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Next Steps: Improving the Medicaid Buy-in for Workers with Disabilities

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STAFF

Lisa Harootunian, J.D.
Associate Director, Health Program

Allison Buffett
Policy Analyst, Health Program

Brian O'Gara
Research Analyst, Health Program

Kamryn Perry
Project Associate, Health Program

Marilyn Serafini
Executive Director

Oliver J. Kim, J.D.
Director, Health Policy

G. William Hoagland
Senior Vice President

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Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., the Bipartisan Policy Center (BPC's) Health Program develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The program focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

ADVISORS

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Glossary of Terms

ABD	Aged, Blind, or Disabled
ACA	Affordable Care Act
ACL	Administration for Community Living
ADA	Americans with Disabilities Act
BBA	Balanced Budget Act of 1997
CMS	Centers for Medicare & Medicaid Services
FMAP	Federal Medical Assistance Percentage
FPL	Federal Poverty Level
HCBS	Home and Community-Based Services
HHS	U.S. Department of Health and Human Services
HWD	Healthcare for Workers with Disabilities
LTSS	Long-Term Services and Supports
MACPro	Medicaid and CHIP Program
MA-EPD	Medical Assistance for Employed Persons with Disabilities
MBI	Medicaid Buy-In
MIG	Medicaid Infrastructure Grant
MWI	Medicaid Work Incentive
NPRM	Notice of Proposed Rulemaking
PHE	Public Health Emergency
PAS	Personal Assistance Services
SMD	State Medicaid Directors
SPA	State Plan Amendment
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
TWHA	The Ticket to Work Health Assurance
WDI	Working Disabled Individuals

Executive Summary

The Bipartisan Policy Center's Health Program is building on its previous report, *Improving Opportunities for Working People with Disabilities* (January 2021), to address barriers to employment for Medicaid beneficiaries with disabilities who often rely on Medicaid's unique services, such as home and community-based services (HCBS), to live independently in the community and work.

The Medicaid Buy-In (MBI) for Workers with Disabilities refers to three eligibility groups within Medicaid that allow states to cover working individuals with disabilities who, excluding earned income, generally meet Social Security's definition of disability.[i] The MBI for Workers with Disabilities therefore allows individuals with disabilities to work and retain their Medicaid coverage, or to use their Medicaid coverage to access wraparound services that are not covered under employer-sponsored insurance or Medicare. As described in more detail in the MBI for Workers with Disabilities Today subsection below, enrollment in the MBI for Workers with Disabilities eligibility groups is associated with increased employment and earnings, while also having a positive impact on the economy, state Medicaid agencies, employers, and state and federal governments.

Notably, states and stakeholders often refer to the MBI for Workers with Disabilities eligibility groups as a program, and many states have state-specific program names. BPC uses the term "MBI for Workers with Disabilities" to refer to the eligibility groups as well as state programs that cover those groups.

Congress passed bipartisan-supported laws in the late 1990s establishing the three optional eligibility groups through Section 4733 of the Balanced Budget Act (BBA) of 1997 and Section 201 of the Ticket to Work and Work Incentives Improvement Act (Ticket to Work Act) of 1999.[ii] Each of those authorities, in combination with other Medicaid authorities such as Section 1902(r)(2) of the Social Security Act or Section 1115 Waivers, provides states with significant flexibility in the design of their MBI for Workers with Disabilities programs. For example, states can charge income-related premiums or other cost-sharing to beneficiaries who qualify for Medicaid through the MBI for Workers with Disabilities eligibility groups. The three optional Medicaid eligibility groups established by the BBA and Ticket to Work Act include:

i As described in the Federal Authorities for MBI for Workers with Disabilities Eligibility Groups subsection below, the Ticket to Work Medical Improvements group is an exception. Individuals eligible for the Ticket to Work Medical Improvements group are those who were previously eligible for the Ticket to Work Basic group but lost eligibility due to medical improvement, and no longer meet the Supplemental Security Income (SSI) program's definition of disability. Individuals in this group, however, must still have a medically determinable impairment.

ii See Appendix A for a summary of these authorities.

- The Work Incentives group;
- The Ticket to Work Basic group; and
- The Ticket to Work Medical Improvements group.

Today, 46 states cover the MBI for Workers with Disabilities eligibility groups. Accordingly, a cumulative total of more than 400,000 individuals with disabilities were able to work and retain Medicaid coverage between 1997 and 2011.[iii, 1] The most recent, publicly available enrollment data are from 2011, when almost 193,000 individuals were enrolled in MBI for Workers with Disabilities programs across 35 states.[iv, 2] During fiscal year 2011, approximately 66 million individuals were enrolled in Medicaid, including almost 10 million adults and children eligible based on disability.[3] Because BPC was unable to find more recent data on enrollment in MBI for Workers with Disabilities programs, we recommend in this report that the Centers for Medicare & Medicaid Services (CMS) and states improve data reporting on this population (see Recommendation II.C.). Out of the 83 million people enrolled in Medicaid during FY2019, nearly 10 million adults and children were eligible based on disability.[4]

Across all age groups, individuals with disabilities are much less likely to be employed than those with no disabilities.[5] Only 1 in 5 adults with disabilities was employed or looking for employment in 2021, versus more than two-thirds of adults with no disability.[6] In that same year, 24.5 million individuals with disabilities were not in the labor force and the unemployment rate was 10%, or double the rate of those with no disability.[7] Improving access to MBI for Workers with Disabilities programs would help address a barrier to employment among individuals with disabilities who might want to work but worry about losing their Medicaid coverage.

BPC interviewed and convened stakeholders and policy experts—including federal and state stakeholders, consumer advocacy organizations, Medicaid beneficiaries, researchers, and others—to identify challenges and bipartisan policy solutions that will improve access to the MBI for Workers with Disabilities eligibility pathways. Although enrollment data are limited, the information available suggests a notably low take-up of this option by the target population and a similarly modest success in making states and eligible individuals with disabilities aware of the MBI for Workers with Disabilities eligibility pathways. BPC's research also suggests that current federal law effectively grants significant flexibility to state Medicaid programs to support individuals with disabilities who want to work and increase their earnings. However, federal implementation of those laws and states' clarity on the program flexibilities have limited the program's reach. We identified three key challenges for states adopting or optimizing their MBI for Workers with Disabilities programs:

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iii Unless otherwise indicated, all years in this report refer to calendar year.

iv While 38 states had MBI for Workers with Disabilities programs in 2011, only 35 states reported data for this enrollment estimate.

1. Inadequate federal guidance on the flexibilities available to states designing their MBI for Workers with Disabilities programs—such as options to remove barriers for adults with disabilities over 65 who wish to continue to work; this lack of guidance limits states' take-up and workforce participation.

2. A lack of clear, consistent, and accessible consumer information and educational resources about MBI for Workers with Disabilities programs; this contributes to Medicaid beneficiaries not seeking out or declining employment opportunities (including new jobs or promotions) due to fear of losing critical Medicaid benefits, such as HCBS.

3. A lack of technical assistance, limited program data such as recent enrollment and service utilization data, and an absence of state-to-state learning opportunities; this makes it difficult for states to identify and adopt promising state practices.

In this report, BPC identifies federal policy reforms that will encourage more states to cover or optimize their coverage of the MBI for Workers with Disabilities eligibility groups. These reforms will improve access to the MBI for Workers with Disabilities programs and, thus, allow more Medicaid beneficiaries with disabilities to work and achieve their employment potential. More specifically, BPC has identified a set of federal policy recommendations that Congress and the administration should advance. These federal policy reforms will clarify existing flexibilities that states can adopt when designing their MBI for Workers with Disabilities programs while also strengthening outreach, data, and interagency coordination.

Recommendations

I. Clarify Existing Options States Can Adopt When Designing Their MBI for Workers with Disabilities Programs

A. Congress should direct CMS to issue agency guidance, no later than 12 months after legislation is enacted, identifying the full range of options available to states under current law for covering or modifying their coverage of the MBI for Workers with Disabilities eligibility groups.

B. Congress should direct CMS to issue a Notice of Proposed Rulemaking (NPRM) to codify the MBI for Workers with Disabilities eligibility groups in regulation and clarify that the eligibility group names are as identified within the Medicaid and

CHIP Program (MACPro) system used by state Medicaid agencies (i.e., Work Incentives group, Ticket to Work Basic group, and Ticket to Work Medical Improvements group). Congress should direct CMS to issue the NPRM following stakeholder engagement and no later than 18 months after legislation is enacted.

C. CMS should improve the State Plan Amendment (SPA) template that states use to establish or amend their MBI for Workers with Disabilities programs. The revised SPA template should make it easier for states to understand their options to adopt program flexibilities allowed under current law.

II. Strengthen Outreach, Data, and Interagency Coordination

A. Congress should authorize and appropriate $5 million per year, over five years, in resources to CMS to establish a national technical assistance center. The center should support states that seek to adopt or optimize their MBI for Workers with Disabilities programs by providing technical resources, including education on promising state practices and data on MBI for Workers with Disabilities programs. CMS should manage the technical assistance center, provide ongoing program support to states, and collaborate with the Social Security Administration and other federal agencies to improve outreach to beneficiaries and benefits counseling.

B. CMS and the Social Security Administration should collaborate on annual updates to materials detailing work incentives, including the Social Security Administration's Red Book; the updates should include accurate and more detailed information on the MBI for Workers with Disabilities programs and every state that offers the program.

C. Congress should establish an eight-year grant program that builds on lessons learned from the Medicaid Infrastructure Grant (MIG) program, and that authorizes and appropriates $260 million over eight years to CMS. CMS should annually award grants to up to 56 states or territories amounts that gradually reduce in the final three years of the program: up to $4 million per awardee in years 1-5, and up to $1 million per awardee in year 8. These grants should provide funding to states or territories to build or improve infrastructure to:

    1. Enhance outreach, interagency coordination, and benefits counseling to educate consumers about the opportunity to continue working while receiving Medicaid benefits, including HCBS, through the MBI for Workers with Disabilities eligibility pathways;

2. **Conduct data collection, analysis, and research; and/or**

3. **Establish or improve MBI for Workers with Disabilities programs.**

In the program's final three years, awardees must use the funds more narrowly to support consumer outreach and benefits counseling.

Congress should also appropriate $3 million in resources to CMS for procuring an independent contractor to evaluate the grant program, and CMS should submit a Report to Congress describing the evaluation.

Background

Medicaid is the United States' publicly financed health insurance program for low-income individuals and families with incomes that do not exceed certain limits. Medicaid beneficiaries include children, pregnant women, adults, individuals with disabilities, and older adults ages 65 and above. Funded jointly by the federal government and states, Medicaid finances the delivery of primary care, acute medical services, and community and facility-based long-term services and supports (LTSS).

Benefit spending for enrollees eligible for Medicaid based on disability was $195.6 billion in FY2019, out of $571.3 billion total spent on Medicaid benefits by the federal government and states.[8]

More than 1 in 5 people in the United States was enrolled in Medicaid in FY2019.[9] Although the federal government requires states to cover certain mandatory populations and benefits to receive federal funding, states design and administer their own Medicaid programs and have wide discretion in determining the scope and duration of these mandatory services. Furthermore, states have additional flexibility to cover more populations and offer an increased number of services with federal matching dollars — and all do take advantage of this flexibility to various degrees (see Figure 1).[10]

Out of the 83 million people enrolled in Medicaid during FY2019, nearly 10 million were eligible based on disability.[11] This figure does not capture the total number of Medicaid enrollees with disabilities, as some individuals with disabilities might not seek a disability determination and might qualify for Medicaid through other, non-disability-based eligibility pathways for low-income adults (e.g., pregnancy or being a parent/caretaker for a child). Publicly available data on the total number of individuals currently qualifying for

Medicaid through the MBI for Workers with Disabilities eligibility groups are limited; however, a cumulative total of more than 400,000 individuals with disabilities were enrolled through those eligibility groups between 1997 and 2011.[12] The most recent, publicly available enrollment data are from the last evaluation required by the Ticket to Work Act; in 2011, almost 193,000 individuals were enrolled in MBI for Workers with Disabilities programs across 35 states, while total Medicaid enrollment was about 66 million.[v,13]

This report focuses on Medicaid for working adults with disabilities, including adults ages 18 through 64 and adults 65 and older. The optional MBI for Workers with Disabilities eligibility groups represent three of several eligibility pathways through which individuals with disabilities can qualify for Medicaid coverage; the MBI for Workers with Disabilities eligibility groups are distinct from other eligibility pathways available to individuals with disabilities, as they allow Medicaid beneficiaries with disabilities to earn above traditional income limits. Total earnings among all Medicaid beneficiaries who qualified through the MBI for Workers with Disabilities eligibility groups were about $1.15 billion in 2011.[14]

Medicaid is the primary source of health insurance for individuals with disabilities, and it covers services that other insurers do not.[15] This reliance on Medicaid services, such as HCBS, has historically forced individuals with disabilities living in the community to choose between health care and employment.

BPC began work on this topic in its 2021 report, *Improving Opportunities for Working People with Disabilities*, and is building on those recommendations to identify more specific actions that Congress, the Biden administration, and states should take to help individuals with disabilities live independently and reach their employment potential. Following BPC's last report, the COVID-19 pandemic increased remote work opportunities, and some states expanded, or plan to expand, access to Medicaid coverage for individuals with disabilities. Specifically, more people are working remotely since the pandemic began, and this shift created new opportunities for individuals who may need certain accommodations or supports—such as those with disabilities —to enter and participate in the workforce.[16] Also, several states have expanded or plan to expand access to Medicaid coverage for individuals with disabilities, and they will need updated federal guidance and technical assistance to effectively implement program improvements (see Looking Ahead).

v See footnote iv.

Figure 1: Mandatory and Optional Medicaid Benefits[17]

Mandatory Benefits (Benefits States Must Offer)	Optional Benefits (Benefits States May Offer)
• Inpatient hospital services • Outpatient hospital services • Early and periodic screening, diagnostic, and treatment services • Nursing facility services • Home health services • Physician services • Rural health clinic services • Laboratory and X-ray services • Family planning services • Nurse midwife services • Certified pediatric and family nurse practitioner services • Freestanding birth center services (when licensed or otherwise recognized by the state) • Transportation to medical care • Tobacco cessation counseling for pregnant women	• Prescription drugs • Clinic services • Physical therapy • Occupational therapy • Speech, hearing, and language disorder services • Respiratory care services • Other diagnostic, screening, preventive, and rehabilitative services • Podiatry services • Optometry services • Dental services • Dentures • Prosthetics • Eyeglasses • Chiropractic services • Other practitioner services • Private duty nursing services • Personal care • Hospice • Case management • Services for Individuals Ages 65 or Older in an Institution for Mental Disease • Services in an intermediate care facility for Individuals with Intellectual Disability • State Plan Home and Community Based Services—1915(i) • Self-Directed Personal Assistance Services—1915(j) • Community First Choice Option—1915(k) • TB-related services • Inpatient psychiatric services for individuals under age 21 • Health Homes for Enrollees with Chronic Conditions—Section 1945 • Other services approved by the secretary, including services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital

THE ROLE OF MEDICAID FOR PEOPLE WITH DISABILITIES

Medicaid is the largest payer of LTSS, which older adults and individuals with disabilities are more likely to need due to physical, cognitive, or mental health impairments.[18] LTSS are a broad range of health, health-related, and social services for people who have functional limitations due to old age, chronic illness, cognitive impairment, disability, or other issues that restrict their ability to care for themselves. In 2020, total Medicaid LTSS spending (federal and state combined) reached $200 billion, accounting for 42% of all LTSS expenditures nationally.[19]

Medicaid LTSS enable millions of older adults and individuals with disabilities to live more independently in their homes and communities. Researchers estimate that 7.5 million Medicaid beneficiaries received HCBS in 2019.[20] In addition to traditional health services, Medicaid covers case management; transportation; specialized medical equipment; and HCBS, including personal care assistant services and home modifications.

Medicare and private health insurance plans do not generally cover LTSS benefits, including HCBS, that are essential to independent living. Just 13% of Medicaid spending was on noninstitutional LTSS in 2019 across all enrollees—but accounted for 27% of spending among enrollees with disabilities and 16% among older adults.[21]

MEDICAID ELIGIBILITY AND SUPPLEMENTAL SECURITY INCOME

Individuals with disabilities of all ages qualify for Medicaid through several pathways in which the categorical eligibility criteria include being aged, blind, or disabled (sometimes referred to as "ABD" or "ABD eligibility"). One such pathway includes Supplemental Security Income- (SSI-) related eligibility groups.[vi] SSI is a federal assistance program that provides monthly payments to ABD individuals with limited income and resources. SSI-related eligibility groups include mandatory and optional eligibility groups that meet the requirements of the federal SSI program (described in more detail below), such as older adults and individuals with disabilities who are SSI eligible or would be SSI eligible if not for a certain program rule. The other ABD pathways are for optional eligibility groups who have levels of income or resources above SSI program rules, such as individuals that work. These groups generally use SSI categorical criteria to define older adults and individuals with disabilities and might use certain SSI financial criteria to determine financial eligibility for expanded Medicaid coverage.

vi While this report only focuses on the MBI for Workers with Disabilities eligibility pathways, a full list of mandatory and optional Medicaid eligibility pathways for older adults and individuals with disabilities can be found in Appendix II of BPC's 2021 report, Improving Opportunities for Working People with Disabilities.

Medicaid eligibility for older adults and individuals with disabilities is based largely on eligibility for SSI. Categorial eligibility for Medicaid comes from the SSI program's definition of ABD populations, and financial eligibility for various Medicaid eligibility pathways is often identical to, or adapted from, the SSI program's financial requirements and counting methodologies.[22]

In 2019, most Medicaid-only beneficiaries who were eligible based on a disability (86%) qualified for Medicaid based on receipt of SSI benefits.[23] To be eligible for SSI on the basis of disability, an individual must be older than 16; must have a severe, medically determinable physical or mental impairment; and must meet program income and resource standards (see Figure 2). Additionally, the impairment must prevent a person from engaging in "substantial gainful activity," which federal law defines differently based on whether an individual is blind. An individual who is not blind is considered to be engaging in substantial gainful activity if they earn more than $1,470 per month in 2023, not including impairment-related work expenses.[24] Similarly, an individual who is blind is considered to be engaging in substantial gainful activity if they earn more than $2,460 per month in 2023, not including impairment-related work expenses.[25] In calendar year 2023, the monthly maximum federal SSI payment amounts are $914 per month for a qualifying individual and $1,371 per month for a qualifying couple.[26] Resource limits, or limits on certain assets, are $2,000 for an individual and $3,000 for a couple.[27] If an individual's income exceeds the monthly amount, the person will lose eligibility for SSI and Medicaid, because the two programs are linked in most states.

It is important to note that not all individuals with disabilities qualify for Medicaid through SSI benefits. Although SSI program rules guide the design of SSI-related pathways and other ABD pathways, older adults and individuals with disabilities can qualify for both traditional Medicaid and expanded coverage groups without ever receiving SSI benefits.

Figure 2: Supplemental Security Income Eligibility Criteria, 2023

Criteria	Description
Categorical[28]	
Aged	Individuals ages 65 and older.
Blind	Individuals of any age who have 20/200 or less vision in the better eye with the use of correcting lenses or tunnel vision of 20 degrees or less.
Disabled	- Adults ages 18 and older who are unable to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment that is expected to last for at least one year or to result in death. In 2023, the SGA earnings standard is $1,470 per month for nonblind individuals. The SGA earnings standard is a proxy measure for total disability; it is not used to determine financial eligibility. - Children under 18 who have a medically determinable physical or mental impairment that results in marked and severe functional limitations and is expected to last for at least one year or to result in death; earnings must not exceed the SGA earnings standard.
Financial[29]	
Federal SSI Payment Amounts	In 2023, the maximum federal SSI payment amounts are $914 per month for an individual and $1,371 per month for a couple.
Income-Counting Methodology	Certain income is disregarded, such as the first $20 per month of any income (earned or unearned) and the first $65 per month of earned income from working plus one half of any earnings above $65.
Resource Standard	$2,000 for an individual and $3,000 for a couple.
Resource-Counting Methodology	Certain resources are disregarded, such as an individual's primary residence, car, household goods and personal effects, and property essential to self-support.

THE NEED FOR THE MBI FOR WORKERS WITH DISABILITIES

Both the adoption of HCBS waivers allowing Medicaid to cover services provided outside of institutional settings throughout the 1980s and the passage of the Americans with Disabilities Act (ADA) in 1990 helped make working and living independently more feasible for many individuals. However, as a program designed to assist low-income individuals, Medicaid forces many individuals with disabilities to make a choice: limit earnings, or work and risk losing health coverage.

Medicaid covers vital community-based services and supports not offered by Medicare and private insurance that allow individuals with disabilities to lead more independent lives. Before passage of the 2010 Affordable Care Act (ACA), individuals with disabilities were unlikely to be able to purchase private health insurance because a disability would be considered a preexisting condition. Although the ACA prohibited preexisting condition exclusions and provided unprecedented access to private health insurance, most private plans still do not cover LTSS that individuals with disabilities often rely on to participate in the workforce. Medicare also does not cover these critical services, such as specialized durable medical equipment, transportation, and personal assistance services (PAS).[30] In addition, individuals qualifying for Medicare are ineligible for Marketplace plans.[31]

Historically, this reliance on Medicaid had forced individuals with disabilities living in the community to choose between health care and employment. For many individuals, working meant risking losing community-based services and supports and becoming completely uninsured, increasing the likelihood of hospitalizations and institutional care. Often, even modest increases in income could result in ineligibility for and loss of the very services that enabled individuals with disabilities to live and work in their communities. As Congress noted in 1999 when it passed the Ticket to Work Act, "For individuals with disabilities, the fear of losing health care and related services is one of the greatest barriers keeping the individuals from maximizing their employment, earning potential, and independence."[32]

Personal Experience #1:

ELLIE, MISSOURI

Ellie, a 25-year-old who recently earned a law degree, lives in Missouri and has been enrolled in Medicaid since age 18. As someone with spinal muscular atrophy, Ellie requires a wheelchair and assistance with daily activities, such as getting in and out of bed, using the restroom, and getting dressed—including overnight support. Since she was young, Ellie's goal was to move out of her parents' home to pursue a career and live on her own. The Ticket to Work Health Assurance (TWHA) program, Missouri's MBI for Workers with Disabilities program, gave her that opportunity to be more independent.

However, Ellie has experienced challenges obtaining necessary services, such as personal care assistance, due to difficulties navigating the complex system and a lack of clear, helpful resources. Despite being eligible for personal care assistance through Medicaid, Ellie often pays out of pocket for personal care services or must rely on friends or family for assistance due to gaps in coverage and the shortage of direct care workers.

Ellie had to choose legal work that pays less than the average attorney's salary due to fear of losing her Medicaid benefits. In the future, Ellie knows she will have to turn down better job offers because she needs to remain within Missouri's TWHA income limits. TWHA's individual monthly earned income limit and individual asset limit are $3,398 and $5,302, respectively.[33] As Ellie described it, while her colleagues might feel excited about potential salary increases, those discussions are stressful to Ellie due to constant concerns of losing eligibility for TWHA. Because the system is challenging to navigate and the income and asset limits are restrictive, Ellie worries about a salary change jeopardizing her eligibility for TWHA. However, without salary increases comparable to those her peers are receiving, Ellie risks being unfairly compensated for her experience and work. She would like to see TWHA remove restrictive eligibility requirements that inhibit Ellie and others like her from maximizing her earnings and career potential.

FEDERAL AUTHORITIES FOR MBI FOR WORKERS WITH DISABILITIES ELIGIBILITY GROUPS

Congress initially addressed these barriers to employment by authorizing three eligibility groups for adult workers with disabilities through the BBA and Ticket to Work Act.[vii] States that choose to cover any of these groups receive federal matching dollars for their expenditures, just as they do for the services they provide to other Medicaid enrollees. In addition, states can require enrollees in these groups to "buy-in" to Medicaid by paying premiums and cost sharing.

The MBI for Workers with Disabilities eligibility groups are:

- Work Incentives;
- Ticket to Work Basic; and
- Ticket to Work Medical Improvements

The BBA and Ticket to Work Act authorities give states the flexibility to offer Medicaid coverage to higher-income workers with disabilities who generally, aside from earned income, meet the Social Security definition of disability.[34,35] The MBI for Workers with Disabilities eligibility groups are designed to allow individuals with disabilities to work and retain their Medicaid coverage, or to use their Medicaid coverage to access wraparound services that are not covered under employer-sponsored insurance or Medicare. States can also utilize Section 1115 Waiver authority and Section 1902(r)(2) of the Social Security Act to set various income and resource standards for program eligibility.[36] For a full list of income, resource, and premium standards in states that cover the MBI for Workers with Disabilities eligibility groups, see Appendix B.

Work Incentives Group

Section 4733 of the BBA allows states to offer Medicaid coverage to workers with disabilities with family incomes less than 250% of the FPL ($33,975 annually for an individual in FY2022).[37,38] Group enrollees must meet the SSI program's definition of disability, aside from earned income. Accordingly, a Medicaid beneficiary with a disability could earn more than $1,470 per month or $17,640 annually (i.e., they could engage in substantial gainful activity) and still retain Medicaid coverage, through the Work Incentives group, in a state that covers workers with disabilities with incomes less than $33,975 in FY2022, if the beneficiary is within that state-established income limit and meets all other SSI eligibility criteria (described in more detail in the Medicaid Eligibility and Supplemental Security Income subsection). Although an enrollee's unearned income and countable resources must fall within SSI standards, states can use Section 1902(r)(2) of the Social Security Act to disregard additional income or

vii The Family Opportunity Act Children with a Disability group is an additional buy-in group for individuals 18 and younger who meet the SSI definition of disability for a child and have a family income that does not exceed the income standard established by the state.

resources under this pathway.[39] As the BBA does not establish an age limit for this group, states can use this authority to cover adults with disabilities who are above or below age 65.

This group requires that an individual have earned income—that the individual be working—but does not allow states to define employment, such as setting standards for number of hours worked or level of earnings. States can, however, require individuals to provide evidence of earnings, such as pay stubs or evidence of having paid Federal Insurance Contributions Act taxes.[40]

Ticket to Work Basic Group

Created by Section 201 of the Ticket to Work Act, this pathway is similar to the Work Incentives group but allows states to expand Medicaid eligibility to individuals with incomes at or above 250% of the FPL.[41] States can also determine their own income and resource standards for the Ticket to Work Basic group, including no standards. If a state does establish standards, it must follow SSI income- and resource-counting methodologies but may exclude additional earned income above the SSI-earned-income disregard, including not counting all earned income under Section 1902(r)(2) of the Social Security Act. An important distinction from the Work Incentives group is that eligible individuals for the Ticket to Work Basic group must be ages 16 to 64.[42]

Similar to the Work Incentives group, individuals in the Ticket to Work Basic group must meet the SSI program's definition of disability aside from earned income limits and must have earned income from working. States offering this group also cannot define employment for enrollees but may require evidence of earnings, such as pay stubs or evidence of having paid Federal Insurance Contributions Act taxes.

Ticket to Work Medical Improvements Group

Section 201 of the Ticket to Work Act also created the Medical Improvements group, an optional eligibility group for states that already cover the Ticket to Work Basic group. Individuals eligible for the Medical Improvements group are those who were previously eligible for the Ticket to Work Basic group but lost eligibility due to medical improvement and thus no longer meet the SSI program's definition of disability. Individuals in this group must still have a medically determinable impairment. For example, an individual who suffers from a major mental health crisis might be able to increase their hours after attending a recovery program. As the individual's health stabilizes and they continue to benefit from community-based support services and medication covered by Medicaid, they might no longer meet the SSI definition of disability and transition from the Ticket to Work Basic group into the Medical Improvements group. States that include the Ticket to Work Basic group are not required to include the Medical Improvements group.

Like the Ticket to Work Basic group, states have the flexibility to create their own income and resource standards for eligibility under the Ticket to Work Medical Improvements group, including no standards at all, and can use Section 1902(r)(2) of the Social Security Act to disregard additional earned income above the SSI-earned-income disregard, including excluding all earned income. Unlike the Work Incentives group and Ticket to Work Basic group, the Ticket to Work Medical Improvements group *does* include specific employment requirements. Eligible workers must earn at least the state minimum wage and work at least 40 hours per month or meet other employment measures determined by the state and approved by CMS.[43]

Medicaid Infrastructure Grant Program

Section 203 of the Ticket to Work Act created the MIG program, a series of 11-year competitive grants to states that began in FY2001 to support infrastructure development to build supports for individuals with disabilities who want to work. The grant program encouraged states to adopt the MBI for Workers with Disabilities eligibility groups, increase the availability of statewide personal assistance services, form connections with other state and local agencies that provide employment related supports, and pursue other efforts to improve infrastructure to maximize employment opportunities for individuals with disabilities. The MIG program's authorization expired in 2011 and was not renewed. See the Challenges section and Recommendation II.C. for additional details on the MIG program.

MBI FOR WORKERS WITH DISABILITIES TODAY

Forty-six states currently offer Medicaid coverage to working adults with disabilities, either through the Ticket to Work Act, BBA, Section 1115 Waiver authority, or some combination of the three.[44] As previously mentioned in the Background section, there is no updated publicly available MBI for Workers with Disabilities enrollment data. Notably, the lack of recent, available enrollment data on this population highlights the need for CMS and states to improve data reporting, as discussed in BPC's Recommendation II.C.. While difficult to quantify, the available data and BPC's interviews with stakeholders both suggest that substantial opportunity likely exists to increase enrollment in these programs that help Medicaid beneficiaries work and improve their employment outcomes. According to data from the Bureau of Labor Statistics, more than 24 million individuals with disabilities ages 16 and over were not part of the United States labor force in 2021.[45]

States have worked to distinguish the MBI for Workers with Disabilities eligibility pathways from other Medicaid eligibility pathways by creating state-specific program names. Examples include Working Health in Kansas, Work Ability in New Jersey, Apple Health for Workers with Disabilities in Washington, Health Benefits for Workers with Disabilities in Illinois,

Health First Colorado, CommonHealth in Massachusetts, and Freedom to Work in Michigan. State-specific program names also reflect the significant variation in program structure across states. In developing and managing MBI for Workers with Disabilities programs, states make several policy decisions regarding participants' earnings, savings, work status, and optional premiums.[46] Nationally, the descriptor "Medicaid Buy-In" has been an identifier for state Medicaid programs offering coverage to workers with disabilities for more than 20 years.

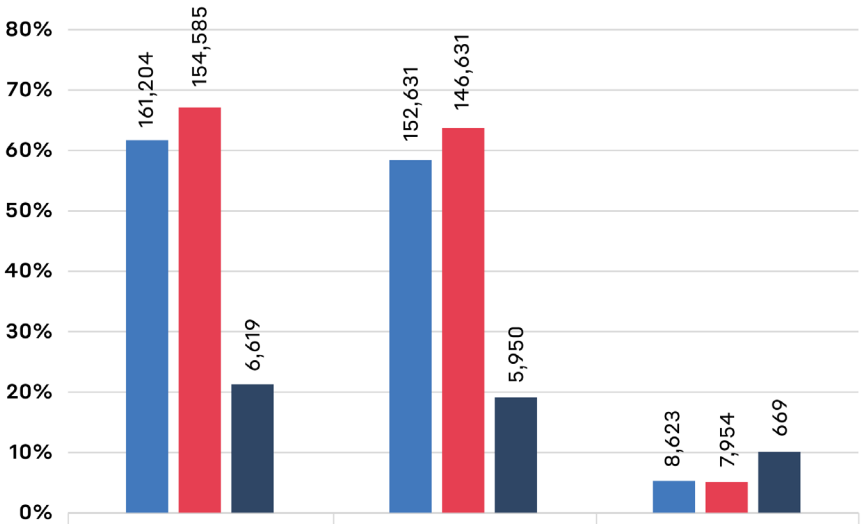
Program Impact

MBI for Workers with Disabilities programs enable workers to improve their economic status and pursue gainful employment. In 2021, just 4% of the civilian labor force was composed of adults with disabilities, even though individuals with disabilities make up 12% of the adult civilian noninstitutional population in the United States. In contrast, adults with no disability constitute 96% of the civilian labor force, yet 88% of the entire adult population.[viii] This suggests what many stakeholders have noted—that the fear of losing Medicaid eligibility by earning too much keeps many individuals with disabilities from seeking work.

Only 1 in 5 adults with disabilities was employed or looking for employment in 2021 (referred to as "labor force participation"), versus more than two-thirds of adults with no disability.[47] Individuals with disabilities are twice as likely to be unemployed, compared with people with no disabilities; in fact, 10% of individuals with disabilities ages 16 years and over were unemployed in 2021, versus 5% of individuals with no disability (see Figure 3).[48] As a result, the median income for an individual with a disability was $28,438 in 2021, compared with $40,948 for an individual with no disabilities.[49]

viii U.S. Bureau of Labor Statistics, Table 1. Employment status of the civilian noninstitutional population by disability status and selected characteristics, 2021 annual averages, February 24, 2022. Available at: https://www.bls.gov/news.release/disabl.t01.htm.

Figure 3: Employment and Disability Status of Workers Ages 16+ (2021)[50] (Numbers in thousands)



	Participation	Employed	Unemployed
Total population	61.7%	58.4%	5.3%
Persons with no disability	67.1%	63.7%	5.1%
Persons with a disability	21.3%	19.1%	10.1%

Note: "Participation" refers to the labor force participation rate—the percentage of the civilian non-institutional population 16 years and older working or actively looking for work, as defined by the U.S. Bureau of Labor Statistics.

However, MBI for Workers with Disabilities programs can help to close this historic employment gap.[51] For example, one year after enrollment, participants in Washington's Healthcare for Workers with Disabilities (HWD) program were four times more likely to be employed, compared with nonparticipants with disabilities, and worked 193 more hours on average.[52] Similarly, individuals with disabilities enrolled in Utah's Medicaid Work Incentive (MWI) program reported earned income during 75% of all calendar quarters over a three-year period, compared with 15% for a comparison group.[53]

Increased labor participation also translates to greater earnings and savings for workers with disabilities. An analysis of nationwide Social Security Administration earnings data showed that an average of 40% of participants increased their wages upon enrollment in MBI for Workers with Disabilities programs.[54] Total earnings among all participants in 35 active state MIG programs in 2011 were about $1.15 billion.[55] In Washington, HWD participants with prior Medicaid coverage earned $2,000 more per year than nonparticipants, while HWD participants without prior Medicaid coverage earned more than $5,000 more per year than nonparticipants.[56] And in Utah's MWI program, participants with earned income made 62% more compared with other Medicaid enrollees with disabilities and reported earned income.[57] Enrollees in MBI for Workers with Disabilities eligibility groups across the country have also reported having a greater opportunity to accrue savings for home purchases, retirement, and other needs as a result of being able to earn more income.[58]

Further, as MBI participants' earnings increase, so too do the average contributions to state revenues via income taxes and health premiums. Washington estimated that 7% of HWD participants' increased earnings contributed to the state general fund tax revenue, for a total of almost $400,000 in one year alone.[59] Between 2003 and 2006, participants in Kansas' Working Healthy program increased the amount of state income taxes from an average of $74 to $123 annually.[60]

Research has shown that the MBI for Workers with Disabilities is not just good for beneficiaries; it is good policy for Medicaid and states. Analyses from Washington and Utah demonstrate that participants in MBI for Workers with Disabilities programs had fewer and less costly health care expenditures and decreased dependence on food stamps and other social services compared with other Medicaid recipients.[61] Utah found that MWI recipients had 57% lower Medicaid expenditures compared with individuals with disabilities not enrolled in the program.[62] Adjusting for inflation, Medicaid expenditures per month for individuals in Kansas' program declined 41% from 2007 to 2011, with the greatest decrease being in outpatient costs such as doctor's visits, case management, and attendant and related services.[63] A University of Kansas study also found that Kansas' Working Healthy program participants had a better quality of life in addition to reduced Medicaid expenditures.[64]

Finally, employers also benefit from hiring workers with disabilities. Numerous studies show that benefits include increased profits and cost-effectiveness, employee retention and loyalty, productivity, and customer loyalty.[65]

Challenges

Through discussions with stakeholders, BPC identified three key challenges for states adopting or optimizing their MBI for Workers with Disabilities programs. First, inadequate federal guidance on the flexibilities that states have in designing their programs is a barrier to states understanding and effectively implementing the range of program design options allowed by current federal authorities. Second, a lack of clear, consistent, and accessible consumer information and educational resources about MBI for Workers with Disabilities programs contributes to Medicaid beneficiaries not seeking out or declining employment opportunities, including new jobs or promotions, due to fear of losing Medicaid benefits. Third, a lack of technical assistance, limited program data such as enrollment and utilization data, and an absence of state-to-state learning opportunities make it difficult for states to identify and adopt promising state practices.

INADEQUATE FEDERAL GUIDANCE

CMS typically codifies Medicaid eligibility groups in regulation; however, CMS has never codified the MBI for Workers with Disabilities eligibility groups in federal regulation, and this is a barrier to states covering or modifying their coverage of those eligibility groups.[66] Current federal regulations at 42 CFR §§ 435.230 – 435.236 include the range of eligibility pathways that states can use to cover adults in the ABD eligibility categories, but the three MBI for Workers with Disabilities eligibility groups are not included. Excluding these eligibility groups from regulation can make state Medicaid agencies and state legislatures hesitant to cover those groups or to redesign their coverage of those groups in ways that would more effectively help Medicaid beneficiaries with disabilities achieve their employment potential.

Congress established the MBI for Workers with Disabilities eligibility groups through legislation that became law. Nevertheless, some states and other stakeholders remain concerned about federal approval for and the permanency of these eligibility groups when they are not codified in regulation among the other eligibility pathways available to cover adults with disabilities. In addition, changes to the Medicaid program—such as the U.S. Department of Health and Human Services (HHS) allowing some states to require that certain adults without disabilities meet work or community engagement requirements as a condition of Medicaid eligibility[ix]—might create confusion among states and beneficiaries. CMS codifying the MBI for Workers with Disabilities eligibility groups in regulation would better distinguish these groups from other Medicaid initiatives or eligibility groups, mitigating confusion and misinformation about these eligibility pathways.

While CMS has the authority to issue an NPRM without congressional intervention, the agency has not done so. As discussed in the Looking Ahead section, CMS released a broader NPRM in September 2022 on streamlining eligibility and enrollment that will affect individuals with disabilities, but that NPRM is not focused on MBI for Workers with Disabilities eligibility groups.[67] Accordingly, BPC's Recommendation I.B. emphasizes the need for congressional action to make issuing an NPRM on the MBI for Workers with Disabilities eligibility groups an agency priority.

States also need additional federal guidance on covering the eligibility groups to better understand the opportunities that exist to optimize Medicaid program design in ways that will incentivize and maximize workforce participation. States construct their MBI for Workers with Disabilities programs by adopting one or more Medicaid program authorities, including the BBA and Ticket to Work Act,

ix Under the Trump administration, HHS approved Section 1115 waivers in 13 states that established work and community engagement requirements for certain beneficiaries as a condition of Medicaid eligibility. Under the Biden administration, HHS withdrew approval of all of those Section 1115 waivers. Source: The Kaiser Family Foundation, "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State," November 2, 2022. Available at: https://www.kff.org/report-section/section-1115-waiver-tracker-work-requirements/.

and can combine either of those authorities with Section 1115 Waiver authority or Section 1902(r)(2) of the Social Security Act to better support workforce participation. Although states have significant flexibility, they lack clarity on what those design flexibilities are (e.g., the treatment of income and resources for eligibility purposes; cost-sharing options, including premiums; how to include workers ages 65 and older, as well as transition-age youth with disabilities ages 16 and 17). The states also lack clarity on the federal requirements of each flexibility and which federal authority, or combination of federal authorities, they must rely on to implement their desired program features.

Since enactment of the MBI for Workers with Disabilities in 1997, CMS has issued only four guidance documents, and it has not released any additional guidance in the past 22 years.[68,x] The guidance documents include four State Medicaid Director (SMD) letters that CMS issued in 1997, 1998, March 2000, and August 2000.[69] Although these important guidance documents provided some information to states, they do not reflect or address any programmatic changes occurring in Medicaid since 2000. And they do not comprehensively detail the range of design flexibilities that states can adopt, the federal requirements of those design flexibilities, or which program authorities states should utilize, or adopt in combination, to implement their desired program features.

Staffing limitations at CMS and state Medicaid agencies, competing agency priorities, and the lack of recent federal guidance have contributed to a loss of institutional knowledge about MBI for Workers with Disabilities programs. In addition, over the past 22 years the health care landscape has changed significantly. For example, federal and state governments have implemented ACA reforms, more states have shifted toward managed care delivery systems, and the COVID-19 pandemic increased demands on federal and state resources. It has thus become difficult for states to uncover their state-specific disincentives to workforce participation and to implement the appropriate changes to address those disincentives.

For instance, states often design their MBI for Workers with Disabilities programs in ways that limit earnings, savings, or other opportunities for working individuals with disabilities. Although some of those decisions might be based on concerns about program costs or other factors, states currently lack the information and resources necessary to make data-informed decisions about how they structure their programs. For example, states might wish to estimate the effects of proposed program changes on enrollment and spending but lack the information or resources necessary to produce those estimates.

Thus, inadequate federal guidance remains the most significant challenge for state and federal agency staff and policymakers. A better understanding of the MBI for Workers with Disabilities authorities and program design

x Notably, however, the HHS Administration for Community Living (ACL) and Department of Labor Office of Disability and Employment Policy (ODEP), with the support of the LEAD Center and input from CMS, released a brief, high-level Medicaid Buy-in Q&A in July 2019. Available at: https://www.dol.gov/sites/dolgov/files/odep/topics/medicaidbuyinqaf.pdf.

flexibilities available to states is needed to incentivize and maximize workforce participation among adults with disabilities. While CMS currently has the authority to issue updated guidance on the MBI for Workers with Disabilities authorities, BPC's Recommendation I.A. calls for Congressional action to ensure that issuing guidance is an agency priority.

LACK OF CLEAR, CONSISTENT, AND ACCESSIBLE CONSUMER INFORMATION AND EDUCATIONAL RESOURCES

Directly related to the lack of federal guidance is the lack of clear, consistent, and accessible information and educational resources describing the program. Frontline staff helping individuals navigate the system of available supports need better information to conduct effective outreach and provide appropriate guidance about the program and who may be eligible for it. Additionally, individuals with disabilities do not have access to clear, consumer-friendly resources about the opportunity to remain eligible for Medicaid while working and accruing savings.

Individuals can learn about MBI for Workers with Disabilities programs through a wide range of state or regional agencies and organizations, but staff at each of these consumer touch points often do not have enough information about the programs, according to interviews with MBI for Workers with Disabilities participants. For example, individuals with disabilities might first learn about the program through state Medicaid agencies, local social services departments, regional Social Security Administration offices, Centers for Independent Living, consumer advocacy organizations, a beneficiary enrolled in the program, or other avenues. BPC's interviews with stakeholders highlighted that potentially eligible beneficiaries often receive conflicting or inaccurate information about the programs from those various consumer touch points due to the lack of clear, accessible program information and educational resources.

Conflicting or inaccurate eligibility information can reduce the programs' impact and hinder states' efforts to incentivize and maximize employment opportunities for individuals with disabilities. Moreover, it results in current and potentially eligible beneficiaries not pursuing or declining employment opportunities due to fear of losing their Medicaid coverage. For example, beneficiaries who want to work might choose not to pursue employment, because they are unaware of the opportunity to work, earn a higher income, and remain eligible for Medicaid through MBI for Workers with Disabilities programs. Similarly, some beneficiaries reported in interviews with BPC that they declined promotions or new, higher paying positions due to a lack of information and to concerns that they might exceed income eligibility limits, which could mean losing access to critical Medicaid benefits.

Personal Experience #2:

MICHAEL, NEW MEXICO

During his 20s, Michael was paralyzed from the chest down, and has since used a wheelchair. He lives in New Mexico and first learned about the state's MBI for Workers with Disabilities program, known as Working Disabled Individuals (WDI), through a benefits counselor. The counselor helped him apply for the program. According to Michael, this assistance was pivotal to his application and access to WDI. Michael believes WDI is not well advertised and that many in the disability community are unaware of it.

Now enrolled in WDI, Michael works and has coverage for the services he needs, such as primary care services and physical therapy, and for help with medical equipment costs. Michael also previously received personal care assistance and nursing services.

However, Michael is advocating for New Mexico to remove or increase the income and asset limits for WDI. He believes the current income and asset limits restrict members' ability to increase earnings and makes it incredibly challenging to build savings. WDI's individual monthly earned income limit is 250% FPL after disregards, and the individual asset limit is $10,000.[70] According to Michael, New Mexico's policy to include spousal income and resources in determining eligibility is also a challenge for individuals who need WDI. In his circumstances, the policy creates a barrier to marriage, as his partner has a doctoral degree and a full-time career. Therefore, combining their incomes and resources could cause Michael to lose Medicaid coverage and its unique services that allow him to continue to work and live in the community.

NEED FOR TECHNICAL ASSISTANCE, PROGRAM DATA, AND STATE-TO-STATE LEARNING OPPORTUNITIES

States do not have access to adequate federal technical assistance or program data, such as enrollment or service utilization data, that would help them identify and adopt promising state practices for program designs; they also lack adequate state-to-state learning opportunities. The Ticket to Work Act established the MIG program, which provided federal technical assistance to states on MBI for Workers with Disabilities programs. It helped states connect with each other to learn how different states were structuring or improving their programs. Stakeholders reported in interviews with BPC that the technical assistance available through the MIG program and the state-to-state learning opportunities were extremely helpful for understanding how to design, improve, or expand MBI for Workers with Disabilities programs. But the MIG funding ended in 2011, and there has since been an unmet need for ongoing technical assistance, informational resources, and a forum that brings states together to share promising state practices, such as examples of clear, educational materials for consumers.

Very limited publicly available data exist on the states that cover the MBI for Workers with Disabilities eligibility groups, including the program features each state has adopted and the authorities that states have used to implement their programs. Available state program data are also often outdated and inaccurate. BPC was unable to identify data disaggregated by race, ethnicity, gender, or disability. BPC was also unable to identify current data on total or state-by-state enrollment in the MBI for Workers with Disabilities programs; the most recent enrollment data was for 2011,[71] which was limited because it only included active MIG grantees' reports at that time. States need a forum that allows staff at state Medicaid agencies in similar states to connect and share accurate, updated information about their programs, challenges they experienced in designing their programs, and how they overcame those challenges.

Looking Ahead

Bipartisan support for improving MBI for Workers with Disabilities programs is growing, and Democratic and Republican lawmakers have recently demonstrated renewed interest in addressing barriers to employment for people with disabilities. In July 2022, House Energy and Commerce Committee Ranking Member Cathy McMorris Rodgers (R-WA) released a memo requesting public comment on how Congress can improve the lives of those with disabilities.[72] In the memo, she described how Medicaid

provides services to people with disabilities that allow them to work and encouraged Congress to "reemphasize its commitment to reducing barriers to employment."[73] In February 2022, the Senate Health, Education, Labor, and Pensions Committee held a hearing on maximizing employment opportunities for people with disabilities where Sen. Tim Kaine (D-VA) discussed how restrictive eligibility requirements for MBI for Workers with Disabilities programs limit employment opportunities.[74]

The Biden administration has also demonstrated interest in addressing barriers to Medicaid enrollment, including barriers for people with disabilities. In September 2022, CMS released an NPRM to simplify the Medicaid application and renewal processes, including proposed changes that affect people eligible for MBI for Workers with Disabilities pathways.[75] President Biden also released Executive Order 14009 aimed at improving access to Medicaid, including HCBS for people with disabilities.[76] In addition, Biden released Executive Order 13985, which tasked federal agencies with identifying strategies to reduce barriers to employment for people with disabilities, including pay and compensation policies.[77]

Similar to the federal push, several states have made recent changes to improve employment opportunities for adults with disabilities. Between 2021 and 2022, around a dozen states modified cost-sharing or eligibility requirements, and a few created or are considering creating MBI for Workers with Disabilities programs. Some of these changes include:

- California became the 10th state to remove premiums for its MBI for Workers with Disabilities program.[78]
- Maryland has proposed changes to eliminate the income limit and add premium tiers up to 7.5% of monthly income for enrollees with incomes greater than 600% FPL. However, the state has not yet received federal approval for the proposed changes.[79]
- A bipartisan state bill, H.B. 664, would add workers ages 65 and older to Ohio's MBI for Workers with Disabilities program.
- New Jersey's governor signed a law removing income and resource limits, added workers 65 and older, and provided continuation of coverage for 12 months following a job loss for a participant on MBI for Workers with Disabilities pathways.[80]
- Hawaii recently adopted a MBI for Workers with Disabilities program, and BPC learned through interviews that at least two states are anecdotally considering creating MBI for Workers with Disabilities programs.[81]

When the COVID-19 public health emergency (PHE) is over, certain temporary policies that encouraged states to pause Medicaid eligibility redeterminations will end and some temporary policies that bolstered the program could end sometime in 2023. As of November 2022, HHS has extended the PHE through January 11, 2023.[82] The Families First Coronavirus Response Act temporarily

increased the Federal Medical Assistance Percentage (FMAP), or the rate at which the federal government matches state Medicaid spending, so long as states met certain requirements.[83] Among those requirements, states could receive an increased FMAP if they continued coverage for enrolled beneficiaries, including Medicaid beneficiaries eligible through MBI for Workers with Disabilities pathways.[84] States will resume Medicaid eligibility redeterminations, and federal matching rates will return to the previous lower amounts when the federal government ends the PHE.

Many health policy experts predict decreases in Medicaid enrollment after the COVID-19 PHE ends, and that forecast includes decreases in Medicaid enrollment among individuals qualifying for Medicaid through the MBI for Workers with Disabilities eligibility pathways.[85] In interviews with BPC, at least one state official noted that some Medicaid beneficiaries with disabilities are in incorrect Medicaid eligibility categories, which could result in additional disenrollment in Medicaid when states resume redeterminations post-PHE. Post-PHE changes to premiums and other cost-sharing charges could also reduce enrollment in MBI for Workers with Disabilities programs. Some states, such as Ohio, Wisconsin, and Wyoming, dropped premiums and other cost-sharing charges during the PHE,[86] and some state officials noted during interviews with BPC that they anticipate resuming these charges after the PHE. Premiums and other cost-sharing charges increase barriers to enrollment for people with disabilities.

Recommendations

I. Clarify Existing Options States Can Adopt When Designing Their MBI for Workers with Disabilities Programs

The following section includes recommendations for actions that Congress and CMS should take to inform states on the MBI for Workers with Disabilities eligibility groups and simplify states' implementation of programs covering those groups. These recommendations would allow states to better understand their options for incentivizing employment among individuals with disabilities who want to work and maintain the benefits offered only by Medicaid.

The recommendations focus on 1) releasing updated federal guidance to promote consistent information, 2) issuing an NPRM to codify and clarify the three eligibility groups, and 3) improving the SPA template that states use to adopt and modify their MBI for Workers with Disabilities programs.

A. Congress should direct CMS to issue agency guidance, no later than 12 months after legislation is enacted, identifying the full range of options available to states under current law for covering or modifying their coverage of the MBI for Workers with Disabilities eligibility groups.

States administering MBI for Workers with Disabilities programs use flexibilities under current law to implement and modify their state programs in several ways.[87] Under the BBA and the Ticket to Work Act, states can determine eligibility criteria and define certain program features for their MBI for Workers with Disabilities programs. States can use these flexibilities to align their MBI for Workers with Disabilities programs with their unique state budgets and HCBS policy frameworks. However, there is a lack of federal guidance detailing the options for states to cover or modify the MBI for Workers with Disabilities eligibility groups and which authorities states can use to adopt flexibilities.

States need more information and guidance from CMS to effectively implement MBI for Workers with Disabilities programs.[xi] CMS has released minimal guidance (only four guidance documents in the form of SMD letters from 1997 to 2000) to assist states with covering the MBI for Workers with Disabilities eligibility groups. The SMD letters primarily explained the eligibility groups and requirements as they existed at that time, but CMS has not released additional guidance in the past 22 years despite changes in the health care delivery landscape.[88,xii] Over the past several years, CMS has approved states' changes to MBI for Workers with Disabilities programs, which are not reflected in any formal guidance materials. Therefore, as MBI for Workers with Disabilities programs evolve to include more complex design features, many states report that existing CMS materials do not adequately support their implementation of MBI for Worker with Disabilities programs. Additionally, federal and state resources and institutional knowledge of the MBI for Workers with Disabilities eligibility groups dropped significantly when the MIG program ended in 2011.

With minimal federal resources and loss of institutional knowledge after the end of the MIG program, states experience challenges implementing or modifying MBI for Workers with Disabilities programs. Also, state policymakers are less inclined to improve their MBI for Workers with Disabilities programs due to competing priorities and insufficient federal guidance. Through interviews, BPC learned

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xi CMS can provide guidance through an NPRM, SMD letters, Informational Bulletins, and Frequently Asked Questions. Each type of guidance offers a different level of information and involves a different process. See Appendix C for information on the types of guidance.

xii See footnote ix.

that many states need more information on the scope of, and how to implement, authorities available to them for designing and modifying MBI for Workers with Disabilities programs. For example, some states, which initially implemented their programs for individuals with disabilities up to age 64, incorrectly believe they cannot increase the eligibility age for the MBI for Workers with Disabilities programs to workers ages 65 and older. However, CMS has approved states' requests to add workers ages 65 and older through layering authorities in the Ticket to Work Act and the BBA even though the agency has not issued guidance on this option.

To fill the guidance gap, Congress should direct CMS to issue updated agency guidance to better inform and help states understand the full range of options for covering the MBI for Workers with Disabilities eligibility groups.[xiii] After issuing the guidance, CMS should provide technical assistance on it and engage stakeholders for feedback on the need for any additional guidance.[xiv] Although CMS currently has the authority to issue guidance and provide technical assistance, Congress should make this a priority by directing CMS to issue updated guidance no later than 12 months after legislation is enacted.

Within this guidance, CMS should detail and clarify the range of options that states have under current law to design and modify their programs, such as the following:

- **Create and/or change premiums or other cost-sharing charges:** Under both existing authorities, states already have the option to set premiums and other cost-sharing charges on a sliding scale based on income. States determine premiums and cost-sharing charges, which must be within federal guidelines (see Appendix A).

  Federal guidance on creating premium and cost-sharing charge structures has been limited and creates uncertainty among states on whether a premium is required for the MBI for Workers with Disabilities eligibility groups.[89] For example, in January 2022, New Jersey passed a law removing age and income limits on its MBI for Workers with Disabilities program, NJ WorkAbility. However, BPC learned through a stakeholder interview and literature review that state Medicaid workers tasked with implementing the new state law are unclear how to interpret the federal statute and if it requires the state to charge a premium.[90] This uncertainty, partially caused by the

xiii Due to the limited existing guidance on MBI for Workers with Disabilities eligibility groups, CMS would likely need to release an SMD letter. CMS could also release an informational bulletin as an interim step to the SMD letter.

xiv When releasing guidance, CMS often coordinates with states to provide technical assistance and receive feedback from stakeholders on the need for additional guidance. For example, CMS often hosts office hours or stakeholder calls to support stakeholders adopting the new guidance.

absence of updated federal guidance, has delayed the state's changes to NJ WorkAbility.[91,xv]

This guidance is important because the existence and structure of a state's premium and cost-sharing charges affects state and federal resources; it also affects whether individuals with disabilities believe they can work and afford to make the premium or cost-sharing payments. For example, individuals with a disability, regardless of their desire to work, might not work if the premium or other cost-sharing charge becomes too expensive for them to pay at a certain income level. However, for some high earners who rely on Medicaid HCBS to supplement their private health insurance coverage, paying Medicaid premiums or other cost-sharing charges might still be more affordable than purchasing HCBS through the private market. Establishing premiums and cost-sharing for these high earners with disabilities also ensures that state and federal resources target those with lower incomes who cannot afford to make any premium or cost-sharing payments.

States can also use updated guidance to understand how to remove premiums or other cost-sharing charges. Some states reported in interviews with BPC that the administrative burden of collecting premiums is not cost-effective for MBI for Workers with Disabilities programs. They therefore want to remove these premiums to alleviate that burden. States should carefully weigh all the above factors to establish premium and cost-sharing charge structures that best meet their unique goals, and federal guidance on those flexibilities and how to implement them will be critical to that effort.

CMS should issue guidance clarifying premiums or other cost-sharing charge options. That guidance should describe how states can establish, modify, or remove premiums and other cost-sharing charges within the MACPro system, which is the web-based system states use to submit their SPAs to implement or modify their MBI for workers with disabilities programs. States should use CMS's guidance to thoughtfully consider how the structure of any premium or other cost-sharing charges will affect the affordability of coverage for beneficiaries across income levels. States should set appropriate income-based premiums or other cost-sharing charges to ensure that individuals with disabilities can work, increase their earnings, or afford any escalating share of Medicaid premiums or other cost-sharing charges.

xv During the October 27, 2022, Medical Assistance Advisory Council meeting, hosted by New Jersey's Department of Human Services, the department's presentation said, "Implementation is pending final decision points between CMS and New Jersey," and the meeting highlighted the importance of further CMS guidance to assist with this implementation.

- **Promote successful employment by modifying or removing restrictive eligibility requirements, such as age, income, and asset limits:** Restrictive eligibility requirements can reduce employment opportunities for people with disabilities. Individuals with disabilities want the option of working past the age of 64. However, some MBI for Workers with Disabilities programs do not allow individuals to work past age 64 and maintain access to Medicaid. Federal agencies and Congress have recognized the importance of increasing the age limits of other programs to meet the increase in life expectancy.[xvi] Medicaid support for workers with disabilities has not kept pace. Individuals with disabilities also want the option to advance professionally without risk of losing crucial health care services. However, some MBI for Workers with Disabilities programs do not allow individuals to receive salary increases and maintain eligibility for Medicaid.

  Using one or more existing authorities, states can modify the eligibility requirements for their MBI for Workers with Disabilities programs by, for example, increasing the eligibility age to include workers 65 and older, setting income and asset limits that are higher than traditional Medicaid limits, or raising expectations by setting no income or resource limits.

  - **Authority to modify age limits:** Although the Ticket to Work Act authority limits eligibility to individuals ages 16-64, the BBA allows states to expand MBI for Workers with Disabilities programs to individuals 65 and older.[xvii]

  - **Authority to modify or remove income and asset limits:** The Ticket to Work Act permits states to establish their own income and resource standards.[xviii] Utilizing Section 1902(r)(2) of the Social Security Act disregards, states can have no income and/or resource limitations.[92] At least eight states do not put limits on earnings and/or assets for MBI for Workers with Disabilities enrollees (see Appendix B).

  States can structure their eligibility requirements to enable more people with disabilities to work. In addition to expanding employment opportunities, less restrictive eligibility requirements (e.g., high income limits or none) allow more people with disabilities to increase their earnings and to access the health care services and supports they need, such as HCBS, to maintain employment. Less restrictive eligibility requirements can also raise expectations and enable people

xvi Beginning in 2000, the Social Security Administration began raising the full retirement age from 65 to 67.

xvii A state can increase the age eligibility limit above 64 years old by layering authorities under Section 4733 of the BBA and Section 1902(r)(2) of the Social Security Act.

xviii The BBA permits state Medicaid programs to cover working individuals with incomes less than 250% of the FPL who, except for earned income, would be eligible to receive SSI benefits.

with disabilities to accrue savings and advance professionally without the risk of losing benefits. States can further support employment for people with disabilities by including a grace period that allows them to continue receiving coverage and access to services if an illness interrupts employment.

BPC learned through interviews with state Medicaid agencies that the lack of federal guidance causes confusion on what authorities states can use to modify eligibility requirements for their MBI for Workers with Disabilities programs. For example, some states are unsure how they can use a SPA to increase the eligibility age for the program to include workers 65 and older. Similarly, some states are unclear whether they can include a grace period that allows continuing coverage during an interruption in employment—even when they learn that other states have this policy. This uncertainty can stall or prevent changes to eligibility requirements, limiting the ability of states to optimize their MBI for Workers with Disabilities programs.

CMS should issue guidance outlining the options states have to design eligibility requirements under the BBA and the Ticket to Work Act. This clarification should clearly indicate states' options to reduce barriers for older workers and set higher expectations for employment and earnings. This clarification should also indicate the authorities to modify restrictive age limits and modify or remove income and/or asset limits. Guidance should further clarify states' options to include a grace period that allows continuing coverage when employment is interrupted. And CMS should provide technical assistance to help states assess or modify their requirements through submission of a SPA via the MACPro system.

- **Consider flexibilities for counting income and assets, such as retirement funds or spousal income and assets:** States have the flexibility to determine what is included when counting an individual's income and assets for the purpose of a Medicaid eligibility determination. Income and asset calculations determine whether an individual is eligible for a MBI for Workers with Disabilities eligibility group and if/how they can increase earnings and assets while maintaining eligibility.

  States can set more restrictive income and asset methodologies for eligibility by including retirement funds or spousal income or assets. This may create a barrier to individuals with disabilities achieving their employment potential. BPC learned in interviews with beneficiaries enrolled in MBI for Workers with Disabilities programs that when states include retirement savings and funds, enrollees risk disqualification from and access to Medicaid if they save above a certain amount for retirement. This not only might disincentivize

saving for retirement, but it also risks increasing an individual's reliance on social benefit programs and raising state and federal government costs. Similarly, these interviews revealed that when a state includes spousal income and assets in determining eligibility for its MBI for Workers with Disabilities program, people with disabilities can face barriers to marriage because the addition of their spouses' income and assets might disqualify them for the program. When states include spousal income and assets, the spouses of people receiving benefits from MBI for Workers with Disabilities programs might not accept career advancement or raises because their higher salaries could affect their spouse's access to benefits that only Medicaid offers.

No federal guidance currently exists explaining states' options for modifying income and asset-counting methodologies for MBI for Workers with Disabilities eligibility groups. BPC's interviews revealed that this creates confusion for some state decision-makers and people with disabilities who want to achieve their employment potential and have more choices with regards to their families. For example, a state policy expert told BPC that CMS historically prohibited states from excluding individuals' retirement accounts accrued during enrollment in MBI for Workers with Disabilities programs when counting assets following retirement. With this practice, people enrolled in MBI for Workers with Disabilities programs would lose Medicaid eligibility after retirement because of the money they accrued in their retirement accounts. But, more recently, CMS has changed its practices. State stakeholders said in interviews with BPC that CMS has approved amendments for states to exclude retirement accounts accrued during enrollment in MBI for Workers with Disabilities programs for the purpose of determining Medicaid eligibility post-retirement. However, CMS has issued no written guidance detailing its change in counting retirement funds.

Similarly, some state officials explained in interviews that they are unsure of their options to count spousal income and assets because there is no federal guidance on the topic. For example, at least one state Medicaid agency was unsure if it had the authority to keep its spousal asset limit for the point of initial enrollment but eliminate the spousal asset limit once an individual participates in the MBI for Workers with Disabilities program. Although the state Medicaid agency ultimately received clarification from CMS that states could not apply different standards for counting spousal income, state and federal resources could be better utilized if CMS released explicit guidance clarifying options for counting spousal assets.

CMS should issue guidance to help states understand their flexibilities for counting income and assets, including retirement funds and income from earnings as well as spousal income and assets. This guidance

should outline the flexibilities and explain how states can implement these flexibilities (e.g., submitting SPAs within the MACPro system to revise their criteria). While developing the guidance CMS should engage stakeholders, particularly state Medicaid agency staff in states that disregard income and assets, to ensure the guidance does not unintentionally harm or disenfranchise existing state practices aimed at maximizing opportunities for beneficiaries to earn and retain assets. This guidance should detail historical changes in related CMS policies, such as changes that allow states to exclude individuals' retirement accounts accrued during enrollment in MBI for Workers with Disabilities programs following retirement or during enrollment in the program.

B. Congress should direct CMS to issue an NPRM to codify the MBI for Workers with Disabilities eligibility groups in regulation and clarify that the eligibility group names are as identified within the MACPro system used by state Medicaid agencies (i.e., Work Incentives group, Ticket to Work Basic group, and Ticket to Work Medical Improvements group). Congress should direct CMS to issue the NPRM following stakeholder engagement and no later than 18 months after legislation is enacted.

CMS typically uses formal rulemaking to codify Medicaid eligibility groups in federal regulation, but it has not done so for the MBI For Workers with Disabilities eligibility groups. Although CMS released agency guidance between 1997 and 2000, it has not released a formal rule related to the MBI for Workers with Disabilities eligibility groups. The rule process, which typically begins with an NPRM, allows federal agencies to announce their plans to address a problem or accomplish a goal.[93] To ensure agencies' rules consider stakeholders' input, the formal rulemaking process also solicits public comment on the proposed rules.

Congress should direct CMS to issue an NPRM and begin the formal rulemaking process for the MBI for Workers with Disabilities eligibility groups. Establishing or optimizing MBI for Workers with Disabilities programs is a complex process and requires interagency coordination at the state and federal level. Absent formal federal guidance, policymakers, advocates, and people with disabilities have expressed confusion about options for designing states' MBI for Workers with Disabilities programs. CMS has historically intended to engage in formal rulemaking and codify the groups in regulation but has not done so because of competing priorities. Although CMS has the authority to release an NPRM, Congress should direct CMS to issue the NPRM no later than 18 months after legislation is enacted to ensure that CMS elevates it to an agency priority.

The rulemaking process would solicit input from stakeholders, including state officials, on how to address existing problems

within the states' MBI for Workers with Disabilities programs; this would allow CMS to specify the pathways that states can utilize to reduce barriers to employment for people with disabilities. Because people with disabilities who want to work have historically been active advocates of policies that advance the MBI for Workers with Disabilities eligibility groups, it is crucial for CMS to consider beneficiaries' experiences and perspectives while issuing final rules.

Timeline for the NPRM: This recommendation is designed to work in tandem with BPC's recommendation for CMS to provide guidance on the MBI for Workers with Disabilities eligibility groups (see Recommendation I.A.). Because of the urgent need for states to fully understand authorities related to MBI for Workers with Disabilities eligibility groups, this report urges CMS to provide formal guidance to immediately address gaps in existing guidance. Specifically, this report suggests Congress direct CMS to provide guidance no later than 12 months after legislation is enacted. However, to support the long-term improvement of MBI for Workers with Disabilities programs, BPC also recommends that Congress direct CMS to issue an NPRM no later than 18 months after legislation is enacted. BPC recommends that Congress direct CMS to issue the guidance and an NPRM in this order because the rulemaking process requires more resources and time than agency guidance.

CMS should act urgently on both recommendations sequentially. As previously discussed, CMS will resume typical Medicaid redetermination processes after the COVID-19 PHE ends (see Looking Ahead). Although CMS released an NPRM in 2022 to simplify the processes for individuals to enroll and retain eligibility in Medicaid, the Children's Health Insurance Program, and the Basic Health Program, people with disabilities encounter additional barriers with Medicaid enrollment that are not addressed in the existing NPRM.[94] To ensure individuals with disabilities who want to work have access to community-based Medicaid services and supports through MBI for Workers with Disabilities programs, it is essential to have updated guidance and regulations in place after the PHE ends.

Contents of the NPRM: BPC recommends Congress direct CMS to issue an NPRM codifying and clarifying the MBI for Workers with Disabilities eligibility groups. While this report highlights some content CMS should include in the NPRM, the agency should also engage stakeholders, including input from states and people with disabilities, to refine the scope of the NPRM. With this recommendation, states should maintain the flexibility to combine aspects of the BBA, the Ticket to Work Act, and Section 1902(r)(2) of the Social Security Act. Specifically, this NPRM should:

- **Codify Eligibility Groups:** As previously discussed, CMS has not codified the three MBI for Workers with Disabilities eligibility groups, and some state Medicaid agencies and federal policy experts explained in interviews with BPC that this creates confusion. Many states do not understand how the three eligibility groups are distinct and can interact with one another. This uncertainty makes it challenging for states to understand the options available to cover or modify their coverage of these eligibility groups and ultimately hinders states' implementation of MBI for Workers with Disabilities programs. Without eligibility group rules or formal guidance, states might make policy or operational mistakes that increase administrative burdens and delay or block federal approval of the programs.

- **Clarify Eligibility Groups:** Nationally, the descriptor "Medicaid Buy-In" has been an identifier for the MBI for Workers with Disabilities eligibility groups for more than 20 years, and many states have created state-specific names for their programs. The national descriptor originated in Section 201 of the Ticket to Work Act, which identifies the eligibility groups as "Medicaid Buy-In." However, CMS has not widely adopted this name and has used a variety of names to refer to the MBI for Workers with Disabilities eligibility groups.[xix] When creating a state-specific program name, states often choose a name that separates the MBI for Workers with Disabilities eligibility groups from lower-income eligibility groups and highlights the beneficiary's working status. For example, New Jersey and Arizona respectively call their programs WorkAbility and Freedom to Work Program.[95] Some states and advocates said during interviews with BPC that naming the state's MBI for Workers with Disabilities program to highlight coverage of those eligibility groups as an employment initiative has helped to build bipartisan support for the programs.

  Although this report does not make recommendations related to state-specific program names, it does recommend that CMS rename the nationally used descriptor to reduce confusion among states and people with disabilities. Through interviews with state policymakers and federal policy experts, BPC learned that "Medicaid Buy-In" is too broad of a descriptor and does not accurately describe some states' implementation of their programs. For example, the description "Medicaid Buy-In" can be confusing for people with disabilities who might have lower incomes and not qualify for the eligibility groups, while some workers with

xix CMS did not refer to the program as "Medicaid Buy-In" in any of the four SMD letters it released from 1997 to 2000.

disabilities enrolled in the eligibility groups do not pay premiums or other cost-sharing charges. This confusion has increased as health policy stakeholders have applied "Medicaid Buy-In" more broadly across the Medicaid program in recent years. For instance, the label "Medicaid Buy-In" can also refer to the more recently established Medicaid expansion group for individuals without disabilities who pay premiums to buy into Medicaid in some states. Some policy experts explained that stakeholders can confuse the Medicaid Buy-In with Medicare Buy-In, a separate group.

In interviews with state Medicaid agencies and policymakers, BPC learned that the descriptor "Medicaid Buy-In" creates confusion among some state policymakers and Medicaid staff. "Medicaid Buy-In" does not align with language in the MACPro system. The MACPro system, similar to the SMD letters, does not refer to the eligibility group as "Medicaid Buy-In."[96] Instead, the MACPro system uses three identifiers for these eligibility groups: Work Incentives group, Ticket to Work Basic group, and Ticket to Work Medical Improvements group. Use of the descriptor "Medicaid Buy-In" causes some states to conclude that they must require a premium with their MBI for Workers with Disabilities programs. As previously discussed, states have the option to impose premiums or other cost-sharing charges, but it is not required by federal law or regulation.[xx]

To assist states and people with disabilities, the NPRM should provide information on and clarify Medicaid benefits for workers with disabilities. To assist states and other stakeholders, the NPRM should also clarify the MACPro identifiers for the eligibility group(s) when discussing Medicaid benefits provided to workers with disabilities: Work Incentives group, Ticket to Work Basic group, and Ticket to Work Medical Improvements group. The alignment of CMS's language and the MACPro system would simplify the SPA process for those implementing or amending MBI for Workers with Disabilities programs. This clarification would also help people with disabilities and advocates understand the different eligibility categories and differentiate Medicaid benefits provided to workers with disabilities from other Medicaid eligibility groups.

C. CMS should improve the SPA template that states use to establish or amend their MBI for Workers with Disabilities programs. The revised SPA template should make it easier for states to understand their options to adopt program flexibilities allowed under current law.

xx As of October 2022, at least 10 states do not charge a premium or other cost-sharing to its members: Arkansas, California, Hawaii, Louisiana, New Jersey, New Mexico, New York, South Dakota, Vermont, and Virginia.

BPC found through interviews with state Medicaid agencies that the current template that CMS suggests states use to establish or amend their MBI for Workers with Disabilities programs in CMS's MACPro system creates confusion among states. The template (see Figure 4) lists the three MBI for Workers with Disabilities eligibility groups and asks states to indicate which eligibility group(s) they cover. The template does not include descriptions of the three eligibility groups or statutory citations associated with the eligibility groups. Without this information, and with no description of the eligibility group names in regulation, some state Medicaid agency staff members told BPC that the template is unclear and that state policymakers need more clarification on how the three eligibility groups are distinct from and interact with one another.

Figure 4: Screenshot of the SPA Template in CMS's MACPro system

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for Cash Except for Institutionalization		☐	☐	○	NEW
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☐	☐	○	NEW
Optional State Supplement Beneficiaries		☐	☐	○	NEW
Individuals in Institutions Eligible under a Special Income Level		☐	☐	○	NEW
PACE Participants		☐	☐	○	NEW
Individuals Receiving Hospice		☐	☐	○	NEW
Children under Age 19 with a Disability		☐	☐	○	NEW
Age and Disability-Related Poverty Level		☐	☐	○	NEW
Work Incentives		☐	—	○	NEW
Ticket to Work Basic		☐	☐	○	NEW
Ticket to Work Medical Improvements		☐	☐	○	NEW
Family Opportunity Act Children with a Disability		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services		☐	☐	○	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers		☐	☐	○	NEW

☐ MBI for Workers with Disabilities eligibility groups

Source: CMS's MACPro system

To clearly outline states' options for their MBI for Workers with Disabilities programs, CMS should revise the SPA template to include explanations of the three eligibility groups and related statutory citations. For example, the SPA template should define the Basic Coverage group, including opportunities for states to modify eligibility requirements within this group, and provide statutory citation to the Ticket to Work Act. By clearly describing the optional eligible groups associated with MBI for Workers with Disabilities pathways, states can more easily modify or expand their programs.

II. Strengthen Outreach, Data, and Interagency Coordination

To ensure people with disabilities are aware of and understand their opportunities for employment, these recommendations aim to address existing gaps in outreach and education among potential enrollees in MBI for Workers with Disabilities programs. To assist states in these efforts, the recommendations bolster states' understanding and implementation of MBI for Workers with Disabilities programs.

These recommendations focus on 1) creating a national technical assistance center to address states' questions and promote state-to-state learning on promising state practices, 2) enhancing collaboration between CMS, the Social Security Administration, and other federal agencies, and 3) establishing a grant program to support states' implementation or optimization of MBI for Workers with Disabilities programs and monitor the effects of this grant program through an independent evaluation.

A. Congress should authorize and appropriate $5 million per year, over five years, in resources to CMS to establish a national technical assistance center. The center should support states that seek to adopt or optimize their MBI for Workers with Disabilities programs by providing technical resources, including education on promising state practices and data on MBI for Workers with Disabilities programs. CMS should manage the technical assistance center, provide ongoing program support to states, and collaborate with the Social Security Administration and other federal agencies to improve outreach to beneficiaries and benefits counseling.

Some state officials said in interviews with BPC that they encounter challenges in implementing MBI for Workers with Disabilities programs and attributed this partially to limited technical assistance and support from the federal government.

The MIG program expired in 2011.[xxi] Since the program's expiration, CMS lacks the resources and staffing needed to provide technical assistance to states on MBI for Workers with Disabilities eligibility groups.

In interviews with BPC, many state officials noted they would benefit from federal technical assistance tools and state-to-state learning opportunities, which could include templates for customizing the design of the program, webinars, and/or one-on-one assistance. Without federal technical assistance, states have inadequate resources for understanding how to implement and optimize their MBI for Workers with Disabilities programs; ultimately, this harms employment opportunities for people with disabilities.

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xxi The MIG program provided states and territories funding to enhance services and supports for workers with disabilities. See Recommendation II.C. for additional information on the MIG program.

States and federal policymakers have limited data to evaluate MBI for Workers with Disabilities programs. BPC could not locate recent federal data on MBI for Workers with Disabilities programs, including enrollment data or aggregated eligibility requirement information (e.g., income limits by state). BPC also could not locate any federal data on MBI for Workers with Disabilities programs disaggregated by race, ethnicity, disability, and gender. States, in interviews with BPC, said they also could not locate this data. Without this data, states and federal policymakers cannot effectively monitor trends or changes to MBI for Worker with Disabilities programs. The information can help states understand how their MBI for Workers with Disabilities programs compare with other state's programs, and can highlight the issues for which technical assistance would be most valuable. Similarly, this data can help federal policymakers and states model the effects of proposed policy changes to MBI for Workers with Disabilities programs and identify disparities in access across these enrollment groups.

Congress should authorize and appropriate $5 million per year, over five years, to CMS to establish a national technical assistance center. This amount is based on Congress's funding for technical assistance and oversight for the Money Follows the Person Demonstration.[97] Funding for the national technical assistance center should be for five years to ensure that states have enough time to effectively use the center's resources to plan and implement program changes. To improve cross-agency education and engagement in MBI for Workers with Disabilities programs, CMS should collaborate with other federal agencies involved with the MBI for Workers with Disabilities eligibility groups; CMS should also design state technical assistance and distribute resources educating federal staff on MBI for Workers with Disabilities programs.[xxii] To mitigate challenges associated with a five-year initial funding limit, CMS should dedicate staff to assist states with implementing MBI for Workers with Disabilities programs once the technical assistance center sunsets. Specifically, to continue this technical assistance, CMS should dedicate full-time program staff within its department responsible for providing support to states and their HCBS programs and policy.

The technical assistance center should publish additional state-specific tools. The resources that CMS produces through the technical assistance center should be informed by and responsive to the needs of Medicaid beneficiaries, states, and other stakeholders, including consumer advocacy groups. As part of this effort, CMS should identify promising state practices for optimizing MBI for Workers

xxii CMS should engage federal agencies that provide support to people with disabilities, including the Social Security Administration, ACL, the Equal Employment Opportunity Commission, and the U.S. Access Board.

with Disabilities programs and release a toolkit describing those practices—examples of how different states have designed their programs—and key considerations for states interested in adopting or modifying their programs. CMS has experience producing similar toolkits to accelerate states' efforts to optimize specific program areas; for example, CMS released the LTSS Rebalancing Toolkit in November 2020.[98] CMS should also develop a Frequently Asked Questions guide for states. CMS provides a similar suite of these resources through its other technical assistance centers, such as the Medicaid and CHIP Learning Collaboratives.[99]

CMS's technical assistance to states should highlight how certain states have removed the age limits for participation and lifted some or all income and asset limits. To determine additional topics for these tools, CMS should engage state agencies to learn what information and guidance states need.

Through the technical assistance center, CMS should promote state-to-state learning. These opportunities could include running a CMS-sponsored webinar series that highlights program designs across states and organizing conferences similar to the MIG conferences.[xxiii] CMS could also create a state-to-state program that matches MBI for Workers with Disabilities-focused staff in one state with staff in different states to share promising practices and lessons learned.[xxiv] See Appendix D for examples of promising state practices that the technical assistance center could build on.

To lessen the data gap, CMS should also use the technical assistance center to collect data on MBI for Workers with Disabilities programs and make this information publicly available to states and other stakeholders. CMS should collect and publish this data disaggregated by race, ethnicity, disability, and gender. Through its other technical assistance centers, CMS often collects and releases data to inform stakeholders of the magnitude of its programs and the trends related to them. For example, CMS releases enrollment reports for its Medicaid managed care entities.[100] Collecting and publicly releasing this type of data elevates the group's priority status and is an important step for future evaluations of MBI for Workers with Disabilities programs.

xxiii Throughout the MIG program, CMS hosted annual conferences in a state that received MIG funding. The last conference was held in 2011 in Denver.

xxiv This state-to-state learning resembles regional partnerships some MIG grantees formed to forge collaboration among states. For example, grantees on the East Coast created a New England Partnership, which met quarterly to discuss implementation of their MBI for Workers with Disabilities programs.

B. CMS and the Social Security Administration should collaborate on annual updates to materials detailing work incentives, including the Social Security Administration's Red Book; the updates should include accurate and more detailed information on the MBI for Workers with Disabilities programs and every state that offers the program.

The Social Security Administration publishes materials, including information about MBI for Workers with Disabilities programs, detailing work incentive programs. These materials are crucial resources for people with disabilities who receive Social Security benefits and want to work. The information also helps guide people with disabilities through the system. For example, the Red Book is a reference tool detailing work incentives to support people with disabilities under Social Security Disability Insurance (SSDI) and Social Security Insurance programs. Individuals with disabilities and people who support them use this book to learn about eligibility groups and states' programs, including eligibility criteria and contact information to receive additional information.

The most recent Red Book, published in 2020, has minimal information on MBI for Workers with Disabilities programs. The 2020 Red Book explains that some states "may allow [people] with disabilities to buy Medicaid if [they] are disabled and no longer entitled to free Medicaid because [they] returned to work."[101] The 2020 Red Book also describes eligibility criteria as: 1) meets the definition of "disabled" under the Social Security Act, and 2) would be eligible for SSI if it were not for their earnings. This information is insufficient, considering variations in eligibility requirements among states' MBI for Workers with Disabilities programs. Additionally, the Red Book does not provide streamlined state Medicaid agency contact information for people who want to learn more about the MBI for Workers with Disabilities programs.

CMS should work with the Social Security Administration to improve and continuously update the information on MBI for Workers with Disabilities programs. For example, CMS can provide to the Social Security Administration a list of states offering MBI for Workers with Disabilities programs and detailing the eligibility groups associated with each state's program. The Social Security Administration can then include this information in the Red Book. This information would better inform people with disabilities and frontline state staff assisting people with disabilities. Additionally, CMS should collaborate with the Social Security Administration to update the Red Book's contact information to provide Medicaid office contact information instead of contact information for Medicare, as the Red Book currently provides.[xxv]

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xxv Medicare does not oversee implementation of MBI for Workers with Disabilities programs.

C. Congress should establish an eight-year grant program that builds on lessons learned from the MIG program, and that authorizes and appropriates $260 million over eight years to CMS. CMS should annually award up to 56 states or territories amounts that gradually reduce in the final three years of the program: up to $4 million per awardee in years 1-5, and up to $1 million per awardee in year 8. These grants should provide funding to states or territories to build or improve infrastructure to:

1. **Enhance outreach, interagency coordination, and benefits counseling to educate consumers about the opportunity to continue working while receiving Medicaid benefits, including HCBS, through the MBI for Workers with Disabilities eligibility pathways;**
2. **Conduct data collection, analysis, and research; and/or**
3. **Establish or improve MBI for Workers with Disabilities programs.**

In the program's final three years, awardees must use the funds more narrowly to support consumer outreach and benefits counseling.

Congress should also appropriate $3 million in resources to CMS for procuring an independent contractor to evaluate the grant program, and CMS should submit a Report to Congress describing the evaluation.

When Section 203 of the Ticket to Work Act established the MIG program, HHS awarded $450 million in MIG funding to almost all states, the District of Columbia, and the U.S. Virgin Islands from 2001 through 2011. To receive a full grant, states needed to include a MBI for Workers with Disabilities eligibility group within their Medicaid program and make PAS available statewide. Grantees in the planning stage of implementing MBI for Workers with Disabilities programs received partial awards.

States could use these grants to enhance their infrastructure to expand services and supports for workers with disabilities. These grants did not fund Medicaid services; instead, the grants helped states implement, develop, and strengthen MBI for Workers with Disabilities programs as well as support states' efforts to promote employment across agencies. These activities included increasing the availability of PAS for workers with disabilities; forming connections between other state and local agencies providing employment-related supports; and creating infrastructure that maximizes the employment potential of individuals with disabilities.[102] The Ticket to Work Act also dedicated

funding for a national evaluation of MBI for Workers with Disabilities programs and technical assistance through the MIG program.

Research evaluating the MIG program's effects demonstrates the program increased enrollment in MBI for Workers with Disabilities programs and improved states' infrastructure to promote employment among people with disabilities. MIG funding accelerated employment opportunities for workers with disabilities. Between 2001 and 2011, the number of individuals receiving benefits from MBI for workers with disabilities pathways increased from 27,000 to almost 200,000.[103] Many states used MIG funding for policy and programmatic changes, such as in-state funding activities, to maintain a MBI for Workers with Disabilities program.[104]

Since MIG funding ended, states said in interviews with BPC, they do not have the resources to conduct adequate consumer outreach and education for people with disabilities for these eligibility groups. Without sufficient consumer outreach and education, many individuals eligible for Medicaid through MBI for Workers with Disabilities pathways receive their information about the program through informal networks. States BPC spoke with indicated a desire to improve their consumer outreach and education for their MBI for Workers with Disabilities programs, but noted they need increased funding to do so.

Between the competing demands of the COVID-19 PHE and the pending PHE unwind, states noted not having adequate infrastructure to make data-driven policy decisions on whether policy or operational actions would be permissible. Through interviews and a private roundtable, BPC learned that many states do not have the data or information to predict the consequences of policy changes or analyze the interface of the group(s) within the larger Medicaid program. Additionally, many states BPC interviewed expressed a desire to improve their MBI for Workers with Disabilities programs but said they do not have enough staff or resources to gather the necessary information to evaluate and implement these improvements. For example, some states are interested in learning about the potential changes in enrollment from increasing the age above 64 years old but do not have the data or staff to predict the outcomes of this policy change.

Therefore, to enable states to optimize and sustain MBI for Workers with Disabilities programs, particularly with the anticipated end of the PHE, Congress should create an eight-year grant program to help the states strengthen their state-level infrastructure. To qualify for an award, states and territories must submit a sustainability plan outlining how the state or territory would maintain program activities, such as consumer outreach and benefits counseling, following the

end of the grant program. Also, grantees must agree to maintaining eligibility for the MBI for Workers with Disabilities population throughout the grant program. After the eight-year grant program, Congress should evaluate the need to extend that program based on the Report to Congress.

Specifically, Congress should authorize and appropriate $260 million over eight years to CMS to establish the grant program and award up to 56 states and territories amounts that gradually reduce in the final three years of the program.[xxvi] CMS should determine the amount of funding for each grantee based on the number of people enrolled or projected to enroll within the state or territory's MBI for Workers with Disabilities program. Over the first five years of the grant program, CMS should award grantees a minimum of $800,000 and a maximum of $4 million per fiscal year. To help states implement sustainability plans throughout the grant program and mitigate challenges following the grant's sunset, CMS should gradually reduce the amount awarded to grantees. In the sixth, seventh, and eighth years of the program, CMS should annually award grantees a minimum of $600,000, $400,000, and $200,000. During these final three years, CMS should annually award grantees a maximum of $3 million, $2 million, and $1 million.

To improve employment opportunities for people with disabilities nationally, CMS should prioritize funding to state applicants that currently do not offer MBI for Workers with Disabilities programs but seek to add the eligibility group(s). Funds under this grant should remain available in succeeding years for the HHS secretary to award to states or territories. The funding structure and grantee requirements of this proposed grant program resemble the MIG program and adjusts for inflation between when CMS awarded MIG funding and 2022.[xxvii]

Under the proposed grant, grantees could use the funding to build or improve state-level infrastructure to:[xxviii]

- **Enhance outreach, interagency coordination, and benefits counseling to educate consumers about the opportunity to continue working while receiving Medicaid benefits, including HCBS, through MBI for Workers with Disabilities eligibility pathways:** States should be permitted to use the grant funding to improve consumer outreach, strengthen collaboration between

xxvi Congress should allow CMS to award the grant to up to 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Commonwealth of the Northern Mariana Islands.

xxvii To estimate a maximum award, BPC analyzed maximum MIG awards between 2001 and 2011 and calculated the average annual maximum MIG between 2001 and 2008. BPC calculated the average between 2001 and 2008 because this eight-year funding structure is most similar to BPC's proposed funding structure.

xxviii No grant funding should be awarded or used to support programmatic changes that have an adverse impact on employment for workers with disabilities or enrollment in MBI for Workers with Disabilities eligibility groups.

state agencies that have a relationship with MBI for Workers with Disabilities programs—such as state Medicaid agencies and Social Security offices—and increase benefits counseling or other consumer education efforts. States should be able to use the funding to hire benefits counselors or similar specialists and to develop training standards or programs to ensure dissemination of accurate and clear program information. Through the grant application process, CMS should encourage states to submit detailed plans for interagency coordination and stakeholder engagement. In addition, states should gather information on beneficiary experiences with the frontline specialist to better inform policy and programmatic decisions.

- **Conduct data collection, analysis, and research on MBI for Workers with Disabilities programs:** The grant program should provide resources to states to strengthen their information-gathering, data analysis, and research efforts specific to MBI for Workers with Disabilities programs. States' activities should include implementation of data management systems, research on the impact of program changes on enrollment, and analysis evaluating costs and savings to the states with potential program changes. Grantees should be permitted to utilize grant resources for the development or enhancement of IT systems where needed. State-level data and research should feed into the evaluation of the federal program to strengthen MBI for Workers with Disabilities programs nationally. Through the grant application process, CMS should give priority to states that focus on health equity within data collection, analysis, and research.

- **Establish or improve implementation of MBI for Workers with Disabilities programs:** The grant program should allow state Medicaid agencies to use funding to hire staff responsible for administering and overseeing MBI for Workers with Disabilities programs, enhance states' infrastructures, including reducing barriers to enrollment, and implement policies to improve employment outcomes for individuals with disabilities. This would help address gaps in states' institutional knowledge of MBI for Workers with Disabilities programs.

Federal policymakers should consider lessons learned from MIG funding when developing this grant program. State and federal stakeholders reported in interviews with BPC that MIG funding and technical assistance resources were essential for grantees as they developed and promoted MBI for Workers with Disabilities programs. However, some federal stakeholders said that grantees might have had too much flexibility in the use of MIG funding. In response, BPC's proposed grant limits the scope of awardees' activities.

Evaluation: As required for the MIG program, Congress should require CMS to procure an independent contractor to evaluate the grant program, and lawmakers should appropriate $3 million for the task. The $3 million considers the amounts of previous evaluation contracts granted from CMS, such as annual funding from Congress to CMS for evaluation and a Report to Congress on the Money Follows the Person program.[105] This amount also considers estimated costs for an additional full-time employee to monitor the contractor's work.[106]

The contractor should conduct periodic evaluations of the qualitative and quantitative effects of the grant program. Congress should require CMS to submit the findings in a Report to Congress. A consumer advisory panel should provide input on the design of the evaluation. In addition to the criteria identified by the advisory panel, the independent contractor should evaluate how states spent the grant funds, states' policy decisions (e.g., increasing the age limit to include ages 65 years and older) and related consequences (e.g., impacts on state spending, savings, and enrollment), and to the effects on quality of life for people enrolled in MBI for Workers with Disabilities programs. The evaluation should also include enrollment and outcomes data disaggregated by race, ethnicity, disability, and gender, as well as examine the ongoing need for Congress to appropriate funding at the end of the eight years.

To support the evaluation, grantees should be required to administer a quality-of-life survey and submit the results on a regular basis and within an annual report to CMS. Using the Quality of Life Scale or something similar, the survey should query people who begin receiving benefits from MBI for Workers with Disabilities programs immediately before enrollment in the program and then and each year after.[107] This requirement is based on the Money Follows the Person demonstration evaluation and ensures that the contractor has qualitative, quality-of-life data to conduct the effectiveness review.[108] This requirement would help the evaluation capture the experiences of people receiving benefits from MBI for Workers with Disabilities programs. In addition to the quality-of-life survey, grantees should be required to submit annual reports to CMS. Within these reports, grantees should describe their ongoing need to receive funding in future years and information on the grantees' progress toward their sustainability plans. The HHS secretary should determine additional content and structure of these annual reports.

The design of this evaluation considers lessons learned from the MBI for Workers with Disabilities evaluation included in the MIG program. In interviews with BPC, some federal, state, and advocacy stakeholders said that the MIG evaluation failed to comprehensively evaluate the outcomes of MBI for Workers with Disabilities programs. For example, the evaluation did not include key qualitative measures, including quality of life, employment and earnings outcomes, and health equity for individuals receiving benefits from MBI for Workers with Disabilities programs.

Personal Experience #3:

BRITTANIE, MINNESOTA

Brittanie is 35, lives in Minnesota, and began receiving Social Security benefits at an early age following a diagnosis of arthrogryposis multiplex congenita (AMC). As an adult, she started receiving Medicaid and Medicare Parts A and B benefits. As a dually eligible beneficiary, Brittanie relies on Medicaid to cover her Medicare premiums and cost-sharing charges. She began working part-time jobs at call centers but feared that working more would result in the loss of those important benefits. Three years ago, that fear came true: While Brittanie was working, she received a letter from the federal government indicating she would have to start paying about $600 per month for Medicare Part A because of her income. Brittanie felt scared and frustrated, because she could not afford that monthly premium payment and had to choose between continuing to work and losing critical services, or not working and maintaining those services.

Fortunately, through the MN Disability Hub hotline, Brittanie learned about Minnesota's MBI for Workers with Disabilities program, which Minnesota calls Medical Assistance for Employed Persons with Disabilities (MA-EPD). The hotline connected Brittanie with professionals who used plain language to discuss the program and answer her questions.

Brittanie found this assistance incredibly helpful and successfully enrolled in Minnesota's MA-EPD. Because of the program, Brittanie can work while maintaining Medicaid services that allow her to continue living independently. Brittanie receives personal care assistance services, a bus card, and modifications such as a self-rising desk for work and van modifications. MA-EPD has no individual monthly earned income limit and a $20,000 asset limit.[109] She appreciates that Minnesota's MA-EPD program allows her to marry and not have her spouse's income count toward her eligibility. However, Brittanie cannot move to the state where her spouse resides, because Brittanie would lose services through the move and would have to join a long wait-list to receive those services in the new state.

Brittanie would like the system to be less challenging for individuals with disabilities to navigate and believes language describing the program should be clearer. She says it is inequitable for policy to limit the employment potential of individuals with disabilities. After personally experiencing these challenges, Brittanie wants to be the representation that others need and considers herself a part of the first generation of benefactors from the ADA.

Conclusion

MBI for Workers with Disabilities programs play a critical role in removing barriers to employment for individuals with disabilities and have positive impacts for state Medicaid agencies, employers, and state and federal governments. To improve access to MBI for Workers with Disabilities programs, federal policymakers and CMS should advance federal policy reforms that will clarify and codify the MBI for Workers with Disabilities eligibility groups and strengthen outreach, data, and interagency coordination. These reforms will allow more Medicaid beneficiaries with disabilities to take advantage of employment opportunities while retaining the services they need to live independently in the community and work.

Appendices

APPENDIX A: SUMMARY OF FEDERAL AUTHORITIES RELATED TO MBI FOR ADULT WORKERS WITH DISABILITIES

Authority	Group	Eligibility Description	Income Standards	Premium Structure
Balanced Budget Act of 1997, Section 4733	Work Incentives	Blind or disabled individuals who (1) have earned income; (2) are in families whose incomes are less than 250% of the FPL ($33,975 for an individual in 2022); and (3) who would, but for their earnings, be considered to be receiving SSI.	Family income must be below 250% of the FPL ($33,975 for an individual in 2022).	States may require individuals to pay premiums or other cost-sharing charges set on a sliding scale based on income. The amount of any premium or cost-sharing is entirely within the state's discretion. Federal law does not require a premium or cost-sharing charge for beneficiaries covered under this authority.
Ticket to Work and Work Incentives Improvement Act of 1999, Section 201	Ticket to Work Basic	Blind or disabled individuals who (1) are ages 16 to 64; (2) who have earned income; and (3) who would, but for their earnings, be considered to be receiving SSI.	There are no federal income or resource standards for this group. States can determine income and resource standards, including no standards.	States may require individuals to pay premiums or other cost-sharing charges set on a slide scale based on income. For any individual whose annual family income is less than 450% of the FPL ($61,155 for an individual in 2022), states can require payment of premiums only to the extent that the amount of the premiums does not exceed 7.5% of the individual's income. For individuals with annual adjusted gross income (as defined by the IRS) that exceeds $75,000, states are required to charge 100% of any premiums they choose to impose. However, states can subsidize the premium cost for these individuals using state funds.
Ticket to Work and Work Incentives Improvement Act of 1999, Section 201	Ticket to Work Medical Improvements	Blind or disabled individuals who (1) are ages 16 to 64; (2) who have earned income; and (3) who lose eligibility under the Ticket to Work Basic group due to an improvement in their medical condition such that they are no longer considered to meet the SSI definition of disability but still have a severe medically determinable impairment as determined under federal regulations. States must cover the Ticket to Work Basic group to cover this eligibility group.	Individuals must earn at least the federal minimum wage and work at least 40 hours per month or be engaged in a work effort that meets certain criteria for hours of work, wages, or other measures, as defined by the state and approved by HHS. States may determine additional income and resource standards beyond those listed above, including no standards.	

Note: This table does not include an exhaustive list of options available to states under each authority. Instead, the table provides a summary of the options described in this report.

APPENDIX B: MBI FOR WORKERS WITH DISABILITIES PROGRAM ELIGIBILITY REQUIREMENTS AND PREMIUMS BY STATE

State	Monthly Earned Income Limit* (Individual)	Asset Limit (Individual)	Monthly Income at Which Premiums Begin
Alabama	—	—	—
Alaska	250% of Alaska FPL ($3,540)	$10,000	100% FPL
Arizona	$2,530	None	Up to $35 per month**
Arkansas	None	None	No premium
California	250% FPL ($2,882)	$130,000	No premium
Colorado	$5,096	None	41% FPL
Connecticut	$6,250	$10,000	200% FPL
Delaware	275% FPL ($3,115)	Unable to locate	100% FPL
District of Columbia	—	—	—
Florida	—	—	—
Georgia	300% FPL ($3,398)	$4,000	150% FPL
Hawaii	138% of Hawaii FPL ($1,797)	$7,970	No premium
Idaho	500% FPL ($5,638)	$10,000	133% FPL
Illinois	350% FPL ($3,964)	$25,000	251% FPL
Indiana	350% FPL ($3,964)	$20,000	150% FPL
Iowa	250% FPL ($2,832)	$12,000	150% FPL
Kansas	300% FPL ($3,398)	$15,000	100% FPL
Kentucky	200% FPL ($2,265)	$4,000	Yes**
Louisiana	$1,133	$10,000	No premium
Maine	$2,832	$8,000	150% FPL
Maryland	None†	$10,000†	$0-$55**†
Massachusetts	None	None	150% FPL
Michigan	250% FPL ($2,832)	$8,400	138% FPL
Minnesota	None	$20,000	0% FPL
Mississippi	250% FPL ($2,832)	$24,000	150% FPL
Missouri	300% FPL ($3,398) in gross income	$5,302	101% FPL
Montana	250% FPL ($2,832)	$15,000	0%
Nebraska	250% FPL ($2,832)	$4,000	200% FPL
Nevada	250% FPL ($2,832) in gross income	$15,000	Yes**
New Hampshire	450% FPL ($5,097) for workers at or under 64 years old; 250% FPL ($2,832) for workers older than 64	$32,471	150% FPL
New Jersey	$5,729	$20,000	No premium
New Mexico	250% FPL ($2,832)	$10,000	No premium
New York	250% FPL ($2,832)	$20,000	No premium
North Carolina	150% FPL ($1,699)	$25,728	200% FPL
North Dakota	$2,549	$13,000	5% of gross income**
Ohio	250%FPL ($2,832)	$13,233	150% FPL
Oklahoma	—	—	—

State	Monthly Earned Income Limit* (Individual)	Asset Limit (Individual)	Monthly Income at Which Premiums Begin
Oregon	250% FPL ($2,832)	$5,000	$0-$150**
Pennsylvania	250% FPL ($2,832)	$10,000	0% FPL
Rhode Island	250% FPL ($2,832)	$10,000	150% FPL
South Carolina	250% FPL ($2,832)	$8,400	Unable to locate
South Dakota	250% FPL ($2,832)	$8,000	No premium
Tennessee	—	—	—
Texas	250% FPL ($2,832)	$2,000	150% FPL
Utah	250% FPL ($2,832)	$15,000	100% FPL
Vermont	250% FPL ($2,832)	$10,000	No premium
Virginia	$1,563	$2,000	No premium
Washington	None	None	0% FPL
West Virginia	250% FPL ($2,832)	$2,000	Yes**
Wisconsin	250% FPL ($2,832)	$15,000	100% FPL
Wyoming	$2,523	None	Yes**

Notes: Data in table are based on the most recently updated information BPC could locate online as of November 2022 and might not be an accurate representation of the MBI for Workers with Disabilities eligibility limits in a state. State might also have unearned income limits and other eligibility and premium criteria not included in this table. Stakeholders should confirm the information in the table with their state before advising consumers or making eligibility decisions.

***** States might list income limits as a fixed-dollar amount, a percentage of the FPL, or both. BPC has translated FPL percentages into 2022 dollar amounts where applicable for comparison purposes. Dollar amounts might be rounded for display purposes.

****** State lists requiring a premium and/or specific premium amounts, but BPC could not locate information on monthly income at which the premium begins.

† State has proposed changes but has not received federal approval for proposed changes.

Unable to locate BPC could not locate information on the state's website.

— State does not have a MBI for Workers with Disabilities program.

APPENDIX C: TYPES OF GUIDANCE RELEASED BY ADMINISTRATIVE AGENCIES

Guidance Type (abbreviation)	Purpose
Frequently Asked Questions (FAQs)	Provides additional information and/or statutory guidance not found in SMD letters or IBs.
Informational Bulletin (IB)	Clarifies existing regulations (i.e., Final Rules), policies, and/or programs.
Letters to State Medicaid Directors (SMD letters)	Provides information about policy and programmatic updates or changes.
Notice of Proposed Rulemaking (NPRM)	Creates a regulatory framework, often building upon SMD letters. An NPRM also solicits public input from relevant stakeholders, which often includes questions on policy implementation. After releasing an NPRM and collecting comments, the agency releases a Final Rule including stakeholders' comments and questions and providing responses.

Note: This table does not include an exhaustive list of guidance released by administrative agencies. Instead, the table provides a description of the guidance discussed in this report.

APPENDIX D: PROMISING PRACTICES FOR STATES

The three promising practices below can serve as a starting point for CMS's technical assistance on MBI for Workers with Disabilities programs. These promising practices are based on interviews and a private roundtable discussion with stakeholders, including states with and without MBI for Workers with Disabilities programs. The federal technical assistance center that BPC recommends (see Recommendation II.A.) should further research these practices. If CMS's contractor, responsible for administering the technical assistance center, were to determine sufficient evidence to support these strategies, the technical assistance center should promote these promising practices among states.

These practices aim to improve states' implementation of MBI for Workers with Disabilities programs by 1) enhancing education and outreach, 2) increasing stakeholder collaboration, and 3) strengthening data collection, monitoring, and research. This section also provides examples of actions states could take to align with these promising practices.

Promising Practice	State Actions
Enhance education and outreach	**Publicly identify a contact person and/or a shared "mailbox" for consumers and other stakeholders:** Some state stakeholders, including applicants and beneficiaries, have trouble finding contact information for states' MBI for Workers with Disabilities programs. This creates a barrier to access for individuals with disabilities, thus limiting state-to-state collaboration. Advocates and people with disabilities also express difficulty finding contact information for states' MBI for Workers with Disabilities. To improve state-to-state learning and consumer education, states should clearly identify a contact person or shared mailbox for stakeholders to direct their questions related to MBI for Workers with Disabilities. **Publicly post the formula used to calculate income for the purposes of eligibility, including the poverty level used in the formula and income-counting methodology:** Financial eligibility for MBI for Workers with Disabilities programs vary by state. States use a formula to calculate an individual's income eligibility for MBI for Workers with Disabilities programs. This formula can include a methodology for counting earned and unearned income to determine eligibility for the programs, and states often establish earned income limits as a percentage of the poverty level. The information states offer for these eligibility groups has inconsistencies. Often, states do not publicly clarify their income-counting methodologies or whether they use a percentage of the national or state poverty level for earned income limits. To assist people with disabilities and frontline staff helping people determine eligibility for the MBI for Workers with Disabilities programs, states should make the financial eligibility criteria more accessible and available, including their income-counting methodologies and the poverty level the state uses in any income limits. **Invest in benefits or work-incentives counselors:** Benefits or work-incentive counselors help workers with disabilities navigate employment and understand the effects of their earned income on assistance programs, such as SSI, SSDI, and their state Medicaid program. This support should help individuals make informed decisions about employment without promoting a reliance on the cash-benefit systems. Workers with disabilities receiving cash benefits and Medicaid outside of MBI for Workers with Disabilities programs need a better understanding of how employment supports their goals for improving their economic well-being and community living. Benefits or work-incentive counselors offer valuable resources for those individuals. Two states BPC interviewed employ benefits or work-incentives counselors to explain how employment can affect individuals with disabilities' eligibility for assistance programs.

Promising Practice	State Actions
Increase stakeholder collaboration	**Partner with educational institutions and disability advocacy organizations in the state:** States can support transition to work through outreach and collaboration with educational institutions. For example, at least one state BPC interviewed partners with educational institutions to help people with disabilities with the transition from education to employment. This is one way to improve awareness of the MBI for Workers with Disabilities programs. Advocacy organizations also often have the beneficiary knowledge state Medicaid offices need to understand the impact of the MBI program for Workers with Disabilities on the lives of individuals with disabilities who work or want to work. Strengthening partnerships between state Medicaid agencies and advocacy organizations would benefit the states and promote the alignment of consumer resources and information about the states' MBI for Workers with Disabilities. **Strengthen the coordination between the Social Security Administration and Medicaid:** People with disabilities sometimes choose to not work, decline promotions, or choose lower-paying positions because they are concerned that they will lose their Social Security disability insurance, Supplemental Security Income, or Medicaid coverage. Whether someone can work and maintain their disability benefits depends on a variety of factors, but many people with disabilities can maintain their access to critical Medicaid services through the MBI for Workers with Disabilities programs while increasing their salaries. Some might even remain eligible for Social Security Administration benefits, including Medicare. To ensure consumers receive accurate and aligned information between agencies, state Medicaid agencies and Social Security offices should increase coordination on MBI for Workers with Disabilities. One state BPC interviewed has created a cross-agency working group to help strengthen this coordination.
Strengthen data collection, monitoring, and research	**Conduct research on employment for people with disabilities, including seeking input from people with disabilities:** States highlight the importance of getting support from advocacy groups and people with disabilities when implementing MBI for Workers with Disabilities. Barriers to employment for people with disabilities vary by state and by disability type, so designing an effective program requires program designers to understand a wide range of state-specific barriers that exist. One Medicaid agency BPC interviewed partners with a state university and a consumer advisory panel to conduct this research. **Include evaluation criteria that examines a wide range of factors affecting the health of people with disabilities:** MBI for Workers with Disabilities programs enable people with disabilities to gain and/or improve their economic security and other nonmedical benefits that affects their health. For example, increased income limits could allow a person with a disability to move to an area with greater access to health services, to transportation or into safer, more accessible housing. Increased income could also reduce an individual's reliance on social support services, such as Section 8 housing vouchers and the Supplemental Nutrition Assistance Program. To understand the implications of MBI for Workers with Disabilities programs, it is important to evaluate effects on nonmedical factors and research how these nonmedical factors impact their health.

Endnotes

1 Matthew Kehn, *Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2011*, Washington, DC: Mathematica Policy Research, 7. Available at: https://www.mathematica.org/publications/enrollment-employment-and-earnings-in-the-medicaid-buyin-program-2011.

2 Ibid., vii.

3 Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book*, December 2021, 24. Available at: https://www.macpac.gov/macstats/.

See also Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Program Statistics*, June 2014, 84. Available at: https://www.macpac.gov/wp-content/uploads/2015/03/June-2014-MACStats.pdf.

4 Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book*, December 2021, 51. Available at: https://www.macpac.gov/macstats/.

5 U.S. Bureau of Labor Statistics, *PERSONS WITH A DISABILITY: LABOR FORCE CHARACTERISTICS — 2021*, February 24, 2022. Available at: www.bls.gov/news.release/pdf/disabl.pdf.

6 U.S. Bureau of Labor Statistics, *Table 1. Employment status of the civilian noninstitutional population by disability status and selected characteristics, 2019 annual averages*, February 24, 2022. Available at: https://www.bls.gov/news.release/disabl.t01.htm.

7 Ibid.

8 Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book*, December 2021, 51. Available at: https://www.macpac.gov/macstats/.

9 "July 2022 Medicaid & CHIP Enrollment Data Highlights," Centers for Medicare & Medicaid Services, June 2022. Available at: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html.

10 § 1902 of the Social Security Act (the Social Security Act), 42 U.S.C. § 1396(a).

11 Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book*, December 2021, 51. Available at: https://www.macpac.gov/macstats/.

12 Matthew Kehn, *Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2011*, Washington, DC: Mathematica Policy Research. Available at: https://www.mathematica.org/publications/enrollment-employment-and-earnings-in-the-medicaid-buyin-program-2011.

13 Ibid.

See also Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book*, December 2021, 24. Available at: https://www.macpac.gov/macstats/.

14 Ibid.

15 Molly O'Malley Watts, MaryBeth Musumeci, and Meghana Amumula, *Medicaid Home & Community-Based Services: People Served and Spending During COVID-19*, Washington, DC: Kaiser Family Foundation, March 4, 2022. Available at: https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief.

16 Kim Parker, Julia Menasce Horowitz, and Rachel Minkin, "COVID-19 Pandemic Continues to Reshape Work in America," Pew Research Center, February 16, 2022. Available at: https://www.pewresearch.org/social-trends/2022/02/16/covid-19-pandemic-continues-to-reshape-work-in-america/.

17 Centers for Medicare & Medicaid Services, *Mandatory & Optional Medicaid Benefits Medicaid*. Available at: https:www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html.

18 Congressional Research Service, *Who Pays for Long-Term Services and Supports?* June 15, 2022. Available at: https://crsreports.congress.gov/product/pdf/IF/IF10343.

19 Ibid.

20 Min-Young Kim, Edward Weizenegger, and Andrea Wysocki, "Medicaid Beneficiaries Who Use Long-Term Services and Supports: 2019," Chicago: Mathematica, July 22, 2022. Available at: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-user-brief-2019.pdf.

21 Medicaid and CHIP Payment and Access Commission, *MACStats: Medicaid and CHIP Data Book*, December 2021. Available at: https://www.macpac.gov/macstats/.

22 42 C.F.R. §435.500-435.541.; 42 C.F.R. §435.601.

23 Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission, *Beneficiaries Dually Eligible for Medicare and Medicaid Data Book*, February 2022. Available at: https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/.

24 Social Security Administration, "Substantial Gainful Activity." Available at: www.ssa.gov/oact/cola/sga.html.

25 Ibid.

26 Social Security Administration, "SSI Federal Payment Amounts." Available at: https://www.ssa.gov/oact/cola/SSIamts.html.

27 Social Security Administration, "Understanding Supplemental Security Income SSI Eligibility Requirements - 2022 Edition." Available at: https://www.ssa.gov/ssi/text-eligibility-ussi.htm.

28 Ibid.

See also "Substantial Gainful Activity," Social Security Administration. Available at: www.ssa.gov/oact/cola/sga.html.

29 Ibid.

See also "SSI Federal Payment Amounts," Social Security Administration. Available at: www.ssa.gov/oact/cola/SSIamts.html.

30 "What's Not Covered by Part A & B," Medicare.gov, Centers for Medicare & Medicaid Services. Available at: https://www.medicare.gov/what-medicare-covers/whats-not-covered-by-part-a-part-b.

31 Centers for Medicare & Medicaid Services, *Medicare & the Health Insurance Marketplace*, September 2022. Available at: https://www.medicare.gov/Pubs/pdf/11694-Medicare-and-Marketplace.pdf.

32 § 2(a)(5) of the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket to Work Act), P.L. 106-170.

33 World Institute on Disability, Disability Benefits 101 "MO Disability Benefits 101." Available at: https://mo.db101.org/mo/programs/health_coverage/how_health/program2b.htm#:~:text=To%20get%20Ticket%20to%20Work,or%20less%20for%20a%20couple.

34 § 4733 of the Balanced Budget Act of 1997 (BBA), P.L. 105-33.

35 § 1902 of the Social Security Act (the Social Security Act), 42 U.S.C. § 1396(a).

36 § 1115A of the Social Security Act (the Social Security Act), 42 U.S.C. §1315(a).

See also § 201 of the Ticket to Work and Work Incentives Improvement Act of 1999 (Ticket to Work Act), P.L. 106-170.

37 § 4733 of the Balanced Budget Act of 1997 (BBA), P.L. 105-33.

38 "HHS Poverty Guidelines for 2022," Office of the Assistant Secretary for Planning and Evaluation, January 12, 2022. Available at: aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

39 Kristen J. Colello and William R. Morton, *Medicaid Eligibility: Older Adults and Individuals with Disabilities*, Congressional Research Service, December 9, 2019. Available at: https://www.everycrsreport.com/reports/R46111.html.

40 Centers for Medicare & Medicaid Services, *Implementation Guide: Medicaid State Plan Eligibility Work Incentives (IG S-70)*. Available at: https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-work-incentives.pdf.

41 §1902(a)(10)(A)(ii)(XV) of the Social Security Act (the Social Security Act).

See also CMS guidance to State Medicaid Directors (August 29, 2000). Available at: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd082900.pdf#page=7.

42 Centers for Medicare & Medicaid Services, *Implementation Guide: Medicaid State Plan Eligibility Ticket to Work Basic (IG-S71)*. Available at: https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-ticket-to-work-basic.pdf.

43 Centers for Medicare & Medicaid Services, *Implementation Guide: Medicaid State Plan Eligibility Ticket to Work Medical Improvements (IG-S72)*. Available at: https://www.medicaid.gov/resources-for-states/downloads/macpro-ig-ticket-to-work-medical-improvements.pdf.

44 Centers for Medicare & Medicaid Services, *Ticket to Work*. Available at: https://www.medicaid.gov/medicaid/long-term-services-supports/employment-initiatives/ticket-work/index.html.

45 U.S. Bureau of Labor Statistics, *Table 1. Employment status of the civilian noninstitutional population by disability status and selected characteristics, 2021 annual averages*, February 24, 2022. Available at: https://www.bls.gov/news.release/disabl.t01.htm.

46 Kaiser Family Foundation, *Medicaid Eligibility through Buy-in Programs for Working People with Disabilities*, 2022. Available at: https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

47 Ibid.

48 Ibid.

49 U.S. Census Bureau, "Table S1811: Selected Economic Characteristics For the Civilian Noninstitutionalized Population by Disability Status," from *2021 American Community Survey*, September 2022. Available at: https://data.census.gov/cedsci/table?q=disability%20wages&tid=ACSST1Y2021.S1811.

50 U.S. Bureau of Labor Statistics, *Table 1. Employment status of the civilian noninstitutional population by disability status and selected characteristics, 2021 annual averages*, February 24, 2022. Available at: https://www.bls.gov/news.release/disabl.t01.htm.

51 Matthew Kehn, *Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2011*, Washington, DC: Mathematica Policy Research. Available at: https://www.mathematica.org/publications/enrollment-employment-and-earnings-in-the-medicaid-buyin-program-2011.

52 Melissa Ford Shah, David Mancuso, et al., *Healthcare for Workers with Disabilities: Supporting and Encouraging Employment*, Washington State Department of Social and Health Services Research and Data Analysis Division, April 2009. Available at: https://www.hireabilitieshawaii.org/wp-content/uploads/2013/11/WA-MBI-impact.pdf.

53 Cathy Chambless, Richard E. Nelson, and Sara McCormick, *Impact of the Medicaid Work Incentive (MWI) Program on Earnings, Health Care Expenditures, and Utilization of Public Assistance for Individuals with Disabilities*, University of Utah Center for Public Policy and Administration, December 20, 2010. Available at: https://www.hireabilitieshawaii.org/wp-content/uploads/2013/11/Utah-MBI-impact.pdf.

54 Brigitte Gavin, Marci McCoy-Roth, et al., *Review of studies regarding the Medicaid Buy-in Program*, Boston: Boston University, Sargent College, Center for Psychiatric Rehabilitation, 2011. Available at: http://www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/medicaid-buy-in/.

55 Matthew Kehn, *Enrollment, Employment, and Earnings in the Medicaid Buy-In Program, 2011*, Washington, DC: Mathematica Policy Research. Available at: https://www.mathematica.org/publications/enrollment-employment-and-earnings-in-the-medicaid-buyin-program-2011.

56 Melissa Ford Shah, David Mancuso, et al., *Healthcare for Workers with Disabilities: Supporting and Encouraging Employment*. Available at: https://www.hireabilitieshawaii.org/wp-content/uploads/2013/11/WA-MBI-impact.pdf.

57 Cathy Chambless, Richard E. Nelson, and Sara McCormick, *Impact of the Medicaid Work Incentive (MWI) Program on Earnings, Health Care Expenditures, and Utilization of Public Assistance for Individuals with Disabilities*. Available at: https://www.hireabilitieshawaii.org/wp-content/uploads/2013/11/Utah-MBI-impact.pdf.

58 Brigitte Gavin, Marci McCoy-Roth, et al., *Review of studies regarding the Medicaid Buy-in Program*, www.bu.edu/drrk/research-syntheses/psychiatric-disabilities/medicaid-buy-in/.

59 Melissa Ford Shah, David Mancuso, et al., *Healthcare for Workers with Disabilities: Supporting and Encouraging Employment*. Available at: https://www.hireabilitieshawaii.org/wp-content/uploads/2013/11/WA-MBI-impact.pdf.

60 Jean Hal, Noelle Kurth, and Kathleen Ireland, *Kansas Medicaid Buy-in Participants Continue to Earn More and Cost Less*, Lawrence, KS: University of Kansas Center for Research on Learning, January 2013. Available at: https://ihdps.ku.edu/kansas-medicaid-buy-participants-continue-earn-more-and-cost-less.

61 Melissa Ford Shah, David Mancuso, et al., *Healthcare for Workers with Disabilities: Supporting and Encouraging Employment*. Available at: https://www.hireabilitieshawaii.org/wp-content/uploads/2013/11/WA-MBI-impact.pdf.

See also Cathy Chambless, Richard E. Nelson, and Sara McCormick, *Impact of the Medicaid Work Incentive (MWI) Program on Earnings, Health Care Expenditures, and Utilization of Public Assistance for Individuals with Disabilities*. Available at: https://www.hireabilitieshawaii.org/wp-content/uploads/2013/11/Utah-MBI-impact.pdf.

62 Cathy Chambless, Richard E. Nelson, and Sara McCormick, *Impact of the Medicaid Work Incentive (MWI) Program on Earnings, Health Care Expenditures, and Utilization of Public Assistance for Individuals with Disabilities*. Available at: https://www.hireabilitieshawaii.org/wp-content/uploads/2013/11/Utah-MBI-impact.pdf.

63 Jean Hal, Noelle Kurth, and Kathleen Ireland, *Kansas Medicaid Buy-in Participants Continue to Earn More and Cost Less*. Available at: ihdps.ku.edu/kansas-medicaid-buy-participants-continue-earn-more-and-cost-less.

64 Ibid.

65 Sally Lindsay, Elaine Cagliostro, et al., "A Systematic Review of the Benefits of Hiring People with Disabilities," *Journal of Occupational Rehabilitation*, 28: 634–655, 2018. Available at: https://link.springer.com/article/10.1007/s10926-018-9756-z#citeas.

66 See generally, options for coverage of the aged, blind, and disabled at 42 CFR §§ 435.230 – 435.236.

67 Centers for Medicare & Medicaid Services, "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," 87 FR 54760-54855, published September 7, 2022. Available at: https://www.federalregister.gov/documents/2022/09/07/2022-18875/streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health-program-application.

68 U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 112497," November 24, 1997. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD112497c.pdf.

See also U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 030998," March 9, 1998. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD030998.pdf.

See also U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 032900," March 29, 2000. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd032900.pdf.

See also U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 082900," August 29, 2000. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd082900.pdf.

69 Ibid.

70 New Mexico Human Services Department, Medical Assistance Division, "Aged, Blind and Disabled Medicaid Programs: Federal Poverty Levels," April 4, 2022. Available at: https://www.hsd.state.nm.us/wp-content/uploads/FPL-MAD-029-Final-2022-2023-003.pdf.

71 Mathematica, *Enrollment, Employment, and Earnings in the Medicaid Buy-In Program*, May 20, 2013. Available at: https://www.mathematica.org/publications/enrollment-employment-and-earnings-in-the-medicaid-buyin-program-2011.

72 U.S. House Energy and Commerce Committee Republicans, *Disability Policies in the 21st Century: Building Opportunities for Work and Inclusion*, 2022. Available at: https://republicans-energycommerce.house.gov/wp-content/uploads/2022/07/7.26.22-Disability-Policy-Memo.pdf.

73 Ibid.

74 U.S. Senate Committee on Health, Education, Labor, and Pensions, "Lessons learned from COVID-19: Highlighting Innovations, Maximizing Inclusive Practices and Overcoming Barriers to Employment for People with Disabilities," February 2022. Available at: https://www.help.senate.gov/hearings/lessons-learned-from-covid-19-highlighting-innovations-maximizing-inclusive-practices-and-overcoming-barriers-to-employment-for-people-with-disabilities.

75 Centers for Medicare & Medicaid Services, "Streamlining Eligibility & Enrollment Notice of Proposed Rulemaking," 2022. Available at: https://www.cms.gov/newsroom/fact-sheets/streamlining-eligibility-enrollment-notice-propose-rulemaking-nprm.

See also Centers for Medicare & Medicaid Services, "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," 87 FR 54760-54855, published September 7, 2022. Available at: https://www.federalregister.gov/documents/2022/09/07/2022-18875/streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health-program-application.

76 The White House, "Executive Order 14009—Strengthening Medicaid and the Affordable Care Act," January 28, 2021. Available at: https://www.govinfo.gov/content/pkg/DCPD-202100099/pdf/DCPD-202100099.pdf.

See also The White House, "Executive Order on Continuing to Strengthen Americans' Access to Affordable, Quality Health Coverage," April 5, 2022. Available at: https://www.whitehouse.gov/briefing-room/presidential-actions/2022/04/05/executive-order-on-continuing-to-strengthen-americans-access-to-affordable-quality-health-coverage/.

77 The White House, Executive Order 13985—Advancing Racial Equity and Support for Underserved Communities Through the Federal Government," January 20, 2021. Available at: https://www.govinfo.gov/content/pkg/DCPD-202100054/pdf/DCPD-202100054.pdf.

78 Centers for Medicare & Medicaid Services, "California State Plan Amendment 22-0034," September 8, 2022. Available at: https://www.medicaid.gov/medicaid/spa/downloads/CA-22-0034.pdf.

79 Maryland Department of Health, "Maryland Medical Assistance Program General Provider Transmittal No. 80," June 10, 2022. Available at: https://ticket2workmd.org/wp-content/uploads/2022/06/PT-43-22-Summer-2022-General-Provider-Updates-tr-2.pdf-2022-06-09-2.pdf.

80 Medical and Support Services Provided to Certain Working Individuals with Disabilities, Pub. L. 1968 c.410, (January 10, 2022). Available at: https://pub.njleg.state.nj.us/Bills/2020/AL21/344_.PDF.

81 State of Hawaii Department of Human Services Med-Quest Division, "Approval of Amendment Under the Medicaid State Plan," May 14, 2021. Available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/med-quest/hawaii-state-plan/spa-memos/SPA_21-04_Distribution_Memo.pdf.

82 Department of Health & Human Services, ASPR, "Renewal of Determination that a Public Health Emergency Exists," October 13, 2022. Available at: https://aspr.hhs.gov/legal/PHE/Pages/covid19-13Oct2022.aspx.

83 Families First Coronavirus Response Act, Pub. L. No 116-127. §6008, (June 30, 2022). Available at:https://www.govinfo.gov/content/pkg/COMPS-15683/pdf/COMPS-15683.pdf.

84 Ibid.

85 Urban Institute, *What Will Happen to Unprecedented High Medicaid Enrollment after the Public Health Emergency*, September 2021. Available at: https://www.urban.org/sites/default/files/publication/104785/what-will-happen-to-unprecedented-high-medicaid-enrollment-after-the-public-health-emergency_0.pdf.

86 Kaiser Family Foundation, *Medicaid Eligibility through Buy-in Programs for Working People with Disabilities*, 2022. Available at: https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

87 Dan Ferris, Yueh-Ya Hsu, et al., "All Over the Map: A Systematic Literature Review and State Policy Scan of Medicaid Buy-In Programs for Working Individuals with Disabilities," January 11, 2021. Available at: http://dx.doi.org/10.2139/ssrn.3745756.

88 U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 112497," November 24, 1997. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD112497c.pdf.

See also U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 030998," March 9, 1998. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD030998.pdf.

See also U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 032900," March 29, 2000. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd032900.pdf.

See also U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 082900," August 29, 2000. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd082900.pdf.

89 Administration for Community Living, "Medicaid Buy-in Q&A," July 2019. Available at: https://www.dol.gov/sites/dolgov/files/odep/topics/medicaidbuyinqaf.pdf.

90 Susan Livio, "Disabled people want to work, and Murphy signed a law to help them. What are state officials holding it up?" Advance Local Media, August 19, 2022. Available at: https://www.nj.com/politics/2022/08/disabled-people-want-to-work-and-murphy-signed-a-law-to-help-them-why-are-state-officials-holding-it-up.html.

91 Ibid.

See also State of New Jersey Department of Human Services, Division of Medical Assistance and Health Services, "Medical Assistance Advisory Council," October 27, 2022. Available at: https://www.state.nj.us/humanservices/dmahs/boards/maac/.

92 Section 1902(r)(2) of the Social Security Act.

See also U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 082900," August 29, 2000. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd082900.pdf.

93 Office of the Federal Register, "A Guide to the Rulemaking Process," 2011. Available at: https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf.

94 Office of the Federal Register, "Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes," September 7, 2022. Available at: https://www.federalregister.gov/documents/2022/09/07/2022-18875/streamlining-the-medicaid-childrens-health-insurance-program-and-basic-health-program-application.

95 State of New Jersey Department of Human Services, Division of Disability Services, "NJ Workability," 2022. Available at: https://www.state.nj.us/humanservices/dds/services/workability/.

See also Arizona Health Care Cost Containment System, "Health Insurance for Working Individuals with a Disability, also known as 'Freedom to Work Program." Available at: https://www.azahcccs.gov/Members/GetCovered/Categories/workingdisabled.html.

96 U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 112497," November 24, 1997. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD112497c.pdf.

See also U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 030998," March 9, 1998. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD030998.pdf.

See also U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 032900," March 29, 2000. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd032900.pdf.

See also U.S. Department of Health and Human Services, "Federal Policy Guidance SMD 082900," August 29, 2000. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd082900.pdf.

97 U.S. Department of Health and Human Services, "Justification of Estimates for Appropriations Committees: Fiscal year 2023,"165, 2022. Available at: https://www.cms.gov/files/document/fy2023-cms-congressional-justification-estimates-appropriations-committees.pdf.

98 Centers for Medicare & Medicaid Services, "CMS Releases Toolkit to Accelerate State Efforts to Rebalance Long-Term Care Systems and Enhance Home and Community-Based Services for Eligible Medicaid Beneficiaries," November 2, 2020. Available at https://www.cms.gov/newsroom/press-releases/cms-releases-toolkit-accelerate-state-efforts-rebalance-long-term-care-systems-and-enhance-home-and.

99 Centers for Medicare & Medicaid Services, "Medicaid and CHIP Learning Collaboratives." Available at: https://www.medicaid.gov/resources-for-states/medicaid-and-chip-mac-learning-collaboratives/index.html.

100 Centers for Medicare & Medicaid Services, "Enrollment Report." Available at: https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html.

101 Social Security Administration, *Red Book*, 2020. Available at: https://www.ssa.gov/pubs/EN-64-030.pdf.

102 Centers for Medicare & Medicaid Services, "Medicaid Infrastructure Gants- States N to W." Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ActiveProjectReports/Active-Projects-Reports-Items/CMS1187452.

103 Mathematica, *A Government and Results Act Report: The Status of the Medicaid Infrastructure Grant Program as on 12/31/08*, December 23, 2009. Available at: https://mathematica.org/publications/a-government-performance-and-results-act-gpra-report-the-status-of-the-medicaid-infrastructure-grants-program-as-of-123108.

See also Mathematica, *Enrollment, Employment, and Earnings in the Medicaid Buy-In Program*, May 20, 2013. Available at: https://www.mathematica.org/publications/enrollment-employment-and-earnings-in-the-medicaid-buyin-program-2011.

104 Mathematica, *What Were the Top Outcomes of State Medicaid Infrastructure Grants*, May 20, 2013. Available at: https://www.mathematica.org/publications/what-were-the-top-outcomes-of-state-medicaid-infrastructure-mig-grants.

105 U.S. Department of Health and Human Services, "Justification of Estimates for Appropriations Committees: Fiscal year 2023,"165, 2022. Available at: https://www.cms.gov/files/document/fy2023-cms-congressional-justification-estimates-appropriations-committees.pdf.

106 Ibid.

107 Carol Burckhardt and Kathryn Anderson, "The Quality of Life Scale (QOLS): reliability, validity, and utilization, Health and Quality of Life Outcomes, 1(60), 2003. Available at: https://doi.org/10.1186/1477-7525-1-60.

108 Mathematic, *Money Follows the Person Demonstration: Overview of State Grantee Progress*, January to December 2016, September 25, 2027. Available at: https://www.mathematica.org/publications/money-follows-the-person-demonstration-overview-of-state-grantee-progress-january-to-december-2016.

109 Minnesota Department of Human Services, "Medical Assistance for Employment for Persons with Disabilities (MA-EPD)," March 23, 2020. https://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/health-care-programs/programs-and-services/ma-epd.jsp.

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