members at some time had dropped out of MEDWorks, 90% of whom stayed on Medicaid, 80% as aid category D and 4% in the Federal disability Medicaid aid categories. (Table A3)
5. Only in the first few months of implementation did a higher proportion of newly Medicaid disabled go into MEDWorks, as compared to other Medicaid disabled (possible woodworking); otherwise, since then, MEDWorks has been more highly populated by existing Medicaid disabled, while a relatively higher proportion of the newly disabled were not MEDWorks members. In other words, the decline in MEDWorks enrollment can in a large part be explained by the long-term decline in new Medicaid disabled in general, but not completely so, because the new Medicaid disabled were also less likely to go to MEDWorks than previously. (Table A4)
6. Compared to other Medicaid disabled, the MEDWorks population is more weighted toward the long-term disabled in a large part because the MEDWorks program has a disproportionate share of the Developmentally Disabled (DD) population (almost 20% participating at least sometime between FY03 and FY07), which has an average term of Medicaid disability of 97 months. The MEDWorks Mentally Ill/ Substance Abuse (MISA) disabled population, averaged 69 months, and the MEDWorks Medically Disabled (PD) population, averaged 54 months, with MEDWorks participation rates of only 10% and 7%, respectively. (Table A6)
7. However, the MEDWorks members of all three diagnostic groups are more likely to be more long-term on Medicaid disability than their non-MEDWorks counterparts, although this difference is greatest for the DD population. MEDWorks members as a whole were 25% more likely to continue on Medicaid disability as of June 2007, 20% less likely to drop off Medicaid alive, and 63% less likely to die. (Table A7) The MEDWorks DD population was enrolled in Medicaid an average 11.7 months out of 12, up 4% from 11.2 months in FY03, following the pattern of other working-age Medicaid DD. Similarly, the average annual term of enrollment for the MEDWorks MISA was up 5% over the six years, to an average 11.2 months by FY08, like their non-MEDWorks counterparts. MEDWorks PD, however, were 9% less continuously
enrolled in FY03, but had increased 14\% and ‘caught up with their counterparts by FY08.  
(Table A30)
8.  Because of the increased representation and extra long-term character of the MEDWorks DD population, DD members comprised a compounded proportion of MEDWorks FY07 on-going population, 31\%, whereas DD on-going members were only 14\% of the FY07 other Medicaid disabled on-going population.  On the other hand, MEDWorks MISA and PD populations were also less likely than their other Medicaid disabled counterparts to discontinue Medicaid disability, but only marginally so, and thus formed a disproportionate share of those who did discontinue from MEDWorks.  (Table A7)
9.  A lower death rate for MEDWorks members as compared to their non-MEDWorks counterparts was consistent across all diagnosis groups, the widest difference being for the MISA population, where it was 70\% lower, and the next widest being the PD population, where it was 58\% lower.  (Table A7)
10.  Given that MEDWorks program as a whole is impacted by both the long-term trends in the Medicaid disability population as whole, as well as by having a different diagnostic mix, it is important to understand the different long-term trends in the separate diagnostic populations.  The largest proportion of the long-term net increase in the working-age Medicaid disability population through from FY95 through FY07 has come from either the PD population (10 of 13 years, including FY99 to FY07) or the MISA population (3 years, FY96 to FY98).  (Table A8)
11.  However, when we look more specifically at who is newly disabled and who drops off Medicaid disability (as the two components of net increase), we can see the differences between diagnostic groups are even greater: for new Medicaid disabled, the PD population growth has averaged 2.4 times the MISA population growth and 8.2 times the DD population growth, while for those who discontinued (dropped off, aged out, or died) the PD population were also much higher, averaging 3.0 times the MISA population loss and 14.4 times the DD population loss.  Thus there is a clear hierarchy in the amount of turnover, or churn, in the Medicaid working-age disability populations, from PD to MISA to DD.  (Table A8)
12.  Furthermore, while the number of new Medicaid disabled has declined for all three diagnostic groups in recent years (since FY04 for PD and MISA, since FY03 for DD), the number who are dropping off has continued to increase for the PD and MISA populations, but less so for the DD population, trending to a net decrease for the PD and MISA in FY08.  (Table A8)
13.  As the MEDWorks program has matured, therefore, there has been somewhat of a shift away from the ongoing Medicaid disabled population and toward an even higher turnover or churn: only 15.5\% of the FY03 MEDWorks population dropped off before the end of the year, but by FY07 this rate was up to 36.5\%.  (Table A9).
14.  Since most MEDWorks members (and especially the DD and MISA) who dropped off remained on Medicaid, the high turnover rate meant that by FY07 there were more Medicaid working-age disabled who were former MEDWorks members than current ones, by FY08 over half again as many.  (Tables A9, A48, A49)  As a consequence, by FY07 less than 32\% of MEDWorks members had been enrolled for as long as two years, but this was unevenly distributed by diagnosis, with only 25\% of MISA and 26\% of PD continuing two years, but 51\% of DD.  (Workbook B: First Month, 19-24 Months).
15.  Yet this turnover has nevertheless somewhat ameliorated the early over-representation of the DD population, which comprised 51\% of MEDWorks’ first year, at an annual penetration rate of almost 12\%, or 3.8 times higher than the MEDWorks MISA and 5.9 times higher than the MEDWorks PD.  By FY08, the MEDWorks DD annual penetration rate had fallen one-third to 34\% while the PD penetration rate had increased 75\% and the MISA penetration rate had increased 32\%.  The MEDWorks DD in FY08 remained substantially over-represented, however, their penetration rate 2.2 times higher than the MISA and 2.5 times higher than the PD.  (Table A30)
16.  Part of this churn appears to be related to spenddown status-- a significant minority of each diagnosis group was on spenddown before and/or after their MEDWorks enrollment, and these minorities are relatively larger for the MISA and secondarily the PD populations, where the turnover rate is highest.  MEDWorks members were also more likely to have SSI and 1619 before their MEDWorks enrollment.  (Table A48)

Medicaid Cost
17. The over-representation of the MEDWorks DD population is the major reason for the high cost structure of the MEDWorks population as a whole. In FY03 MEDWorks DD members averaged almost $43,000 in expenditures per member, or 2.6 times the cost of the average PD member and 3.1 times the cost of the average MISA member. (Table A10)

18. Accordingly, the churn dramatically affects the cost structure of MEDWorks members in the aggregate, because new MEDWorks members have been consistently less expensive than their on-going counterparts, even though the latter’s numbers have continued to decrease, comprising only 25% of the FY07 MEDWorks population. (Table A9)

19. In addition, for the MISA and PD populations, the MEDWorks members who were more likely to remain on MEDWorks were more expensive members in the first place. (Workbook B, Medical Trend)

20. In FY03 MEDWorks DD members realized 63% of total expenditures for MEDWorks members, but by FY07 this percentage had fallen to 56%, even though average annual DD costs per member had increased 9%. (Table A10)

21. Since the DD population is on average roughly twice as expensive as the MI and PD populations, their continuing prevalence in the MEDWorks population dramatically affects the cost structure of the program membership as a whole. They are not only more expensive on a PMPM basis, they are more expensive because they are more likely to be continuously enrolled, and therefore have on average more MEDWorks months and more Medicaid months within each year. As a consequence, over the first five years of the MEDWorks program, the 25% who were DD accounted for 59% of the total cost. (Tables A10, A12, A13, A20)

22. From FY03 through FY07, the top 10% most expensive of MEDWorks members were responsible for 51% of total MEDWorks cost, and 60% of these were DD, who alone accounted for 37% of total MEDWorks cost. On the other hand, the least expensive 40% of MEDWorks members were responsible for less than 3% of total MEDWorks cost, and only 18% of these were DD. (Table A20)

23. As skewed as this distribution is, it nevertheless understates the impact of DD costs in the MEDWorks population, because the majority of costs for the highest-cost members with MISA and PD disability diagnoses are in fact DD-related costs: 80% for the MISA members who fall into the top 10%, and 55% for the PD members who fall into the top 10%. In other words, even though their original primary diagnosis appears as MISA or PD, many in this most expensive population are in fact dually diagnosed, with the bulk of their cost being derived from their DD-related services. Even in the next less-costly tier, comprising 20% of the MEDWorks population with more than 35% of the total MEDWorks cost, a significant minority of MISA and PD diagnosed members have relatively high DD costs. Thus DD costs comprised almost 2/3 of all MEDWorks costs. (Tables A20, A21)

24. The convergence of these trends means that the MEDWorks program exhibits an exaggerated version of the two-tailed distribution of the Medicaid working-age population in general: dominated on the one hand by a large core of expensive continuing members, yet partially offset in the aggregate by an increasingly significant minority low-cost population with a much larger degree of turnover (Tables A5, A11) yet with the net effect of becoming increasingly populated by a stable population (Table A9)

25. Accordingly, MEDWorks members were in general more likely than other working-age disabled to be institutionalized, having a 17.8% chance of being institutionalized at least one day during the year, a rate 85% higher. (Tables A31, A45)

26. Thus we see that, for a small (9%) high-cost population, there is an association between MEDWorks membership and ICF/MR services, which account for 49% of all costs for MEDWorks members. In addition, the next-largest service category for MEDWorks members was Waiver Services, utilized by only 18% of the MEDWorks population but accounting for 26% of costs. Interestingly, when MEDWorks members were off MEDWorks, but still on Medicaid, average costs were lower, but by far the greatest difference was in ICF/MR costs. (Table A22)

27. Likewise, the gradual reduction of the MEDWorks DD-diagnosed population accounts for a large part of the 13% reduction of the average MEDWorks PMPM over the period. Most of the MEDWorks cost decrease was for waiver services between FY05 and FY06, and secondarily for ICF/MR services and pharmacy (Medicare Part D) between FY06 and FY07. Yet this potential cost improvement from a reduced DD population was substantially offset by a 5%
increase in the average PMPM for MEDWorks DD members who remained over the same period, thus yielding the appearance that less expensive DD members were more likely to transition off MEDWorks. Furthermore, MEDWorks DD members were substantially more expensive than their non-MEDWorks counterparts, who in fact experienced a 16% reduced PMPM over the same period, so that in FY03 MEDWorks DD were 55% more expensive than their non-MEDWorks counterparts, but by FY07 were 94% more expensive. (Tables A10, A13, A23, A45)

28. Yet the trend in the institutionalization of the MEDWorks population as a whole is dramatically toward less cost. In FY03 26% of the MEDWorks population were institutionalized for over 90% of the time, 3.7 times the rate for other working-age disabled, for over 56% of the total MEDWorks member cost. By FY07 only 6% of the MEDWorks population was institutionalized over 90% of the time, only a 28% higher rate than other working-age disabled, for less than 20% of the total MEDWorks-related cost. Their average cost per member remained however 23% higher than their non-MEDWorks counterparts. (Table A32).

29. Although DD institutionalization was substantially reduced in the disabled working-age population in general, the relative reduction in the non-MEDWorks population was greater (29% between FY03 and FY08) than it was for the MEDWorks DD institutionalized population (24%). (Table A45).

30. On the other hand, MEDWorks MISA and PD members as a whole, while also more expensive than their non-MEDWorks MISA and PD counterparts, experienced more reduced cost over the period. MEDWorks MISA as a group were down 22%-- even though MEDWorks mental health expenditures were up 16% on a per-member basis-- as compared to a 14% drop for the non-MEDWorks MISA, the former moving from being 12% more expensive to being only 2% more expensive. MEDWorks PD likewise decreased 8%, as compared to a 6% drop for the non-MEDWorks PD, moving from 28% more expensive to 25% more expensive. (Tables A10, A13, A23)

31. Furthermore, those MISA and PD members who did not work tended to have increased cost, so that when they are separated out, the reduced cost structure for those who did work is even greater. MEDWorks MISA workers of FY07 on average cost 31% less than those in FY03, while MEDWorks MISA non-workers on average cost 82% more. For the PD, MEDWorkers in FY07 cost 20% less than those in FY03, while non-workers cost 63% more. (Table A38)

**Program Changes Affecting Cost**

32. However, most of the reduced cost for MEDWorks members was due to reduced Medicaid coverage of waiver and pharmacy services. Between FY05 and FY06, waiver services for MEDWorks members, which had in FY04 accounted for 31% of all MEDWorks costs, fell 51%; and between FY05 and FY07 pharmacy costs for MEDWorks members, which in FY05 had reached almost 14% of MEDWorks costs, fell 64%, due to migration of dual (Medicare) pharmacy costs to Medicare Part D (the clawback not being allocated on a per-member level). By these two changes alone, more than 18% of MEDWorks costs were reduced between FY04 and FY07. (Table A23)

33. The waiver reduction was primarily enrollment based: at the peak in FY04 more than 23% of all MEDWorks members and 27% of all MEDWorks workers were on waivers (workers being 6.8 times more likely to be on waivers than non-workers), by FY07 this was down to less than 14% of MEDWorks members and 15% of MEDWorks workers. 68% of this drop came in FY06 alone. DD workers, the most likely to be on waivers in the first place, were affected the most in numbers, dropping from over 48% of MEDWorks DD workers in FY05 to over 38% in FY06. The MEDWorks PD working population, however, was more impacted proportionately, falling from 17% on waivers in FY03 to less than 7% in FY07, with 53% of this drop coming in FY06. MEDWorks PD workers were however still 4 times as likely as non-workers to be on waivers. MISA workers also were impacted, decreasing from over 9% of workers on waivers in FY03 to 4.5% in FY07, 52% of the drop coming in FY06. (Tables A39, A45)

34. While waiver members are generally more expensive than non-waiver members, this shifting of membership from waiver to non-waiver affected the average costs rates for the remaining MEDWorks waiver groups the most, apparently because lower-cost waiver members were more likely to shift off MEDWorks. In FY03 the average PMPM for MEDWorks waiver members was 34% higher than non-waiver MEDWorks members, by FY07 it had increased
34%, while the non-waiver average PMPM had fallen 23%, so that the former was 2.4 times higher the latter. This rate shift was most dramatic for MEDWorks MISA workers, where the waiver average PMPM was 2.0 times higher than that of MISA non-waiver workers in FY03, but increased 50% from FY03 to FY07, while the non-waiver average decreased 34%, so that the waiver average PMPM in FY07 was 6.8 times higher. MEDWorks DD workers also exhibited the same trend, yet waiver workers were in FY03 30% less expensive than non-waiver DD workers as a group, presumably because of the high rate of institutionalization among non-waiver DD workers. By FY07, however, the average MEDWorks worker's PMPM on a waiver had increased 41%, while the comparable non-waiver PMPM had decreased 17%, so that the former were now on average 18% more expensive. (Tables A39, A40, A45)

35. The pharmacy change affected MISA-diagnosed and PD-diagnosed members the most, with respectively 26% and 19% of their total Medicaid cost coming from pharmacy, while DD-diagnosed had only 5% of their total cost coming from pharmacy. (Tables A24, A25)

36. For this reason, and since complementary participation in Federal disability programs is a consideration for evaluating member incentives, it is important to look at the Medicaid dual and non-dual populations separately (Tables A14 through A17). Here again there are substantial differences between the DD population on the one hand, and the MISA and PD populations on the other hand.

37. In the first place, from the beginning duals have been more represented in the MEDWorks population, 65% in FY03 as opposed to 55% in the other working-age disabled. This disparity was due mainly to the over-representation of the MEDWorks DD population, which was 86% dual in FY03, as opposed to 62% dual for the other Medicaid working-age disabled—but partially due as well to the MEDWorks MISA population, which was 59% dual, as opposed to 51% dual in the other Medicaid working-age disabled. The PD populations were in fact opposite, with the MEDWorks PD being only 47% dual in FY03 and the other Medicaid PD being 51%. (Table A14)

38. Most of these populations participated in SSDI, which roughly follows the same proportions, being especially prevalent in the DD population (82% for the majority of their MEDWorks enrollment), and secondarily by the MISA (56%), but nevertheless a significant factor for the PD (48%). It should be noted that there is also an across the board tendency for continuing Medicaid population (those remaining on Medicaid disability after going off MEDWorks) to be more likely to be on SSDI. (Table A47)

39. While duals as a whole have become increasingly represented in the other Medicaid working-age disabled population, duals increasing in number 27% from FY03 to FY07 while non-duals increased only 5%, the opposite is true in the MEDWorks population, where the non-duals have increased in number by 59% in the same period, while the duals increased only 17% (Tables A14, A15, and A19).

40. Yet this trend breaks down very differently by diagnosis. To begin with, in the first year, the MEDWorks DD population was 86% dual, while the MISA population was only 59% dual and the PD population was only 47% dual. (Table A14) For the MEDWorks DD population, non-duals increased in number 32% while duals decreased 12%; for the MISA population, both duals and non-duals increased 48%; and for the PD population non-duals increased 72% while duals increased 46%.

41. These differences have major implications for the cost structure of the MEDWorks program. By far the most expensive are the over-represented MEDWorks DD duals, who by FY07 had decreased in numbers, yet averaged $51,000 each per year, or 3.9 times more expensive than their non-dual MEDWorks counterparts and 3.3 times as expensive as the non-MEDWorks DD duals, increasing in cost 15% from FY03 to FY07, in spite of Medicare Part D. The extra average cost for this group, multiplied by their over-representation, meant that this group cost 6.1 times more than they would have if they had been equally represented and equal average cost. In fact, if not for this single group, MEDWorks members would have on the whole cost less than their non-MEDWorks counterparts. (Tables A18, A19)

42. The next most expensive MEDWorks group were the PD, where both duals and non-duals had increased their representation in MEDWorks, but especially the duals, who at $15,700 each were 2.2 times more expensive than their non-MEDWorks counterparts, even though they had decreased in average cost 33% between FY03 and FY07. The net cost impact of PD duals was mitigated, however, because they were substantially under-represented in the MEDWorks
population. MEDWorks PD non-duals, on the other hand, substantially over-represented in the MEDWorks population, in FY07 cost on average 18% less than their other disabled counterparts, even though they had increased in cost 57.1% between FY03 and FY07 and thus significantly contributed to buoying the average MEDWorks cost rate up. (Tables A18, A19)

43. The least expensive MEDWorks population were the MISA, where the duals were also more expensive than the other disabled MISA duals, 81% more expensive, yet were so less represented in the MEDWorks population that as a group they cost less. The MEDWorks MISA non-duals, on the other hand, in FY07 cost on average only 57% as much as their non-MEDWorks counterparts. (Tables A18, A19)

**Employment**

44. Over the first five years of the MEDWorks program, from FY03 through FY07, MEDWorks members on average experienced large gains in employment, realizing a net 87% increase in average annual earnings, while non-MEDWorks disabled workers averaged a 3.5% loss in earnings. This improvement was most dramatic for the PD population, whose income improved 84% over the five years, while the average income of non-MEDWorks PD workers fell 17% over the same period. Likewise, MEDWorks MISA average income increased 54% over the five years, while average income for their non-MEDWorks counterparts fell 10%. Even the MEDWorks DD population experienced an increase in income greater than their non-MEDWorks counterparts, increasing 80% over the five years, but only part of this increase was attributable to their MEDWorks status, because their counterparts also increased 35% over the same period. (Table A29)

45. The majority of Medicaid working-age disabled having reported earnings were not enrolled in MEDWorks, the peak penetration rate of 43.3% MEDWorks enrollment being reached in FY05. In addition, many of those with MEDWorks enrollment (38% in FY07) spend a part of each year on Medicaid working, but not on MEDWorks. (Table A26)

46. Most of the earnings improvement was due to increased hours worked, although average earned per hour also substantially improved. Over the five years, MEDWorks PD improved their hours 48% and their average rate 24%, MEDWorks DD improved their hours 47% and their rate 23%, and MEDWorks MISA improved their hours 33% and their rate 16%. All three diagnosis groups also improved in the percentage of MEDWorks members who worked, with the greatest improvement being in the PD and MISA populations, respectively. (Tables A26, A27, A28)

47. MEDWorks workers of all three diagnosis groups showed substantial employment improvement in both hours and hourly rate, relative to their non-MEDWorks Medicaid working-age disabled counterparts, the former improving 87% over the five years, while the latter lost 4%. About 72% of this relative improvement came from increased hours worked, where improvement was strong in all diagnosis groups (33% to 48% over five years), with relative improvement highest for the PD and next-highest for the MISA population. Although the DD population also had large improvement in the number of hours worked, this was also true for the non-MEDWorks DD population, so that the MEDWorks DD relative improvement in hours worked was somewhat lower, compared to the other MEDWorks diagnoses. There were also substantial gains in the average hourly rate across the board, although of secondary magnitude, and since there were also small hourly rate gains for non-MEDWorks working age disabled, the relative MEDWorks gains were even smaller. This was especially true for the MISA population, the group for which the MEDWorks average hourly rate improved the least, and for which the non-MEDWorks hourly wage rate improved the most. (Tables A27, A28, A29)

48. Those MEDWorks members who did not work at all were on average enrolled in MEDWorks only 3 months out of the year, although this was somewhat higher for the DD population. (Table A38)

49. Much of the employment gain is masked in the aggregate, because those who were enrolled in MEDWorks for relatively shorter periods of time tended to work more and earn more, and thus reduced the overall rate when they dropped out; yet those who remained in the program longer as a group had begun by working fewer hours and earning less, but over time showed relatively more improvement. This was true for all diagnoses, but more pronounced for the PD and MISA. (Workbook B: Hours Trend, Earnings Trend)
50. Over the first five years of the MEDWorks program, 85% of all earnings by MEDWorks workers between FY03 and FY07 came from wages and salaries, but 20% of all MEDWorks workers had earnings from sheltered workshops, for almost 8% of all MEDWorks-related earnings. The average wage and salary rate was $8.12 per hour; the average sheltered workshop rate was only $3.12 per hour. 9% of MEDWorks members had some earnings from self-employment, for 6% of all MEDWorks-related earnings. (Table A32)

51. Following the population shifts described above, in FY03 only 53% of MEDWorks members who worked had income from wages and salaries, working an average of 80 hours per month, while over 30% had earnings from sheltered workshops, working only 39 hours per month. By FY07 the number with wages and salaries had increased 57%, to almost 64% of all MEDWorks workers, their average hours per month had also increased 19%, and their average hourly rate had increased 17%, so that net MEDWorks income from wages and salaries had increased 2.9 times. Over the same five years 19% fewer had earnings from sheltered workshops and average hours was down slightly, and the average hourly rate increased only 3%, so that net earnings from sheltered workshops had fallen to from 13% of all MEDWorks earnings to only 5%. The number with self employment likewise increased, by 93%, or from less than 6% of all MEDWorks workers to over 8%, but self-employed average hours fell 31% and the average hourly rate improved only18%. (Table A36)

52. By diagnosis, between FY03 and FY07 only 56% of those MEDWorks members classified as DD had earnings from wages and salaries, for 72% of total MEDWorks DD earned income, and less than 2% had self-employment income, while 50% had sheltered workshop earnings. On the other hand, 80% of the MISA had earnings from wages and salaries, 9% had self-employment income, and only 5% had sheltered workshop earnings; and 65% of the MEDWorks PD had wages and salaries income, 11% had self-employment income, and 8% had sheltered workshop income. (Table A37)

53. For the MISA and PD populations, those who did not work tended to have increased costs, in spite of any possible waiver or Part D offsets, as described above. (Table A38)

54. When MEDWorks earnings for workers are evaluated by diagnosis and waiver status, all categories exhibited at least a 50% improvement in average earnings between FY03 and FY07. Although in aggregate the non-waiver populations improved 79% while the waiver population improved 65%, the MISA-diagnosed population ran counter to this trend, with MISA waiver workers improving 75%, with 61% of this improvement coming from 40% higher average hourly rate, while MISA non-waiver workers improved only 50%, with 69% of the improvement coming from a 31% improvement in average hours. The DD and PD groups, on the other hand, both had significantly more earnings improvement in their non-waiver sub-populations than in their waiver sub-populations, and like the non-waiver MISA workers, mainly from working more hours. For the DD waiver workers most of their improvement also came from increased hours, but for the PD waiver workers it was about fifty-fifty. (Tables A39, A40)

55. Looking at type of employment by diagnosis and waiver status, MEDWorks DD non-waiver workers were in FY03 69% more likely to be employed in sheltered workshops than their DD waiver counterparts, with the latter becoming by FY07 32% less likely to be in sheltered workshops. Although DD waiver workers’ average earnings improved substantially both in wages and salaries and in sheltered workshops, DD non-waiver workers had higher average wage and salary incomes that improved even more, but lower average sheltered workshop incomes that improved less. For those with PD and especially MISA diagnostists there were relatively fewer waiver workers, but they reported sheltered workshop employment only a little less frequently than they reported wage and salary employment, yet showed great earnings improvement where they did have wage and salary earnings. Most MISA and PD overall improvement in earnings was of course due to the large non-waiver percentage with wage and salary income, which improved substantially between FY03 and FY07, although the relative small MISA and PD non-waiver sheltered workshop minorities also showed substantial improvement there as well (Tables A42, A43)

General

56. MEDWorks members were almost twice as likely as other working-age disabled to have third-party liability (primarily other insurance), although the probability of having other insurance diminished substantially for both groups between FY03 and FY07, falling from one out of eight
to one out of eleven for the MEDWorks population (a 30% decline), and from one out of 16 to one out of 20 for the others. (Table A44)

57. There is some indication that barriers to employment are a greater cause for losing MEDWork status than deteriorating health. For those MEDWorks members who had Medicaid both before and after their MEDWorks enrollment, their costs tended to be lower afterwards (DD 25% and MISA 12%), or only slightly higher (PD 4%), while their earnings were relatively lower, down 31% for the PD, 17% for the MISA, and 8% for the DD. (Table A50)

58. Because of all these trends and changes, coming to particular conclusions relative to incentives and participation in companion Federal programs is problematic. It can be said that there is considerable shifting of status, and that participation in Federal programs is one factor that needs to be considered along with health condition, employment barriers and supports, and other program changes.

Remaining Questions
Although much has been learned about both the MEDWorks population and their non-MEDWorks counterparts, including demonstrating the value of supporting employment, much of this general review has served to point the way toward a sharper framing of the questions, in that evaluation needs to be even more sensitive to the variability across the disability population.

Why are so many Medicaid working age disabled workers not enrolled in MEDWorks? (review disqualifications)

Since diagnosis is so important to understanding outcomes…
Should progress be evaluated on the basis of treated diagnoses, as opposed to MRT diagnoses? (Yes, at a high-level)
Should progress be evaluated on the basis of sub-classifications (severity and/or chronic conditions)? (Yes, at a detail-level)

While some of the factors have been identified above, given the continuing high rate of MEDWorks discontinuance and the observed employment benefits, there is a need to focus on those who discontinue, evaluate the relative weight of those factors, and consider outcomes more closely.
Likewise, all evaluation should separate short-term and long-term populations.

While this evaluation has measured the amount of employment benefits certain groups have achieved in the aggregate, another approach would be to identify those who have had employment success and those who have not, and identify the differences between them.

How is this success or the lack of success related to employment supports?

Similarly, this evaluation has attempted to measure Medicaid cost differences of groups in the aggregate, with conclusions difficult to interpret because of program changes that have impacted or shifted costs. Another approach would be to compare populations where costs have improved, remained constant, or worsened.

How is this improvement or the lack of improvement related to employment?

For each of these questions above, what difference does participation in what federal programs make? This evaluation has identified great variability in Federal participation and indicated some relationships, but has had difficulty accounting for Federal participation in light of the dimensions of analysis outlined above. For example, to what extent is the observed extra participation of SSI and 1619, in the “before” population due to their prevalence in the continuing population as opposed to the new Medicaid population, and to what extent is it due to the loss of those benefits by the continuing population, or to factors of health or employment barriers?