The Expansion Dual Challenge

When Work Requirements Meet the Rarest Form of Medicare-Medicaid Coordination

For a few hundred thousand Americans who entered Medicaid through expansion before qualifying for Medicare disability, work requirements create unprecedented complexity

Maria is 48, lives with bipolar disorder and diabetes, and receives both Medicare (because of her disability determination three years ago) and Medicaid (because she originally qualified through expansion based on income). Medicare covers her psychiatric care and diabetes management. Medicaid covers her medications, transportation to appointments, and care coordination services.

Under OBBBA's work requirements beginning January 2027, Maria faces a unique puzzle. She's an "expansion dual" - someone who first qualified for Medicaid through income-based expansion pathways before later qualifying for Medicare through disability. Her disability qualified her for Medicare. But does that same disability automatically exempt her from Medicaid work requirements? Or must she document her exemption separately despite the federal disability determination?

The answer depends on which state she lives in, how that state interprets exemption categories, and whether the disability determination made for Medicare purposes transfers to current Medicaid verification systems.

If Maria loses Medicaid coverage because she cannot navigate exemption documentation requirements, she keeps Medicare but loses the wrap-around services that make her Medicare coverage usable. No care coordination. Limited prescription drug coverage. No non-emergency medical transportation. Her Medicare card becomes effectively worthless without the Medicaid supports that enable her to access care.

Understanding the Dual Eligible Landscape

Most Duals Are Automatically Exempt

Before examining expansion duals, the critical context: most dual eligibles face no work requirement exposure whatsoever.

Of 13.7 million dual eligibles nationally, the vast majority are automatically exempt:

- Approximately 5.2 million (38 percent) receive Supplemental Security Income for disability or blindness, providing automatic exemption from work requirements
- Most others are over age 60, receiving automatic age-based exemption
- Traditional duals who entered Medicaid through disability or age pathways rather than expansion face no work requirements

The dual eligible population affected by work requirements consists almost entirely of "expansion duals" - people who originally qualified for Medicaid through expansion based solely on income, then later qualified for Medicare through disability determination. This pathway exists only in states that adopted Medicaid expansion and only for people who became disabled after expansion enrollment.

National estimates suggest expansion duals number in the few hundred thousand, not millions. They represent perhaps 2-4 percent of the total dual eligible population. But for this subset, the coordination challenges are profound.

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The Expansion Dual Pathway

Someone under 65 without traditional Medicaid eligibility (not disabled enough for SSI, no dependent children) qualifies for expansion Medicaid based solely on income under 138 percent of federal poverty level beginning in 2014 or when their state adopted expansion. They maintain coverage for several years. Then they develop or their pre-existing condition worsens to the point of qualifying for Social Security Disability Insurance. After SSDI's five-month waiting period and Medicare's 24-month waiting period, they qualify for Medicare based on disability.

Now they're dual eligible - Medicare from disability, Medicaid continuing from expansion pathway. This matters immensely for work requirements. They entered Medicaid through expansion where work requirements apply, not through SSI or disability pathways with built-in exemptions. Their current disability may warrant exemption, but they must document it rather than receiving automatic protection.

Demographics of Expansion Duals

The expansion dual population looks fundamentally different from traditional duals. Traditional duals average age 70 or above, typically entered Medicare at 65, face relatively few years navigating the systems. Expansion duals entering Medicare through disability average in their 40s and 50s. They face decades of potential enrollment volatility.

Their disabilities reflect different patterns. Behavioral health conditions affect an estimated 35 percent, substance use disorders 22 percent, chronic pain 18 percent, progressive neurological or musculoskeletal conditions 15 percent. These working-age disabilities create episodic functional capacity, fluctuating ability to maintain employment, and complex medication management needs.

Life circumstances differ dramatically. Expansion duals remain in economically active life phases despite disability. They have school-age children requiring active caregiving. They aspire to employment when health permits. They face housing instability, competing demands that disability doesn't eliminate. Work requirements intersect with life complexity traditional duals largely escaped before Medicare eligibility.

Geographic Concentration

Expansion duals exist only in states that adopted Medicaid expansion. Non-expansion states have no expansion dual population because no one could enter through that pathway. Among expansion states, concentration matters.

California likely has the largest expansion dual population, estimated 40,000-70,000. New York perhaps 35,000-60,000. Pennsylvania, Ohio, Illinois, Washington, and Michigan each likely have 15,000-35,000. These seven states probably contain 60-70 percent of all expansion duals nationally.

Policy decisions in these states disproportionately affect the national expansion dual population. California choosing automatic Medicare disability exemptions helps perhaps 40,000-70,000 people. Texas, which delayed expansion until 2023, has minimal expansion dual population - people haven't had time to enter expansion, develop disability qualifying for Medicare, and complete the 29-month SSDI/Medicare waiting process.

D-SNP Integration Types and Differential Impact

Dual Eligible Special Needs Plans serve dual eligibles through varying integration models, with dramatically different implications for work requirement exposure.

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Most D-SNPs Serve Traditional Duals

The critical fact: most D-SNP enrollment consists of traditional duals (SSI recipients, over-60 populations) automatically exempt from work requirements. The typical D-SNP has minimal to no expansion dual enrollment. Work requirements create operational challenges for only a subset of D-SNPs serving younger disabled populations in expansion states.

Coordination-Only D-SNPs (60.6 percent of plans, approximately 3.4 million enrollees)

These plans coordinate Medicare and Medicaid benefits but different organizations hold the contracts. Work requirements affecting the small expansion dual subset create coordination challenges but not existential contract crises. Plans can separate Medicare operations from Medicaid volatility relatively easily since contracts were always separate.

Highly Integrated D-SNPs - HIDE (29.8 percent of plans, approximately 1.7 million enrollees)

Same parent organization holds Medicare and Medicaid contracts with tighter operational integration. For the minority of HIDE SNPs serving significant expansion dual proportions, work requirements create more disruption when Medicaid terminates because care models assume both revenue streams. But most HIDE SNPs serve traditional duals with minimal exposure.

Fully Integrated D-SNPs - FIDE (8 percent of plans, approximately 450,000 enrollees)

FIDE SNPs must cover comprehensive long-term services and supports, behavioral health, and home health with exclusively aligned enrollment - members cannot enroll in the FIDE SNP without the aligned Medicaid plan. Work requirement-driven Medicaid termination forces disenrollment from the FIDE SNP entirely.

Only 12 states offer FIDE SNPs with limited geographic availability. Most FIDE SNP enrollment consists of traditional duals. But FIDE SNPs serving expansion duals face genuine existential threat. Their entire business model requires Medicaid enrollment continuity that work requirements systematically disrupt for this subset.

State Implementation Choices Determining Outcomes

States control critical implementation decisions determining expansion dual outcomes. The choices matter enormously for the few hundred thousand affected individuals despite limited numbers.

Automatic Medicare Disability Exemption Versus Separate Determination

First choice: do Medicare disability beneficiaries receive automatic Medicaid work requirement exemptions? This decision determines whether expansion duals face minimal documentation burden or substantial verification requirements.

Someone qualified for Medicare based on disability already underwent rigorous Social Security Administration disability determination. That process required substantial medical evidence, functional capacity evaluation, and adjudication. The disability determination stands unless medical improvement occurs, triggering continuing disability reviews.

States choosing automatic exemption policy: if you qualified for Medicare through disability, you automatically receive Medicaid work requirement exemption. No separate application. No additional medical documentation. The existing federal disability determination suffices. This policy reduces burden exponentially for expansion duals.

States requiring separate determination: Medicare disability doesn't automatically exempt from Medicaid work requirements. The individual must apply for exemption, submit current medical evidence, undergo

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state evaluation of functional capacity, and receive exemption approval. This creates redundant evaluation imposing substantial burden despite existing federal disability determination.

The rationale for separate determination: disability sufficient for Medicare (inability to engage in substantial gainful activity) differs from disability precluding 80 hours monthly work. Someone might be too disabled for full-time employment but capable of part-time work meeting requirements. This distinction has theoretical validity but practical application is murky.

California, New York, and Washington will likely implement automatic exemptions based on Medicare disability. Their Medicaid programs emphasize access and beneficiary protection. They will respect prior federal adjudications, minimize redundant evaluations, reduce documentation burden. Implementation will be smoother for their expansion dual populations.

Texas, Florida, and Georgia will likely require stringent separate determinations despite Medicare disability. Their Medicaid history reflects priorities emphasizing program integrity over administrative efficiency. They will verify everything, require current medical evidence regardless of Medicare determinations. Documentation burden will be substantial for their smaller expansion dual populations.

Ohio, Pennsylvania, and Michigan represent uncertain territory where decisions remain unclear. Their choices will reveal whether political dynamics or administrative capacity drives implementation.

Medicare Savings Program Enrollees

Second choice: are Medicare Savings Program enrollees subject to work requirements? Partial benefit duals (approximately 4.7 million nationally, mostly traditional duals over 60) receive help paying Medicare premiums through MSPs but have limited or no other Medicaid benefits.

Most MSP enrollees are traditional duals automatically exempt through age or SSI. But small numbers entered through expansion-like pathways. Do states apply work requirements to premium assistance? Arguments exist both directions.

Some states will exempt MSP enrollees entirely, treating premium assistance as fundamentally different from comprehensive Medicaid. Other states will apply work requirements, reasoning that any Medicaid benefit requires reciprocal obligation. This choice primarily affects traditional MSP populations, not expansion duals, but creates additional complexity in systems already strained.

Documentation Standards and Presumptive Eligibility

Third choice: documentation standards for exemptions. States accepting Medicare enrollment files showing disability-based eligibility as sufficient proof create minimal burden. States requiring current medical evidence from treating physicians impose substantial burden. States allowing D-SNP care coordinators to document medical frailty based on clinical knowledge streamline processes. States requiring formal evaluations by state-contracted assessors create bottlenecks.

Fourth choice: presumptive eligibility during processing. An expansion dual applies for exemption while Medicare disability determination is verified. Does Medicaid continue during verification or terminate pending approval? States choosing presumptive eligibility prevent coverage gaps. States requiring approval before exemption activates create gaps even for ultimately successful applications.

These choices vary by orders of magnitude in their burden on the expansion dual population.

D-SNP Operational Responses

D-SNPs serving significant expansion dual enrollment must prepare for complexity affecting this subset. Most D-SNPs serve traditional duals with minimal exposure and require limited operational changes. But plans serving younger disabled populations in expansion states face genuine challenges.

Risk Stratification for Expansion Duals

Plans must identify which enrolled duals entered through expansion pathways versus traditional disability/age pathways. This requires data integration D-SNPs may not currently have. Medicare eligibility files show disability-based qualification but not whether someone receives SSI. Medicaid eligibility files show entry pathway but not current exemption status.

Expansion duals need intensive support: exemption documentation assistance, coordination with treating providers, navigation of state verification systems, presumptive eligibility advocacy during processing, and gap coverage strategies if exemptions fail.

Traditional duals need standard care coordination assuming automatic exemptions apply and minimal work requirement exposure.

The segmentation enables resource targeting. A D-SNP with 25,000 members might have 1,000-2,000 expansion duals requiring intensive support and 23,000-24,000 traditional duals requiring minimal changes. Treating all duals identically wastes resources while under-serving those actually exposed.

Care Coordinator Training

Care coordinators serving expansion dual populations need training on exemption processes, disability documentation standards, state-specific verification requirements, provider attestation facilitation, and appeals navigation. This differs substantially from traditional care coordination focused on clinical needs and LTSS coordination.

Technology Integration

D-SNPs need systems tracking exemption status alongside clinical information, alert mechanisms for upcoming exemption renewals, documentation workflow tools for gathering medical evidence, integration with state exemption portals where they exist, and gap management capabilities for members losing coverage pending appeals.

These technology investments make sense for D-SNPs serving significant expansion dual proportions. For D-SNPs serving primarily traditional duals, the investment may not justify the limited exposure.

Financial Implications

Cost analysis must reflect the actual affected population. Early estimates assuming millions of duals face requirements dramatically overstated financial exposure.

For D-SNPs serving expansion dual populations: intensive support costs perhaps $500-1,000 per member per month additional for the subset requiring exemption documentation assistance. A D-SNP with 2,000 expansion duals might face $1-2 million monthly additional costs, or $12-24 million annually. Manageable but not trivial.

System-wide costs across all D-SNPs serving expansion duals nationally: perhaps $300-500 million annually, not the multi-billion dollar estimates implied when assuming all 13.7 million duals were exposed.

The costs are real, concentrated in specific plans serving specific populations in specific states. They're not distributed across all D-SNPs or all dual eligibles. The market concentration matters for investment decisions and risk management.

Quality Measurement Complications

HEDIS measures and Medicare Star Ratings assume stable enrollment. Expansion duals facing work verification-driven enrollment volatility fragment measurement periods. Someone enrolls, loses Medicaid

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during verification failure, reinstates after appeals, loses again at next cycle. Quality measures designed for stability cannot fairly evaluate outcomes in systematically unstable environment.

CMS faces choices: create separate quality reporting for D-SNPs serving high proportions of expansion duals, acknowledging different operating environments, or apply uniform standards potentially driving plans to avoid expansion duals to protect scores.

The perverse outcome: work requirements intended to promote responsibility could reduce quality measurement validity and create incentives for plans to avoid serving the most vulnerable dual eligible population.

Looking Forward

Work requirements begin January 2027, 14 months from now. D-SNPs serving expansion dual populations must identify affected members, stratify support needs, train care coordinators, build technology infrastructure, and negotiate state integration points.

Most D-SNPs serving traditional duals face minimal operational changes and can maintain existing approaches with minor monitoring for policy changes.

For the few hundred thousand expansion duals nationally, the stakes are profound. They face the most complex coordination challenge in American healthcare: Medicare disability determination, Medicaid work requirements, exemption documentation, and integrated care - all converging in ways that haven't existed before.

For D-SNPs serving this population, success requires identifying them accurately, stratifying support intensity appropriately, building operational capabilities specifically for their needs, and advocating with states for policies minimizing redundant burden on people already navigating disability and dual coverage complexity.

For states, the choice is whether existing federal disability determinations suffice for exemption or whether redundant state processes impose additional burden on already multiply-burdened populations. The efficiency and burden implications vary by orders of magnitude based on these choices affecting a small but intensely challenged subset of dual eligibles.

The policy affects few. But for those few, the complexity is extraordinary. Implementation excellence matters enormously for people already navigating more system complexity than virtually any other population. Getting it right requires accuracy about population size, precision about who faces exposure, and proportionate response scaled to actual rather than imagined scope.

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