Interim Report on the Demonstration to Maintain Independence and Employment

Executive Summary

April 2009

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Policy Research, Inc.

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EXECUTIVE SUMMARY

Many working adults with physical and mental impairments do not have adequate access to the health and employment services that could prevent their impairment from becoming a disability. With better access to such services, these individuals may be able to stay employed, maintain or improve their health, and avoid becoming dependent on federal disability benefits. To help American workers with potentially disabling conditions to achieve these goals, Congress authorized the Demonstration to Maintain Independence and Employment (DMIE) under the Ticket to Work and Work Incentives Improvement Act of 1999. The DMIE program provides funds to states to develop, implement, and evaluate interventions for working adults with potentially disabling conditions, such as diabetes, HIV, or mental illness.

This report is an interim assessment of the national DMIE evaluation. It integrates quantitative and qualitative data assembled from multiple sources, including information provided by the state evaluation teams, and presents a summary of the enrollment and implementation experiences of the state DMIE projects through December 2008. The next report, tentatively scheduled for completion in the spring of 2010, will include the results of an analysis of whether the DMIE program improved outcomes for individuals participating in the states' programs, a comprehensive evaluation of the implementation of the DMIE, and a summary of the states' phase-down activities.

DMIE OBJECTIVES

The DMIE initiative is important because it embodies three key Congressional objectives. First, it encourages states to provide health care coverage and employment related services to workers with physical and mental impairments *before* they become so disabled that they can no longer work. The DMIE aims to make accessible the services and supports that will prevent or delay an impairment from becoming the kind of disability that makes work impossible and leads to enrollment in federal income support programs. If individuals with potentially disabling conditions can keep working, they can maintain their independence and productivity.

Second, the DMIE enhances access to both medical care *and* employment supports. The programs implemented by participating states recognize that workers who have

potentially disabling conditions need adequate access to both health services that keep them well and job supports that keep them employed. Specifically, states can provide (1) either health coverage equivalent to their standard Medicaid benefit package or "wrap-around" coverage, which supplements employer-sponsored or public insurance and (2) employment supports, such as case management or job coaching.

Third, the DMIE is a *demonstration* program. Congress delayed full scale implementation pending the results of an evaluation to assess the program's impact. The Centers for Medicare & Medicaid Services (CMS), which was given the responsibility for managing the DMIE initiative, developed a multi-faceted approach to the evaluation that will provide strong evidence on the extent to which the program achieves its goals. Specifically, CMS required most states with a DMIE project to conduct independent, state-specific evaluations using randomized trials (generally considered to be the most rigorous evaluation design) and also contracted with Mathematica Policy Research (MPR) to conduct a national evaluation of the DMIE.

OVERVIEW OF STATE DMIE PROGRAMS

State DMIE interventions have two broad components: health-related services and employment assistance. States may provide health coverage that is equivalent to their standard Medicaid benefit package or "wrap-around" coverage for additional services, such as dental or vision care, that are not fully covered under existing public or employer-sponsored plans. States also may offer employment assistance, including case management, vocational rehabilitation services, or job coaching, to encourage people to continue working.

In the 2006 solicitation, CMS approved demonstrations in Kansas, Minnesota, Texas, and Hawaii. In each program, qualifying participants were between 18 and 64 years old at the start of the project, working at least 40 hours per month, and not receiving or applying for federal disability benefits at the time of DMIE enrollment. The state projects focus on different target populations of working adults, which began their enrollment at different times, and enrolled varied numbers of participants:

- Kansas is focusing on workers who are in the state's high-risk insurance pool, which serves people with pre-existing medical conditions; the state program started enrollment in April 2006 and enrolled 500 participants.

- Minnesota is focusing on workers with mental illness participating in public insurance programs in selected counties; the state program began enrollment in January 2007 and enrolled 1,793 participants.

- Texas is focusing workers with severe mental illness or behavioral health conditions occurring with a physical impairment, and who were members of the Harris County Hospital District, a safety net provider in the Houston area. The state program began enrollment in April 2007 and enrolled 1,616 participants.

- Hawaii is focusing on workers with diabetes. The state program started enrollment in April 2008 and enrolled 190 participants.

In addition, an earlier DMIE program, which was approved in 2002 under a prior solicitation, was implemented in the District of Columbia and focused on workers with HIV/AIDS. Unlike the other state programs, the District's program did not use random assignment and ended on December 31, 2008. The District began enrollment in September 2002, with a maximum of 420 individuals enrolled at any one time.

Recruitment of DMIE program participants in the four states ended on September 30, 2008. This enrollment cutoff date ensured that all participants would be enrolled in the DMIE programs for at least one year because the authorizing legislation specified that no DMIE program services could be provided after September 30, 2009. The state evaluations will be completed within the following year; the national evaluation will conclude in May 2011.

OVERVIEW OF DMIE PARTICIPANTS

Because the state DMIE programs differ in their target populations, DMIE participants as a group vary widely with respect to their demographic, health, and employment characteristics. For example, the DMIE participants in Kansas have a variety of diagnostic conditions, reflecting the diverse medical conditions of individuals in the state's high-risk insurance pool; in Minnesota and Texas, DMIE participants have mental illnesses or physical conditions occurring with mental illness; in Hawaii, all DMIE participants have diabetes; and in the District of Columbia, participants have HIV/AIDS. Overall, the mix of potentially disabling conditions of the entire group of DMIE participants reflects the wide differences in the states' target populations and recruitment strategies.

From a national perspective, the group of DMIE participants varies with respect to age, race, education, marital status, and self-reported physical and mental health. The majority of participants in the DMIE programs are between 35 and 54 years old, although there is a greater concentration of older workers (above age 55) in Kansas and younger workers (under age 35) in Minnesota. The large majority of participants in the Kansas and Minnesota programs were white, while substantial numbers of participants in the Texas and Hawaii programs were African American or Asian, respectively. The educational attainment of DMIE participants is generally high across all programs, although Kansas and Hawaii have a higher share of college graduates than Minnesota and Texas. Approximately half of DMIE participants in the Kansas and Hawaii programs were married at the time of enrollment, while most participants in the Minnesota and Texas programs were not. Although a wide range of physical and mental health status was reported, all four states had a substantial number of persons who reported having fair or poor health status.

DMIE participants were employed in a wide range of industries when they enrolled, working as lab technicians, teachers, nurses, or teacher or nursing aides, and in various trades, transportation settings, utility companies, and the hospitality industry. Overall, a majority of DMIE participants were working at least half time in each program; many were working full time. They also had a wide range of personal earnings in the year before their enrollment. In Texas and Minnesota, a majority of participants had earnings less than $20,000; in Hawaii most had earnings greater than $30,000. In Kansas, many participants had self-employment income.

INTERIM REPORT FINDINGS

Overall, states were successful in recruiting individuals to their DMIE programs. Total baseline enrollment in the DMIE as of September 2008 was 4,099 participants across the four states. Three of the four states that used random assignment surpassed their enrollment targets, signaling that the assessment of the impact of the national DMIE (to be covered in a future report) will be based on strong evidence. Analysis of the quantitative and qualitative data collected to date leads to the following conclusions:

The DMIE program can be implemented in a wide range of settings to serve different target populations. One important feature of the DMIE initiative is the flexibility for states to design and customize benefits to meet the needs of different target populations with a variety of potentially disabling conditions. For example, Minnesota targeted its program and services for persons with mental illness and required that each treatment group member conduct an initial assessment with a wellness navigator. Kansas offered enhanced benefits and premium subsidies to address unmet needs of enrollees in the state's high-risk insurance pool. Texas offered health care services, employment assistance, and case management to uninsured members of the Harris County Hospital District. Hawaii provided life coaching and pharmacist counseling as part of its intervention to help with the management of diabetes. The diversity in state programs strengthens the evaluation, because we will be able to evaluate the impact of program interventions across different settings and for different groups.

Focusing the DMIE program on eligible workers already covered under an existing public health program provided an effective means for identifying individuals likely to benefit from enhanced health services and employment supports. One of the initial challenges for states was identifying an appropriate target population of workers with potentially disabling conditions who could be contacted with reasonable efficiency. States that focused on workers already enrolled in existing health programs (such as a high-risk insurance pool or a county-based health insurance program) were able to obtain the administrative data and contact information that supported efficient outreach. Furthermore, the additional services and supports provided through the DMIE could strategically extend benefits already available in the existing program and use existing provider networks. The program that relied on outreach to workers through multiple employers had more difficulty with identifying and recruiting candidates.

Recruitment in each DMIE state required more than 12 months to complete because of various challenges that hindered rapid enrollment. All four states using random assignment for their evaluation had to modify and extend recruitment procedures in ways not anticipated at the start of the project. Some key challenges that hindered enrollment included: (1) developing the operational procedures for identifying individuals potentially interested in participating in the project, (2) poor contact information for potential participants, (3) lack of response to direct mail outreach efforts, (4) obtaining approval from institutional review boards (IRBs) for evaluation protocols and participant consent forms, and (5) screening applicants and verifying employment information. Each step required more time and effort than originally anticipated. All four states changed or adapted their initial recruitment strategy to increase the enrollment of DMIE participants.

Random assignment worked well in all four DMIE states to generate a similar distribution of baseline characteristics between the treatment group and control group. This key finding reflects the successful application of methods to generate two groups with similar characteristics and is a promising start for conducting a rigorous national evaluation of program impacts on health status, employment, and use of federal disability benefits.

NEXT STEPS

In the spring of 2010, MPR will prepare and submit to CMS a report with initial estimates of DMIE program impacts on health, earnings, and use of federal disability benefits. The report will examine whether the DMIE intervention led to an improvement in participant outcomes in the four states with random assignment. Specifically, we will compare outcomes for the groups of individuals who were offered an expanded set of services through the DMIE project with groups of similar individuals who had access to the services normally available. We also will include a detailed assessment of phase-down activities based on a final site visit to be conducted with each state in the later summer or fall of 2009.

MPR will continue to integrate and analyze all data submitted by the states through 2010 with information on participant earnings, employment, and enrollment in federal disability programs gathered from federal databases. A final report on the national evaluation of the DMIE will be submitted to CMS in spring of 2011.

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