REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Employment Incentives for People with Disabilities through Medicaid Buy-In Options

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 8

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COMMONWEALTH of VIRGINIA

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TO: The General Assembly of Virginia

This report is in response to Senate Joint Resolution (SJR) 128 and House Joint Resolution (HJR) 219 from the 2002 Session of the Virginia General Assembly that directed the Department of Medical Assistance Services, in collaboration with the Department of Rehabilitative Services and the Department for the Rights of People with Disabilities to proceed with the development of a Medicaid Buy-In opportunity for working Virginians with disabilities. A Medicaid Buy-In program would help reduce barriers to competitive employment for individuals with disabilities by enabling them to become employed or have increased earnings without fear of losing needed health care coverage.

If you have any questions about this report or require additional information, please feel free to contact me at 804-786-8099.

Sincerely,

Patrick W. Finnerty

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EXECUTIVE SUMMARY

EMPLOYMENT INCENTIVES FOR PEOPLE WITH DISABILITIES THROUGH MEDICAID BUY-IN OPTIONS

This report is in response to Senate Joint Resolution (SJR) 128 and House Joint Resolution (HJR) 219 from the 2002 Session of the Virginia General Assembly that directed the Department of Medical Assistance Services, in collaboration with the Department of Rehabilitative Services and the Department for the Rights of Virginian with Disabilities (the Virginia Office for Protection and Advocacy as of July 26, 2002) to proceed with the development of a Medicaid Buy-In opportunity for working Virginians with disabilities. A Medicaid Buy-In program would help to reduce barriers to competitive employment for individuals with disabilities by enabling them to become employed or have increased earnings without fear of losing needed health care coverage.

Federal legislation under the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) authorize States to develop and implement Medicaid Buy-In programs. TWWIIA also provided funding for the Center for Medicare and Medicaid Services (CMS) to initiate Medicaid Infrastructure Grants to support States in the research and development of Medicaid Buy-In programs. The Department of Medical Assistance Services received this grant funding effective January 1, 2002. This report provides further explanation of the main components of the above Acts and how DMAS is utilizing the CMS grant to develop a program to support individuals with disabilities in going to work and maintaining employment.

Two major eligibility prerequisites for a Medicaid Buy-In program are that individuals must be considered disabled, as defined by the Social Security Administration, and they must be employed in a competitive, integrated environment. It is expected that potential participants will mainly come from current Federal programs assisting individuals with disabilities, which are Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). This report provides information about the SSI and SSDI programs, as well as about Virginia Medicaid programs that currently serve individuals with disabilities.

SJR 128 and HJR 219 directed DMAS to utilize the Medicaid Infrastructure Grant to identify the steps needed to implement an effective Medicaid Buy-In program and utilize data to develop initial legislation and budgetary recommendations necessary to implement the Buy-In program in Virginia. DMAS was to utilize the Medicaid Infrastructure Grant to survey the potential population, delineate financing for the program, and assess the cost-effectiveness, availability of funding and economic benefits. DMAS was also directed to seek the participation of other State health and human service agencies, establish an advisory committee of consumers, advocates, and other stakeholders, as well as solicit input from disability advocates and business employers. This report describes DMAS' efforts to satisfy the above directives through numerous research initiatives and public input opportunities. Some methodologies used to acquire information and insight included:

- Continuation of a Medicaid Buy-In Work Group established 2001;
- A Consumer Forum to gain more information about barriers and solutions to providing employment for individuals with disabilities;
- DMAS commissioned a survey and report on working SSI recipients with disabilities in Virginia;
- Creation of a Medicaid Infrastructure Grant Advisory Committee to provide recommendations on design, education and coordination;
- An Employer Leadership Forum to educate and seek input from the business community;
- DMAS commissioned a statewide "listening tour" to solicit Medicaid Buy-In design recommendations and provide information about the potential Buy-In opportunity.
- DMAS commissioned a survey and report on individuals with disabilities who were enrolled in Medicaid's Aged, Blind, and Disabled covered group

Additional research included in this report is a section provided by the Department of Rehabilitative Services (DRS). As part of an ongoing collaborative effort, DRS staff prepared an analysis of data on Vocational Rehabilitation (VR) Program clients receiving SSI or SSDI in fiscal year 2002. Highlights from their study include that VR completed providing services to 3,086 individuals last year, 828 of whom were successfully employed. Of these employed individuals, 19% were working full-time while 63% worked 25 hours or less. Though the majority were earning less than $200 per week, it is reasonable to expect that many of these individuals will increase their work week and earned income as they become more familiar and better trained in their job. Further research activities to aid Buy-In development are underway with DRS.

Throughout this process, DMAS has received substantial technical support from experts with the American Public Human Services Association's Center for Workers with Disabilities. In addition to the direct support and advice provided by these professionals, DMAS staff benefited from the experience of other States through national conferences and regular teleconferences with State Medicaid Buy-In/Grant staff as part of a State-to-State partnership

Within this report, there is discussion on the primary components in the design of a Medicaid Buy-In program that play a major role in the program's success or failure: eligibility requirements regarding allowable income and resources, and methods for participants sharing in the cost of the program (cost-sharing). A successful program will enroll those individuals with disabilities who are willing to engage in a significant work effort and further increase their independence through earnings and participation in competitive employment. Hopefully, it would also meet or approximate its enrollment and cost projections. An unsuccessful program would certainly be one that fails to attract consumer participation and, thus, reach its enrollment goals. However, the success of a program cannot merely be measured on the basis of meeting its enrollment/cost expectations. Program participants should be actively engaged in significant employment efforts and not working "token" amounts simply to gain access to Medicaid coverage, which has unfortunately occurred in some existing State programs with calamitous budget impacts. The Medicaid Buy-In is not intended as a Medicaid expansion but an

employment support for workers with disabilities. Effective use of the aforementioned design components can significantly influence the outcome.

The experiences of some "early implementation" States illustrate several important things: how difficult it is to predict enrollment and how important the decisions on income, resources and cost-sharing can be. For example, South Carolina had a generous earned income limit, no cost-share requirements, and a modest resource level, but was far below its projected participation goal. Iowa had the same income limit as South Carolina, excluded unearned income, had a generous resource level, and charged a monthly premium, but greatly exceeded enrollment forecasts. Iowa underestimated participation such that it exceeded its 2002 budget by $27,000,000. The State of Minnesota had no income limits, a generous resource limit, and a graduated premium, but reached its third year budget predictions in the first year of operation. Additional information on these States' programs will be found within this report and provides further indication of the importance of decisions on Medicaid Buy-In components and how they ultimately precipitate participation and fiscal exposure for the State.

DMAS developed enrollment and cost projections based on the experiences of other States and their methodologies. Technical experts recommended that DMAS use information from Iowa (SSDI participation rates), Nevada (methodology), and New Mexico (gradual monthly enrollment up to full participation) in forecast development. These cost projections extrapolate the annual cost of SSDI recipient participation in Medicaid Buy-In and account for expected participation, cost to the State, potential premiums paid by participants, and overall General Fund cost. From this methodology, DMAS reported several options of what a Medicaid Buy-In could cost, based on various unearned income limits.

Major findings of this study overall may be summarized as follows:

- There is broad support from Virginians with disabilities, advocates, and employers for a Medicaid Buy-In program.
- The MBI program should utilize monthly premiums and reasonable co-payments for medical services used by participants to "buy-into" the program.
- Higher resource levels should be allowed for MBI participants, rather than regular Medicaid allowances, to enable and promote independence and less reliance on government entitlements.
- The maximum income level established for eligibility in the MBI program should be sufficiently high as to encourage and attract SSI and SSDI recipients to participate in gainful, competitive employment and the MBI.
- Four program design options and associated cost estimations were prepared for this study with projections ranging from enrollment of 1,391 participants at a General Fund cost of $4,000,000, to 5,261 participants at a General Fund cost of $15,100,000.

Further study of these and other MBI options as requested by Lieutenant Governor Kaine and the Disability Commission will continue with the goal of removing barriers that prevent individuals with disabilities from maximizing their employment, earning potential and independence.

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INTRODUCTION

Senate Joint Resolution (SJR) 128 and House Joint Resolution (HJR) 219 from the 2002 Session of the Virginia General Assembly directed the Department of Medical Assistance Services, in collaboration with the Department of Rehabilitative Services and the Department for the Rights of Virginians with Disabilities (the Virginia Office for Protection and Advocacy as of July 16, 2002), to proceed with the development of a Medicaid Buy-In opportunity for working Virginians with disabilities.

SJR 128 and HJR 219 directed DMAS to utilize the Medicaid Infrastructure Grant to identify the steps needed to implement an effective Medicaid Buy-In Program for Virginia, with the goal of utilizing data to develop initial legislation and budgetary recommendations that will be necessary to implement the Buy-In. DMAS was specifically directed to use the Medicaid Infrastructure Grant to survey the potential population, delineate financing for the program, and assess the cost-effectiveness, availability of funding, and economic benefits, in order to make recommendations as to the effective implementation of a Medicaid Buy-In program for the Commonwealth under the federal "Ticket to Work and Work Incentives Improvement Act of 1999" (see Appendix A for copies of the resolutions). DMAS was further directed to seek the participation of other State health and human service agencies in this effort, establish an advisory committee of consumers, advocates and other stakeholders, and solicit input from disability advocates, business employers and others for the benefit of the study, including the Business Leadership Forum.

This report focuses on individuals with disabilities and how access to health insurance affects their employment. Federal and State laws can influence a person's health benefits in employment and DMAS will list how some of these regulations may encourage or discourage full-time employment. The report will then describe the results of DMAS' research efforts to obtain input on the health care needs of individuals with disabilities. These needs will be compared to the economic impact on the State to provide these services. This report will then outline Medicaid Buy-In options for Virginia.

Study Methods

As directed by the Senate and House Joint Resolutions, DMAS solicited input from potential recipients, employers, disability advocates and other stakeholders using a variety of methods, including surveys, forums, work groups and national conference calls, to determine Medicaid Buy-In (MBI) options. The following is a description of these methods.

Medicaid Buy-In Work Group. In January 2001, a Medicaid Buy-In Work Group was formed to organize research activities, comprised of representatives from the Department of Medical Assistance Services (DMAS), the Department of Rehabilitative Services (DRS), the Department for the Rights of Virginians with Disabilities (the Virginia Office for Protection and Advocacy (VOPA) as of July 16,2002), the Department for the Deaf and Hard of Hearing, the

Department of Social Services (DSS), the Department of Blind and Vision Impaired (DBVI), and the Department for Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS). Other participants included representatives from the Virginia Commonwealth University (VCU) Rehabilitation Research and Training Center (RRTC), the Virginia Board for People with Disabilities, the Social Security Administration (SSA), and a number of private employment providers. This work group was instrumental in organizing and recommending participants for various surveys, focus groups, and consumer committees. (See Appendix B for members.)

Consumer Forum. DMAS and DRS sponsored a consumer forum on February 27, 2001, in Richmond that included over 100 consumers, advocates, and providers from throughout the State. The forum garnered statewide input into issues and barriers that impede the competitive employment of people with disabilities. This information was valuable in identifying community knowledge and sponsorship of a MBI. (See Appendix C for forum attendance roster and recommendations.)

Survey of 1619(b) Recipients. DMAS commissioned the VCU Survey and Evaluation and Research Laboratory (SERL) to survey Virginia residents who were eligible for Medicaid coverage under the only current work incentive program available in Virginia, through Section 1619(b) of the Social Security Act. DMAS worked with the VCU RRTC, DMHMRSAS, and DRS to develop a survey and focus group format. The purpose of the survey was to gather information from individuals with disabilities about their health insurance coverage, Medicaid status, and knowledge of 1619(b) and work incentives such as MBI programs. The survey and focus groups were initiated in November and December 2001. (See Appendix D for the VCU SERL 1619(b) survey and focus group report.)

Medicaid Infrastructure Grant Advisory Committee. DMAS organized a Medicaid Infrastructure Grant Advisory Committee comprised of statewide representatives of consumers, disability advocacy groups, service providers, business, and State agencies. The initial meeting was held on May 28, 2002, and formed three subcommittees (technical design, communication/education, coordination of services) to research MBI parameters, education of all interested parties, and coordination with other services for individuals with disabilities. The full Advisory Committee reconvened in September 2002 in an effort to finalize the subcommittees' recommendations. (See Appendix E for a roster of participants and recommendations.)

Employer Leadership Forum. DMAS and DRS organized an Employer Leadership Forum, which was held on June 18, 2002, at SunTrust Bank. Lieutenant Governor Tim Kaine and the Honorable John Hager led the discussion at the meeting. More than 30 employers attended the meeting with the purpose of discussing details of how a MBI could benefit Virginia employers. Presented as an economic and workforce opportunity, the forum demonstrated that employers from around the State are supportive of the MBI concept and interested in the long-term employment of individuals with disabilities. (See Appendix F for the Forum agenda and attendance roster.)

Listening Tour. DMAS commissioned the VCU SERL to organize and conduct a "listening tour" throughout the State in July and August 2002. "Listening tour" participants consisted of consumers, advocates, service providers, State agency representatives and other stakeholders at one of two sessions held in each of the five regions of the State. The meetings were successful in gathering valuable input on the development of a MBI program and educating the community about a MBI. (See Appendix G for VCU SERL "Listening Tour" report.)

Survey of Medicaid Recipients who are Blind and Disabled. DMAS commissioned the VCU SERL to survey a segment of the State's Medicaid population, individuals who are blind and disabled and participate in the Aged, Blind and Disabled covered group (80% Federal Poverty Level[1]). The survey sought information about health insurance access, employment patterns and other demographic data. This survey has helped describe one potential MBI population's need for health insurance and desire to work. (See Appendix H for the VCU SERL report.)

1619(b) Pilot Implementation. In the Spring of 2002, members of the OneSource Capacity Building Team, a project of the Northern Virginia Workforce Investment Board, agreed to partner with the Department of Medical Assistance Services (DMAS) to address what appeared to be systemic problems resulting in under-utilization of the work incentive available under Section 1619(b) of the Social Security Act. DMAS proposed a pilot project in Northern Virginia to identify and address the problems or misunderstandings associated with Medicaid eligibility and enrollment under 1619(b). With the cooperation of the Social Security Administration (SSA) and the Virginia Department of Social Services (DSS), the 1619(b) Pilot has focused on: (1) retraining and educating the Northern Virginia staffs of SSA and DSS offices; (2) training the benefits professionals and consumer advocates who assist individuals with disabilities; and (3) informing consumers of the work incentive.

Monthly Conference Calls. DMAS staff regularly participates in a series of monthly conference calls coordinated by the American Public Human Services Association (APHSA) Center for Workers with Disabilities to exchange ideas about MBI development and programs in other states. These conference calls involve staff from other states that are in the process of designing, implementing, or improving current MBI programs. DMAS staff participate in the main conference call on general MBI topics, but also participate in task forces created by the APHSA to discuss MBI employer relations, employment support programs, third party liability, and personal assistant services. These conferences have helped the DMAS staff locate reference material and exchange MBI design ideas.

These study methods are described in more detail later in this report.

[1] The Federal Poverty Level (FPL) is the amount of income determined by the Department of Health and Human Services (DHHS) to provide a bare minimum for food, clothing, transportation, shelter and other necessities. The level varies according to family size and changes yearly.

Summary of Findings

There are a number of major findings that emerged from this research. These findings are a culmination of ideas garnered from mailed surveys, focus groups, consumer and employer forums, and a statewide "listening tour". The Medicaid Infrastructure Grant Advisory Committee developed recommendations relating to plans for effective communication/education efforts, coordination with other benefits or services available to Virginians with disabilities, and a vision statement that highlights elements they believe are important for an effective Medicaid Buy-In. In addition, DMAS staff gathered invaluable information on implementation and complying with federal regulations through monthly national conference calls with other states that have instituted a MBI or who are designing a MBI.

The following summarizes the major findings of this study:

- There is broad support from Virginians with disabilities, advocates, and employers for a Medicaid Buy-In program.
- The MBI program should utilize monthly premiums and reasonable co-payments for medical services used by participants to "buy-into" the program.
- Higher resource levels should be allowed for MBI participants, rather than regular Medicaid allowances, to enable and promote independence and less reliance on government entitlements.
- The maximum income level established for eligibility in the MBI program should be sufficiently high as to encourage and attract SSI and SSDI recipients to participate in gainful, competitive employment and the MBI.

The following illustrates the MBI program options and associated cost projections developed for this report:

- Option 1: Unearned income limit @ 81.2% Federal Poverty Level
  1,391 projected participants
  $4.0 million projected General Fund expense
- Option 2: Unearned income limit @ 94.7% Federal Poverty Level
  2,820 projected participants
  $8.1 million projected General Fund costs
- Option 3: Unearned income limit @ 108.3% Federal Poverty Level
  4,004 projected participants
  $11.5 million projected General Fund expense
- Option 4: No unearned income limit
  5,261 projected participants
  $15.1 million projected General Fund costs

This report focuses on individuals with disabilities' support of a MBI and their requirements of a MBI. The focus then shifts to describe the results of other states that have implemented a MBI program. Finally, the report will describe which Virginians with disabilities might benefit the most from a MBI and the costs of operating a MBI in Virginia.

BACKGROUND

As directed by Senate Joint Resolution (SJR) 128 and House Joint Resolution (HJR) 219 in the 2002 Session of the Virginia General Assembly, the Department of Medical Assistance Services (DMAS), in collaboration with the Department of Rehabilitative Services and the Department for the Rights of Virginians with Disabilities (now the Virginia Office for Protection and Advocacy) proceeded with the development of a Medicaid Buy-In opportunity for working Virginians with disabilities. DMAS was further directed to utilize the Medicaid Infrastructure Grant to identify the steps needed to implement an effective Medicaid Buy-In Program for Virginia and to utilize data to develop initial legislation and necessary budgetary recommendations. In addition, the grant was to be used to survey the potential population, delineate financing for the program and assess the cost-effectiveness, availability of funding and economic benefits.

SJR 128 and HJR 219 also directed DMAS to seek the participation of the Department for the Blind and Vision Impaired, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department for the Deaf and Hard-of-Hearing, the Virginia Board for People with Disabilities, and establish an advisory committee of consumers, advocates, and stakeholders. DMAS was to solicit input from stakeholders, disability advocates, business employers, and others deemed to have valuable information for the benefit of the study, including the Business Leadership Forum with the purpose of unveiling the Buy-In as an economic and workforce opportunity for business. This report illustrates DMAS' efforts in addressing the charges put forth in SJR 128 and HJR 219.

The goal of the Medicaid Infrastructure Grant (MIG) is to reduce barriers to competitive employment for individuals with disabilities. Funding from the Grant will help to make this goal a reality and expand employment opportunities for persons with disabilities. While there is no one reason why many individuals with disabilities do not seek or increase competitive employment, the probable loss of health insurance as a direct result of working can serve as a strong disincentive to employment. Enhanced access to Medicaid because of work may provide the reassurance that many individuals with disabilities need to begin or increase employment and not suddenly be without medical care. DMAS has researched other states' experience in setting up MBI programs, federal requirements, and solicited consumer and other stakeholder input from throughout the State in attempting to address these issues. The following sections provide more background about the targeted populations and the legislation that enables a MBI program.

Current Social Security Programs for People with Disabilities

Two major programs that provide benefits based on disability or blindness currently exist through the Social Security Administration (SSA): Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). Both classifications require that participants be defined by the SSA as disabled to be eligible for benefits. As specified by SSA, disability is "the inability to engage in any substantial gainful activity (SGA) because of a medically determinable

physical or mental impairment that can be expected to result in death, or that has lasted or that we can expect to last for a continuous period of not less than 12 months"[2]. SGA, for 2002, is earnings averaging over $780 a month ($9,360 a year) for an individual and $1,300 a month ($15,600 a year) for the blind[3]. The following is more specific information about each program.

Social Security Disability Insurance (SSDI): Title II of the Social Security Act establishes Social Security Disability Insurance. SSDI is a federal disability insurance cash benefit for workers who have contributed to the Social Security trust funds and became disabled or blind before retirement age. Benefits are available because of the Federal Insurance Contributions Act (FICA) Social Security tax paid on their earnings or those of their spouses or parents. Individuals who have been entitled to SSDI benefits for 24 consecutive months are eligible to receive health insurance benefits under the Medicare program.

Supplemental Security Income (SSI): Title XVI of the Social Security Act establishes the Supplemental Security Income program. The SSI program is a means-tested program providing a monthly cash benefit to low-income persons with limited resources on the basis of age and on the basis of disability. The federal government funds SSI from general tax revenues. Since the SSI program was implemented in 1974, work incentive provisions have been included in the Social Security Act for persons with severe disabilities.

Section 1619 of the Social Security Act contains the work incentive program for SSI beneficiaries with disabilities. Under 1619(a), a SSI recipient, or a SSDI recipient that is eligible for SSI, can work and still retain a cash benefit and continue to remain eligible for Medicaid coverage. However, as the individual's earnings increase, this causes a concurrent, gradual reduction in their SSI cash benefit which can continue with increased earnings until the individual's benefit is reduced to zero. Under 1619(b), the individual who no longer receives a SSI cash benefit will continue as an active SSI case and can remain eligible for Medicaid if needed. The recipient can continue to receive Medicaid services if earning less than the state's standard threshold amount as established by SSA, which in Virginia in 2002 is $1,776 per month ($21,319 per year)[4].

Information from the Social Security Administration[5] indicates that of the 74,555 working age (18-64) Virginians with disabilities who were receiving SSI in December 2001, only 2.05% (1,526 individuals) were eligible to continue receiving Medicaid under 1619(b) work incentive program. During the same period, relatively few individuals with disabilities were using some of the other SSA employment support provisions: only 26 had Plans for Achieving Self-Support (PASS); 82 were benefiting from use of Blind Work Expenses provisions; and 554 individuals had Impairment-Related Work Expenses (IRWE).

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[2] Source: http://www.ssa.gov/work/ResourcesToolkit/Health/redbook.html (page 17).
[3] Source: Ibid.
[4] Source: http://www.ssa.gov/work/ResourcesToolkit/redbook.html
[5] Social Security Administration. *SSI Annual Statistical Report 2001*. June 2002.

Current Medicaid Programs for Individuals with Disabilities

Medicaid currently covers approximately 500,000 individuals at any one time during the year under numerous categories of eligibility, such as categorically needy, medically needy, and medically indigent. Persons with disabilities are also eligible in a number of these program categories. In 2001, Virginia expanded coverage for individuals with incomes up to 80% of Federal Poverty Level (FPL) to qualify for Medicaid coverage under a newly established Aged, Blind and Disabled category. Adoption of this categorically needy group provides medical coverage for individuals not previously eligible for Medicaid benefits and allows many individuals to become eligible for full Medicaid coverage without having to spend down to the medically needy income limits which are approximately 38% of FPL.

For the purposes of this report, the focus of this section is to illustrate the primary categories of Medicaid programs that specifically include individuals with disabilities, as follows:

- Aged, Blind and Disabled (income to 80% FPL) receive full Medicaid coverage:
  - Aged: Individuals who are aged 65 and older
  - Blind: Individuals who are statutorily blind
  - Disabled: Individuals who are unable to perform any substantial gainful activity by reasons of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.
- Qualified Medicare Beneficiary (income to 100% FPL): An aged, blind or disabled individual who is eligible for Medicare Part A and who meets the QMB income and resource limits -- Medicaid pays Medicare premiums and cost sharing expenses.
- Special Low Income Medicare Beneficiary (income to 120% FPL): Individuals who would be qualified Medicare beneficiaries but for the fact that their income exceeds 100% but is less than 120% of FPL. These individuals are eligible for Medicaid payment of Medicare Part B premiums only.
- Qualified Individuals (income to 135% and 175% FPL): Individuals entitled to Medicare Part A
  - QI-1: Income exceeds 120% but is less than 135% of FPL. Eligible for Medicaid payment of Medicare Part B premiums only.
  - QI-2: Income exceeds 135% but is less than 175% of FPL. Eligible for Medicaid payment of a portion of Medicare Part B premiums only.
- Qualified Disabled and Working Individual (income to 200% FPL): An individual who is entitled to enroll for Part A Medicare, who is not otherwise eligible for Medicaid and who meets the QDWI income and resource limits. These individuals are eligible for Medicaid payment of Medicare Part A premiums only.
- Qualified Severely Disabled Individual (income eligible per SSA): A disabled individual who received Supplemental Security Income and Medicaid but who lost SSI cash benefit because of increased earnings from employment, and the

Social Security Administration determined that the individual remains eligible for full Medicaid coverage under Section 1619(b) of the Social Security Act if the individual:

- Continues to have a disabling impairment;
- Would, except for earnings, continue to be eligible for SSI;
- Would be seriously inhibited from continuing or obtaining employment without Medicaid benefits; and
- Whose earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under SSI, Medicaid and publicly funded attendant care services that would be available to him in the absence of such earnings.

Federal Legislation Authorizing Medicaid Buy-In Options

The concept of a Medicaid Buy-In stemmed from two federal legislative acts, the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). These pieces of legislation provided opportunities for states to allow working individuals with disabilities to buy into a state's Medicaid program. The BBA and TWWIIA permit increased access for working individuals with disabilities to a state's Medicaid plan but had no immediate impact on the types of benefits a state provides in its Medicaid plan.

Both legislative acts share some common principles. Primarily, under BBA and TWWIIA, MBI participants must be considered disabled according to the SSA definition of disability. The second common principle is that all participants must be employed if they are to receive Medicaid benefits. The major differences in BBA and TWWIIA have to do with the options the State has in designing allowable income, resource levels, and the method of cost-sharing. States have the option of implementing a MBI by choosing to use BBA or TWWIIA legislation. Because each state determines its own MBI limits, these three components distinguish different MBI programs throughout the country. The following is more specific information about the BBA and TWWIIA.

Balanced Budget Act of 1997. The Balanced Budget Act of 1997 (BBA), Public Law (P.L.) 105-33, permits states to extend Medicaid coverage to certain working people with disabilities, regardless of age, whose earnings are too high to qualify for Medicaid under existing rules. The BBA sets an income limit of 250% of FPL but states are allowed to set their own resource limits. The BBA cost-sharing component permits states to impose a cost to MBI participants. The most common types of cost-sharing are a monthly premium and/or co-payments at the time medical services are provided to the individual.

As of October 2002, 12 states have implemented a MBI program using BBA guidelines.

Ticket to Work and Work Incentives Improvement act of 1999. The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) (P.L. 106-170) is a modification of the BBA of 1997 (See Appendix I for a comparison of the two programs.). The two main

differences are that TWWIIA requires participants to be between 18 and 64 years old and states have the flexibility to set their own income and resource standards. TWWIIA does not impose limits for income or resource standards, therefore, states may establish their own income and resource eligibility guidelines, though there are some stipulations.

TWWIIA does set specific guidelines for the cost-sharing component of the program. Cost-sharing must be on a sliding scale consistent with income. Premiums can not exceed 7.5% of income for individuals with income below 250% FPL. The state can charge 100% of the premium for any individual whose income falls between 250% and 450% FPL, but the total amount of the premium can not exceed 7.5% of income. States must charge 100% of the premium for any individual whose gross adjusted income exceeds $75,000. A state can also impose co-payment requirements as part of its system of cost-sharing.

Another difference from BBA is that in TWWIIA a state has the option of covering a medical improvement group. These employed individuals have a medically severe impairment but are no longer considered disabled because they no longer meet the definition of disability under SSI or SSDI programs. A state can choose to cover this group but it must also cover the basic group of individuals with disabilities who do satisfy the SSA definition of disability under the same eligibility and MBI requirements.

As of October 2002, 15 states have implemented a MBI using TWWIIA guidelines.

Medicaid Infrastructure Grant. Section 203 of the Ticket to Work and Work Incentives Improvement Act of 1999 directed the Secretary of the Department of Health and Human Services (DHHS) to establish a grant program to support state efforts to enhance employment options for people with disabilities. The goal of the Medicaid Infrastructure Grant (MIG) program is to support people with disabilities in securing and sustaining competitive employment in an integrated setting. The grant program will achieve this goal by providing money to states to develop and implement core elements of the TWWIIA so as to modify state health care delivery systems to meet the needs of people with disabilities who want to work.

In May 2001, DMAS applied for a MIG and was awarded the grant in September 2001 with a funding date effective January 1, 2002. CMS approved the grant with "Conditions" that DMAS had to meet to continue to receive grant funding of $500,000 per year for four years. Conditions include quarterly and annual reports to CMS that describe the state efforts to create and gain State approval of a MBI. Upon State approval and implementation of a MBI, DMAS would have to submit reports that describe the type of Medicaid services provided to individuals with disabilities and the associated costs.

DHHS' Center for Medicare and Medicaid Services (CMS) recognizes that the planning and legislative approval of a MBI is unlikely to occur in the first year due to time and organizational constraints. Therefore, the first-year benchmarks do not require MBI legislative approval. One benchmark for DMAS in the first year is to begin the regulatory process to change the DMAS Home and Community-Based Services (HCBS) waiver regulations to specifically allow personal assistance services in and outside of the home, including the workplace. In

accordance with these changes, DMAS is also to revise the HCBS waiver provider manuals to notify potential providers and consumers. Other benchmarks are to conduct analyses of adding the MBI eligibility group to all HCBS 1915(c) waivers and adding personal care services as an optional service under the Medicaid State Plan.

The first year of the grant is a period of coordination among the various stakeholders that work with Virginians with disabilities. Special emphasis is to be given to collaboration with organizations representing individuals with HIV/AIDS, State agencies, employers, and advocacy groups. DMAS is to take this input and determine what services individuals with disabilities need to participate and maintain competitive employment. These services will have a cost to the State that DMAS will determine and report. Premiums and/or co-payments that MBI participants will pay for coverage and services will defray some of these costs. The grant funding enables DMAS to provide several options to the State that are expected to increase competitive employment for individuals with disabilities as well as examine the potential costs of providing this coverage.

METHODS OF PUBLIC INPUT

As directed by Senate Joint Resolution (SJR) 128 and House Joint Resolution (HJR) 219 in the 2002 Session of the Virginia General Assembly, the Department of Medical Assistance Services (DMAS), was to survey and otherwise solicit input from stakeholders, disability advocates, business employers, and others deemed to have valuable information for the benefit of the study. The Study Methods section earlier in this report listed the various methodologies that DMAS instituted to gather information about the workplace supports that Virginians with disabilities need to begin or maintain competitive employment. Much of this research indicates that individuals with disabilities need health insurance to sustain employment. Without health insurance, many individuals with disabilities could not maintain their health status, experience debilitation, lose their job, lose their self-determination, and potentially be forced to rely on Medicaid and other government entitlements.

Many individuals with disabilities want to work but fear losing SSI and SSDI cash benefits and health insurance in the form of Medicaid and/or Medicare. That these individuals need such supports is evident in that "only one-half of 1% of SSDI beneficiaries and about 1% of SSI beneficiaries leave social security rolls because of work"[6]. DMAS was advised of these barriers during a Consumer Forum (Appendix C) that was held in February 2001 to gain information about the needs and barriers to employment for Virginians with disabilities. According to the Forum participants, the biggest barrier to employment for Virginians with disabilities is the fear of losing health insurance, or Medicaid. Many individuals with disabilities rely on Medicaid services for access to comprehensive medical care. The fear of earning too much, not qualifying for employer sponsored health insurance, and then losing Medicaid is a strong disincentive to seek or increase employment. A survey of 1619(b) eligible persons in

[6] Social Security Administration. *Social Security and Supplemental Security Income Disability Programs: Managing for Today, Planning for Tomorrow.* March 11, 1999. Page 22.

Virginia (Appendix D) conducted for DMAS reported that 35% of the respondents who were currently receiving Medicaid limited their work hours in order to continue receiving benefits. A DMAS sponsored "listening tour" (Appendix G) provided more testimony about the necessity of health insurance for persons with disabilities.

The following is a more in-depth review of key information learned from the various sources of public input from consumers and other stakeholders that DMAS pursued to gain insight into the necessary components for a Virginia Medicaid Buy-In program. (Please reference the appendices for more detail about each source of information). The following information represents the main themes reported from the research initiatives.

Survey of 1619(b) Recipients

In April 2001, the Virginia Department of Medical Assistance Services (DMAS) applied for a $50,000 Real Choice Systems Change Starter Grant to help Virginia facilitate a public and private collaboration to better assist Virginians with disabilities to live and participate in their communities. The Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration-HCFA) awarded DMAS this grant in July 2001. DMAS used this award to study Virginians with disabilities and how competitive employment interacts with their ability to maintain adequate heath insurance.

The Real Choice Systems Change Starter Grant was an opportunity for DMAS to fund a survey that targeted specific Virginians with disabilities to gauge their healthcare and employment needs. Discussions with a technical expert, Allen Jensen (George Washington University), suggested that individuals eligible for continued Medicaid coverage under Section 1619(b) of the Social Security Act would have significant potential for participating in a Buy-In program. Therefore, DMAS chose to solicit information about a number of issues from Virginians who were enrolled by the Social Security Administration (SSA) in SSI under 1619(b). DMAS contracted with the Virginia Commonwealth University (VCU) Survey and Evaluation Research Laboratory (SERL) to conduct a mail survey and coordinate a series of focus groups. The mail survey and focus groups took place between October 8, 2001 and February 28, 2002 (See Appendix D for these reports).

In November 2001, DMAS evaluated SSA data and identified 1,692 Virginians who were designated by the SSA as 1619(b) eligible and were either currently receiving Medicaid (986 persons), had received Medicaid in the past (438 persons), or never received Medicaid (268 persons). This group represented the entire Virginia population of 1619(b) eligible citizens. The SERL and DMAS sent the survey to this entire group.

DMAS and the SERL designed a closed-ended survey around several categories. The survey questions dealt with employment, demographics, health insurance coverage, Medicaid status, and knowledge of 1619(b). Stakeholders at DMAS, other state agencies, the SERL, and technical experts in Oregon and Chicago reviewed the survey for content approval. DMAS then arranged for a pilot of individuals with disabilities to complete the survey prior to conducting the

survey. These test completions generated survey design feedback concerning question wording and clarity, question order, and skip patterns.

During this period, the SERL assisted DMAS with finalizing the survey, managing all aspects of the mail survey, conducting a two-wave mailing, data entry, data analysis, and generating a findings report. The SERL also coordinated the invitation and selection of focus group participants and coordinated the logistical aspects of the focus groups.

The purpose of the focus groups was to discuss the design features that potential participants would like to see implemented in a Medicaid Buy-In program. DMAS and the SERL intended to conduct a series of regional focus groups, each consisting of 8-10 participants in December 2001. The focus groups were planned for different regions of the state (Richmond/Central, Tidewater/Southeast, Northern, Northwest, and Southwest). The SERL mailed invitation postcards to the same people that received the mail survey - all 1619(b) recipients. Interested persons then called SERL using a toll-free number and were screened for potential participation by a SERL telephone interviewer. The SERL recommended an appropriate focus group facilitator that had an understanding of disability issues as well as content knowledge of Medicaid. The Department of Rehabilitative Services (DRS) arranged transportation for the participants to and from the focus groups. Each focus group was scheduled to last between 90 and 110 minutes.

One focus group was held on December 17, 2001 in Richmond and another was held on December 18, 2001 in Virginia Beach. Focus groups planned for Northern, Northwestern, and Southwestern Virginia were cancelled because of a lack of participant interest, despite additional follow-up telephone contacts to encourage participation.

The focus group participants had a minimal knowledge of 1619(b) and only one person recognized the program because of a DMAS survey. Thus, before proceeding with the sessions, the facilitators provided an overview of 1619(b) and Medicaid programs. The meetings then resumed with the facilitator leading a discussion of how health insurance affects people with disabilities and their employment opportunities.

The general reaction to a potential Medicaid Buy-In was positive. All the participants responded that they would be able and willing to work more hours. This additional work would lead to a higher income, which turned the discussion to expense deductions. The participants thought medical and/or disability related expenses should be excluded from the Medicaid Buy-In if these items were necessary for employment. Other exclusions included transportation costs, all medications, personal assistants, dental and eye care, and medical equipment. With these cost exclusions the majority of participants said they would be willing to earn above the 1619(b) income limit.

All participants felt there should be an increase to the allowable resource limits under current Medicaid standards. Specifically, the participants thought retirement accounts, children's college funds, medical savings funds, savings for home purchase and repair, transportation (for a car up to $10,000), and life insurance programs should not be included in the resource limits.

Some members did not want the inclusion of other family member's earnings, such as an elderly parent or young adult. All participants wanted to increase their income and not be penalized for saving money.

The discussion then shifted to the contribution costs of a potential Medicaid Buy-In. In general, the groups decided they would prefer a sliding fee schedule with premiums set as a percentage of income. However, they also thought that Buy-In participants should have their Medicaid automatically reinstated should they lose their jobs, or that there should be a 30 day grace period. There was some disagreement about a minimum level of earnings. The groups also tended to agree on the need for co-payments (range of $5 - $15) for prescriptions, doctor visits, and inpatient and outpatient care.

A total of 1,692 surveys were mailed to the 1619(b) population. Bad addresses reduced the sample size to 1,430 people and a total of 730 surveys were completed to yield a response rate of 51 percent. Three cases were excluded from the analyses because the respondents were under the age of 18.

Responses for many demographic, health insurance, education, disability type, employment status, and knowledge of 1619(b) questions were very similar across all three Medicaid categories (Currently on Medicaid, No longer on Medicaid, Never on Medicaid). Differences were seen between respondents based on Medicaid status for questions related to hours worked per week, earnings, and limitation of work hours. Those currently on Medicaid tended to work fewer hours per week, earn less money, and limit their hours to a greater degree than their counterparts who had their Medicaid cancelled or had never been on Medicaid.

Of special note are the results concerning the issues of ancillary services and work, and knowledge of 1619(b). Respondents were asked to identify the types of services they receive that make it possible for them to work. Transportation is the largest need but this population also noted a need for prescription medications and personal assistant services. Eighty-four percent of the respondents reported currently having health insurance. Of these, 18 percent reported that their health insurance was through their employer. The vast majority of the remaining respondents indicated that their health insurance was either through Medicaid (76 percent) or Medicare (59 percent).

A question regarding their knowledge of 1619(b) yielded only 9%, or 65 people, had ever heard of 1619(b). This response level is significant in as much as the 1619(b) status assigned by SSA is a result of personal action on their part and entitles them to continued Medicaid coverage if they meet additional Virginia specific eligibility requirements. The response on this question demonstrates the need for further promotion of this current work incentive program.

Medicaid Infrastructure Grant Advisory Committee

On May 28, 2002, the initial meeting of the Medicaid Infrastructure Grant Advisory Committee was held in Richmond. The Advisory Committee was created to gather input from

numerous stakeholders throughout the Commonwealth representing various sectors of the disability community (Please see Appendix E for a list of committee participants). The group was established as another source of information regarding the needs of individuals with disabilities that would enable and encourage employment. This inaugural meeting began with opening remarks by the Virginia's Secretary of Health and Human Resources, Jane H. Woods. Michael Cheek, Project Director of the Center for Workers with Disabilities at the American Public Human Services Association (APHSA), then explained the federal legislation that enables a Medicaid Buy-In and described current programs in other states. Susan O'Mara, Virginia Commonwealth University's Rehabilitation Research and Training Center on Workplace Supports & Benefits Assistance Resource Center (VCU RRTC), then outlined current Social Security Administration policies and benefits as further background for the day's discussions.

The afternoon session centered on the establishment of three sub-committees: Technical Design, Communication/Education, and Coordination of Services. These subcommittees were formed to research and develop recommendations to DMAS on MBI parameters, education of all interested parties, and coordination with other benefits and services available to individuals with disabilities. The subcommittees were specifically charged with accomplishing the following tasks by September 1, 2002:

- Technical Design: Gain consensus and report ideas and suggestions for the technical design of a Virginia Medicaid Buy-In, including consideration of the underlying values of an appropriate, effective Medicaid Buy-In program for the Commonwealth and specific input on the income and resource criteria for the program, such as Income and eligibility, Assets, and Premiums.
- Communication and Education: Gain consensus and report on ideas for an effective communication and education plan that will ensure the success and appropriate use of a Virginia Medicaid Buy-In. Consider all the stakeholders: Individuals with disabilities; Families/guardians/spouses; Employers; Agencies; Taxpayers/the public; and Others
- Coordination of Services: Identify the policies, procedures, and services of related assistance programs that may be in conflict with a new Medicaid Buy-In program (e.g., housing programs, transportation stipends, food stamps). Reach agreement on a recommended plan to assist in improving communication strategies and/or modification possibilities.

Separate meetings were conducted during the summer to outline specific issues and possible solutions for a Virginia MBI in developing recommendations for the full Committee's consideration.

On September 10, 2002, the full MIG Advisory Committee reconvened so each subcommittee could detail their findings and recommendations. The Advisory Committee approved the Communication/ Education and Coordination of Services subcommittees' recommendations. However, the Technical Design subcommittee had been unable to reach consensus on primary design elements (income, resources, cost-sharing) due to the complexities involved and the time frame for this report. It is expected that this group will continue

deliberations toward development of recommendations. In the interim, the Technical Design subcommittee did develop conclusions on what are important elements for consideration in designing an effective MBI program. The complete reports by these subcommittees can be found in Appendix E.

Employer Leadership Forum

The Medicaid Buy-In (MBI) Workgroup planned and conducted an Employer Leadership Forum breakfast on June 18, 2002. The meeting was hosted by SunTrust Bank and held in Richmond. The VCU Business Roundtable and Business Leadership Network also supported the activity. Lieutenant Governor Kaine, Chair of the Virginia Disability Commission, and the Honorable John Hager facilitated discussions during the meeting. The meeting was intended to solicit input from a select group of small, medium and large employers on Medicaid Buy-In as an economic and workforce opportunity for Virginia businesses. Information was sought on identifying employment issues related to health care coverage and the Businesses were asked to identify concerns on Buy-In elements.

The forum included a brief video about the MBI and how it supports workers with disabilities in New Hampshire and several speakers who elaborated on disability issues and the potential benefit of a MBI. The meeting was attended by approximately 30 employers from throughout the state and participants expressed a great deal of interest in the concept of a Medicaid Buy-In program. Attendees offered advice on program design as well as describing how this type of opportunity could assist existing employees at their companies. (Please see Appendix F for a list of attendees and a draft of the SunTrust Bank press release regarding the meeting.) Some specific comments and recommendations by the group included:

- acknowledged persons with disabilities as an untapped labor pool
- frustrated with barriers to employment for employees
- advised to keep it simple
- advised to keep it invisible to business - no paperwork
- encouraged to support choice to work

DMAS expects to continue working with the employer community in the coming year. The support and active involvement of employers is a key component for a successful MBI program.

Listening Tour

In the summer of 2002, DMAS contracted with the Center for Public Policy (CPP) at VCU to conduct and document a series of facilitated public discussions designed to gather first-hand input on key aspects of a MBI program. Individuals were invited to provide "input on the development of a Medicaid Buy-In Program for Virginia". The invitations described the potential loss of health care coverage as a barrier to employment and briefly described how a Medicaid Buy-In could address this barrier. These discussions were composed of ten public

input sessions of approximately three hours in length, held in five geographic locations of Virginia: Abingdon, Manassas, Richmond, Roanoke, and Virginia Beach. Between July 22 and August 1, 2002, approximately 50 individuals representing consumers, advocacy groups, service providers and health and human service agencies were invited to attend one of two sessions held in each location. A total of 145 people attended the sessions.

DMAS wanted to gain direct input on the design for a MBI that would make it practical and beneficial for individuals with disabilities. To do so, the facilitator provided the participants with a general explanation of Medicaid and MBI. In addition, a DMAS representative attended each session to serve as a technical resource for questions, but did not participate in the group discussions. After an initial explanation of reference material, the facilitator initiated discussion about the three MBI topics: allowable income; resource or asset limits; and methods of cost-sharing. The main report lists the most frequently sited themes from all ten sessions. The full report is in Appendix G but the following information represents a summary of these main themes.

The income limit signifies the amount an individual can earn before they become ineligible for the MBI program. In general, the Listening Tour participants agreed that a maximum income of 250% of Federal Poverty Limit (FPL) is a reasonable amount. Currently the State of Virginia has a limit of 80% FPL ($7,088) for blind and disabled individuals so the adoption of 250% FPL ($22,150) for the MBI would represent an allowable income increase of $15,000 per individual, per year. The 250% FPL was even more heartily supported by the participants if there were exceptions as to what counted as earned income.

The participants thought the current Medicaid limits on personal resources and assets were unrealistic and did not support the goal of increased self-sufficiency and independence. In general, participants agreed that the current Medicaid eligibility guidelines required individuals to spend down their resources to subsistence levels. An MBI program with the current resource limits would not allow individuals with disabilities to increase their standard of living and decrease their dependence on government assistance. In 2002, the Virginia Medicaid resource limit was $2,000 per individual or $3,000 per couple. Individuals with more resources are not eligible for Medicaid unless they spend down to the acceptable amounts.

The Listening Tour participants recommended a cap on personal assets ranging from $4,000 to $10,000 for individuals as a more realistic and reasonable. This increase in allowable savings would enable a MBI participant to create a "rainy day" fund that would provide a financial cushion during times of unemployment or for unanticipated expenses.

Many session participants emphasized excluding specific assets like houses, property, and automobiles from resource limits. Participants thought these items were basic human needs and should not exclude a person from participating in the MBI. Many individuals with disabilities want to acquire or maintain these assets because they reinforce self-reliance and provide an incentive for employment.

Participants at every session expressed a need for special savings accounts. These accounts would not be counted as part of the resource limits because they would directly influence a person's ability to increase self-sufficiency and improve quality of life. These funds may be general accounts set up to provide funds for future home, car, and equipment maintenance, or job training and education. Similarly, MBI participants should be allowed to contribute to prepaid burial plans and retirement accounts to save for their long-term needs. In essence, session participants wanted to exclude any resources that would help produce income or provide for current and future basic living needs. Several people mentioned that these allowable resources should be determined on an individual basis by the administering entity because all of these exclusions could become confusing to the potential MBI participant.

Once the groups decided on the necessary financial resources, discussion turned to methods to buy into Medicaid. In general, session participants agreed that monthly premiums should represent the majority of the Buy-In cost-sharing. A monthly premium provides individuals with financial predictability because they can budget and set aside this payment. Listening Tour participants thought premiums should be determined on a sliding fee schedule based on countable income. There were several ideas about the amount of premium, but there was a general consensus that 5% of countable income was a reasonable amount.

In contrast, there was agreement that co-payments are reasonable, but there was disagreement about the amount and frequency of payments. Co-payments should be paid when a person receives care from any provider (e.g., physician, therapist), fills a prescription, uses an emergency room, and receives inpatient or outpatient care. Attendees thought co-payments encouraged responsible use of services but could be a financial disincentive to seeking services. Some participants thought co-payments would place financial burden on individuals who need a high level of care or who suddenly need more medical services. One solution suggested would be to create a cap on the number of co-payments. Once the person hits this cap, the person would not have to pay additional co-payments for a given time period. This alternative would help shield the individual from financial hardship but could create problems for providers and the administration of Medicaid.

The conclusion of the Listening Tour sessions consisted of a recap of the suggestions and allowed for miscellaneous comments about a MBI program. In several sessions individuals emphasized the need to have a "soft landing" for individuals who lose their jobs or who are no longer able to work. A "soft landing" would allow these individuals to resume receiving normal Medicaid without a break in coverage. Many people also expressed a need to coordinate eligibility, if possible, with other government programs like housing assistance, food stamps, transportation and other services so that individuals with disabilities are able to work more but not lose other services that provide for their basic needs.

The Listening Tours elicited broad support for a Medicaid Buy-In program. Attendees were very optimistic for a MBI and encouraged MBI program staff and stakeholders to continue to seek consumer input including after MBI implementation. Participants also expressed a desire to not have the MBI as part of a waiver because the current waivers are difficult to understand and are not sufficiently funded to fully support effective implementation.

Survey of Medicaid Recipients who are Blind and Disabled

In the summer of 2002, DMAS contracted with the VCU SERL to survey blind and disabled Virginians who were enrolled in Medicaid under the eligibility category for Aged, Blind and Disabled. As of 2001, the State of Virginia extended Medicaid eligibility to individuals who are aged, blind or disabled and have income up to 80% FPL. DMAS chose to survey this group because they are the most likely current Medicaid eligibility group to participate in a MBI. Therefore, representatives from DMAS, the SERL and disability advocates developed a survey to ask this group about their specific disabilities, their employment, employment barriers, earned income, and health insurance requirements.

DMAS prepared a list individuals of 3,052 Virginians classified as blind or disabled who qualified for the 80% FPL Medicaid eligibility group. The SERL then sent these 3,052 individuals a notification postcard that alerted them that they would be receiving a survey from the SERL on behalf of DMAS. The survey was sent to all recipients seven days. A reminder postcard was mailed two weeks after the initial mailing of the survey. A new survey was sent to all recipients who had failed respond after another seven days.

The SERL determined that the actual sample size was 2,920 individuals. The original number was reduced from 3,052 as a result of bad addresses among other reasons. Of the 2,920 sample, the SERL received 1,754 completed surveys that included 96 surveys completed by telephone. The response rate was 60% with 64% stating that they had a physical disability and 33% having a mental disability. The full survey is in Appendix H but the following lists the major findings that pertain to employment status and health insurance.

The survey reported that 102 (6%) respondents had a job and that 55% of these respondents had been working at their current job for over one year. Approximately 43% of the 102 individuals worked more than twenty hours a week. However, only 28% of all these individuals stated that they wanted to work more hours per week and 51% stated that they limited the number of hours they worked per week in order to keep disability benefits. The option of a Medicaid Buy-In would allow these individuals to increase their earnings without losing Medicaid. Services like job training, Medicaid, prescription medication, and transportation assistance were the most requested services to allow these individuals to increase their employment. This idea is reinforced by the fact that 25% of the 102 respondents stated that the fear of losing their insurance coverage was a motivating factor in avoiding an increase in work hours or wages.

Equally important to knowing who is working is to understand why individuals in this eligibility group do not seek employment. The survey reports that 1,596 (94%) of respondents were not currently working and 82% of these individuals could not work because their disability prevented them from working. Other barriers to work were a fear of losing Medicaid benefits, the need for job training, and a lack of reliable transportation. These three items were also the most sited services that would enable these respondents to work. In addition, 579 (36%) of these non-employed respondents stated that they wanted to work. A MBI would allow these 579

individuals to significantly increase the number of people working in this eligibility group which could result in an increase in their self-reliance and independence.

Many people with disabilities must have regular access to medical care so the survey asked about health insurance coverage. Most of the respondents stated that they had Medicaid (92%) and many also had Medicare (79%). Of these respondents with Medicaid, 45% stated that they had Medicaid to supplement other health insurance that did not cover certain health care costs. Many of these recipients must count Medicare as their primary insurer because respondents did not significantly list[7] another public or private health insurer.

ANALYSIS ON VIRGINIA VOCATIONAL REHABILITATION PROGRAM CLIENTS RECEIVING SUPPLEMENTAL SECURITY INCOME OR SOCIAL SECURITY DISABILITY INSURANCE

The Virginia Department of Rehabilitative Services (DRS) maintains extensive information on clients of the Vocational Rehabilitation (VR) Program. In order to provide background data to assist in the development of a Medicaid Buy-In program for Virginia, data were extracted from the Virginia Rehabilitation Information System (VRIS) on all cases served during state fiscal year (SFY) 2002 that were receiving or had applied for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). The extract included 7,348 cases,[8] over half (58%) of which were either in application or active service status at the end of the fiscal year. Among the 42% of cases that were closed sometime during year, 828 of them were successfully employed at the time of case closure. It is these cases that were examined in detail for this report.

Among the 828 VR cases with successful employment outcomes in SFY 2002, just over half (54%) were receiving SSI, and almost as many (51%) were receiving SSDI. However, only 12% of all VR cases were receiving **both** SSI and SSDI (see Table 1, below).

[7] Respondents listed other forms of insurance such as Tricare or Champus each response was 1% to 2% of responses.

[8] It is important to note that these VRIS records are on cases, not individuals. It is technically possible that a single individual might be represented on more than one case; however, during any given service period of 1 year or less, the likelihood of duplication is extremely small.

Table 1. Number of Successfully Employed VR Clients Receiving SSI or SSDI, SFY 2002		
	Number	Percent
Receiving SSI?		
Yes	446	54%
No	335	40%
Application pending	47	6%
Receiving SSDI?		
Yes	423	51%
No	343	41%
Application pending	62	7%
Receiving both SSI and SSDI?		
Yes	99	12%
No	729	88%

Data on the types of disabilities experienced by VR clients are recorded in VRIS by primary impairment and cause of primary impairment. (Data are also obtained on secondary impairment and cause, but are not included here because of the large quantity of missing data). The primary impairments of successfully employed VR clients receiving SSI or SSDI during SFY 2002 included a broad range of functional limitations. However, over three-fourths of all cases fell into one of three types of impairments: cognitive impairments (i.e., impairments in learning, thinking, etc), which constituted 35% of all cases; psychosocial impairments (i.e., impairments in interpersonal behavior, etc.), which made up 26% of all cases; and mobility/manipulation impairments, which totaled 21% of all cases. See Table 2, below, for further details.

Table 2. Primary Impairment of Successfully Employed VR Clients Receiving SSI and/or SSDI, SFY 2002		
Type of impairment	Number	Percent
Cognitive impairments (learning, thinking, etc.)	287	35%
Psychosocial impairments (interpersonal, etc.)	216	26%
Mobility/manipulation impairments, orthopedic/neurological	171	21%
Deafness & hearing impairments	51	6%
Other physical impairments	65	8%
Other mental impairments	38	5%
Total	828	

The data on cause of primary impairment provide further insight into the types of disabilities experienced by successfully employed VR clients receiving SSI and/or SSDI. The most common single cause of impairment is mental retardation (18% of all cases), and some type of mental illness (schizophrenia and other psychotic disorders, anxiety disorders, and other mental illness) accounts for the primary impairment for one-fourth (28%) of all cases analyzed for this report. Accidents and injuries, including spinal cord injury and brain injury, account for 17% of all cases. See Table 2, below, for further details.

Table 3. Cause of Primary Impairment of Successfully Employed VR Clients Receiving SSI and/or SSDI, SFY 2002		
Type of impairment	**Number**	Percent
Schizophrenia and other psychotic disorders	110	13%
Anxiety disorders	87	11%
Other mental illness	34	4%
Traumatic brain injury/stroke	42	5%
Spinal cord injury	43	5%
Accident/injury other than SCI or TBI	30	4%
Mental retardation	253	31%
Congenital condition/birth injury	86	10%
Other causes (including respiratory disorders, learning disabilities, substance abuse, arthritis, diabetes, etc.)	124	15%
Cause unknown	19	2%
	6584	100%

Of particular interest for the development of a Medicaid Buy-In program for Virginia is the available VRIS data on earnings of successfully employed VR clients who receive either SSI or SSDI. At the time that the case is closed, DRS collects information on clients' weekly earnings and hours worked. From this information, estimates of both monthly earnings and hourly wages can be computed.

Although some clients had substantial weekly earnings – the maximum earnings reported for these cases was $833 – over half of them earned less than $150. The median earnings were $143.50, and 81% of them earned less than $250 (see Table 4).

Table 4. Weekly Earnings of Successfully Employed VR Clients Receiving SSI and/or SSDI, SFY 2002		
Amount earned	**Number**	**Percent**
$0-50	121	15%
$51-100	129	16%
$101-150	203	25%
$151-200	135	16%
$201-250	84	10%
$251-300	62	7%
$301-350	39	5%
$351-400	18	2%
more than $400	37	4%
Total	828	

The modest weekly earnings of many of these VR clients can be attributed partly to the fact that most of them worked less than full time. Half of them (49%) reported working 20 hours or less during the week that their cases were closed, and only 20% worked a "full-time" schedule of 36 hours or more (see Table 5).

Table 5. Weekly Hours Worked by Successfully Employed VR Clients Receiving SSI and/or SSDI, SFY 2002		
Hours worked	**Number**	**Percent**
0-5 hours	64	8%
6-10 hours	58	7%
11-15 hours	78	9%
16-20 hours	202	24%
21-25 hours	118	14%
26-30 hours	89	11%
31-35 hours	49	6%
36-40 hours	160	19%
more than 40 hours	10	1%
Total	828	

Although their weekly earnings are relatively low, most (86%) of these clients were receiving an estimated hourly wage above the minimum wage rate of $5.15/hour. As shown in Table 6, the majority (59%) earned over $6.00/hour, and almost one-quarter (22%) earned over $8.00/hour.

Table 6. Estimated Hourly Wages of Successfully Employed VR Clients Receiving SSI and/or SSDI, SFY 2002		
Hourly wage	**Number**	**Percent**
less than $5.15	109	14%
$5.15-$5.50	97	13%
$5.51-$6.00	111	14%
$6.01-$6.50	90	12%
$6.51-$7.00	90	12%
$7.01-$7.50	51	7%
$7.51-$8.00	51	7%
$8.01-$8.50	39	5%
$8.51-$9.00	27	4%
over $9.00	103	13%
Missing	60	N/A
Total	828	

These earnings data also provide some support for the frequent reports from clients, employers, and service providers indicating that SSI and SSDI recipients intentionally keep their earnings low so as not to jeopardize their eligibility for some benefits. As Table 7 shows, only 54% have estimated monthly earnings above the current income limit for Virginia Medicaid (80% of the Federal Poverty Level (FPL), or $591/month). Even fewer (282 cases, or 34%) have estimated monthly earnings that are above the Social Security Administration's (SSA) substantial gainful activity (SGA) level of $780/month – and only 37 cases (4%) have estimated annual earnings above the income threshold for continued Medicaid eligibility under the SSA 1619(b) work incentive.

Table 7. Numbers of Successfully Employed VR Clients Receiving SSI and/or SSDI with Estimated Monthly Earnings above Certain Benefit Program Limits, SFY 2002

Benefit Program and Limit	Number	Percent
Virginia Medicaid income limit (currently 80% FPL, or $591/month)		
Above limit	444	54%
Below limit	384	46%
SSA SGA level (currently $780/month)		
Above SGA	282	34%
Below SGA	546	66%
SSA 1619(b) work incentive threshold (currently $21,319/year in Virginia)		
Above threshold	37	96%
Below threshold	791	4%

Although these data provide important insights on a subset of Virginians with disabilities who receive SSI and/or SSDI and are employed, they are somewhat limited. Therefore, it will be important to obtain additional information from other sources on the ongoing earnings of this population, as well as their unearned income (including their ongoing receipt of SSI and/or SSDI); the extent to which they are eligible for and are making use of employer-based health insurance. Some of this information may be obtained from existing data sources such as the earnings records of the Virginia Employment Commission; other data will have to be collected through such mechanisms as surveys of VR program clients and other benefits recipients.

MAJOR MEDICAID BUY-IN COMPONENTS

The BBA of 1997 and the TWWIIA of 1999 allow the State to determine eligibility standards for income, types of allowable resources, and some types of cost-share. The following provides some general information about these three variables and how they may influence the design of a Medicaid Buy-In program for Virginia.

Income

Income is separated into two forms: earned and unearned. Earned income is generally derived from employment or investments. Unearned income is generally thought of as cash assistance received from the federal or state government, though it also could include such things as pension benefits. For the MBI, unearned income is usually associated with SSDI and/or SSI cash assistance. SSI and SSDI recipients receive financial assistance because of their severe disabilities and inability to maintain full-time employment. According to SSA, less than one-half

of 1% of SSDI beneficiaries and about 1% of SSI beneficiaries leave Social Security disability rolls because of work activity[9].

In order to participate in a MBI, individuals must have earned income and they must be disabled, as defined the SSA. In most cases, therefore, the individual will also be receiving a cash benefit from the government as a result of the disability. Some of the initial states to implement a MBI did so with little or no requirement on either earned or unearned income and the results of subsequent enrollment in the programs was significant. Establishing eligibility parameters around the levels of earned and unearned income may help to mitigate the impact of unanticipated enrollment. According to technical consultant Allen Jensen, approximately 14% of MBI SSDI beneficiaries in existing MBI programs exceeded the Substantial Gainful Activity (SGA) earnings level[10]. SSDI beneficiaries risk losing their SSDI cash assistance if they exceed SGA and, thus, many choose to limit their employment and earned income. The primary effect on SSDI recipients is that they increase their disposable income without reducing SSDI payments[11]. Some of these individuals may be severely disabled and be unable to work more hours. Some these individuals could also be SSDI recipients who do not receive Medicaid or Medicare and participate with the MBI to receive medical insurance. A minimum earned income would limit the number of SSDI recipients that gain jobs only to gain access to Medicaid.

The imposition of an unearned income floor or ceiling can also determine how many individuals with disabilities apply for the MBI. A person's SSDI cash payment is determined by the individual's amount of past employment. An individual with a high SSDI payment probably worked in the labor market for several years and became disabled later in life. These individuals may not want to work because they are older, may have a severe disability, and already receive adequate income support. Individuals that receive little SSDI cash assistance may be under 18 years of age and/or mentally retarded. The State of Iowa did not record many of these individuals returning to work through the MBI. The majority of Iowa's MBI participants received between $500 and $800 in SSDI cash assistance. An unearned income floor or ceiling in this range would limit the impact of unanticipated enrollment.

Another important consideration in regarding income levels for participant eligibility in a MBI is the way earned income is counted. Under BBA and TWWIIA, SSI methodology is used in establishing the amount of earned income that is considered against eligibility standards; that is, a certain amount of earnings is disregarded in determining eligibility. Because a significant portion is not counted, a MBI participant can actually earn substantially more than it seems. The example below illustrates how earnings would be counted for MBI eligibility.

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[9] Source: Social Security Administration. *Social Security and Supplemental Security Income Disability Programs: Managing for Today, Planning for Tomorrow.* March 11, 1999. Page 22.

[10] Source: Jensen, Allen. Robert Silverstein, Donna Folkemer and Tara Straw. *Policy Frameworks for Designing Medicaid Buy-In Programs and Related State Work Incentive Initiatives.* May 2002. Page 7.

[11] Ibid. Page 24.

Earned income is figured as follows to determine the "countable earned income" amount:

- Wages of $1,000 per month:
- Subtract the $20 General Income exclusion ($1,000 -$20 = $980)
- Next, subtract the "earned Income exclusion" of $65 ($980 -$65 = $915)
- Next subtract 1/2 of the remainder ($915 / 2 = $457.50)
- $457.50 is the amount of "Countable EARNED income"

This amount is then added to any countable "unearned income" to come up with Total Countable Income.

Allowable Resources

The State is able to develop resource methodologies with few limitations from CMS. The opportunity to have additional income from employment is attractive to individuals with disabilities who receive SSI/SSDI cash benefits because it provides disposable income and gives them the ability to save for future expenditures as well as maintain independence. Under TWWIIA, the State can determine allowable types of resources. Some common resources allowed through MBI may include: savings accounts, retirement accounts, accounts for assistive technology needs, and medical expense accounts. A restrictive resource cap (e.g., $2,000 is SSI eligibility resource cap) would likely increase participation by individuals with higher earnings, if combined with other cost-sharing methods. These individuals would not have substantial resources to help with premium costs and would need to have high earnings in order to afford the higher premiums. A restrictive resource cap would also ensure that only individuals who are committed to substantive employment would participate in the program. These individuals will not be reliant on resources to pay for premiums and, therefore, would not simply work a minimal number of hours just so they could get Medicaid.

Cost Sharing

The State has the option of including a cost share component. In general, the public input regarding cost sharing has been positive. The Medicaid Infrastructure Grant Advisory Committee acknowledged that premiums and cost sharing are integral components of the Medicaid Buy-In opportunity. Individuals at the "listening tours" also supported a cost share so participants could contribute to the cost of services. If the State decides to implement a MBI under TWWIIA, the cost share must also be on a sliding scale according to income. Some common types of cost share include an entrance fee, a monthly premium, a co-payment with medical services, or a combination of these cost shares. Please note that as a cost share becomes more complex, it requires more attention to detail by MBI program administrators and participants. A cost share requires State staff to maintain information systems and compliance. The following provides some information about each type of cost share.

A monthly premium is a cost share that the State can impose and which participants can budget for each month. Premiums can serve as an offset to a portion of the cost of Medicaid. The State can set a low premium that starts at a specific measure of income—earned, unearned, or a combination—or the State can set a high premium. A high premium reduces the fiscal exposure of the state by making it not financially worthwhile for the low-earning individual to participate[12]. These higher fees can also be used to contribute to the general cost of the program. High program premiums also increase the probability of participation by individuals who work more hours and have higher incomes because they could afford to contribute more to the cost of their healthcare. The State is less likely, therefore, to encounter MBI participants who are seeking Medicaid coverage instead of expanding their employment/earnings potential. Experience from states with MBI programs indicates that MBI premiums in general have not offset any significant portion of the cost of provided Medicaid services[13]. This may, in part, be due to some states allowing MBI participation with no premiums until a high level of income was reached (e.g., Minnesota initially no premiums charged until 200% FPL) before premiums are actually required. There is also a cost associated with the administration of premium collection in the form of staff and systems support.

With respect to co-payments, again, the MIG Advisory Committee supports the need for this cost sharing mechanism and the Listening Tours also recorded support for co-payments when individuals seek medical care. Neither BBA nor TWWIIA regulate the amount that can be charged as a co-payment, though a total cost-sharing maximum exists. Co-payments for provider services (e.g., physician, therapist), inpatient services, outpatient services, durable medical equipment, and/or pharmaceuticals requires the participant to pay for services each time they receive services. As it is commonplace, the co-payment also provides parity with private health insurance so the individual will be acclimated to employer sponsored health insurance when they have the opportunity.

Premiums and co-payments can be designed to activate at any income level and can be scaled accordingly. The implementation of cost sharing components and the amounts charged are dependent upon the significance (and potential offset) the State places on having individuals, who are otherwise ineligible for Medicaid, "buy into" the Medicaid program and pay for some portion of the cost their care.

OTHER STATE MEDICAID BUY-IN PROGRAMS

Several states have already implemented Buy-In programs under BBA or TWWIIA. DMAS' staff researched these states' experiences in an effort design a potential Virginia Buy-In program. Appendix J lists the states that have a MBI program along with major features. These programs are important because they demonstrate how income, resource limits, and cost-share methods impact participation and the overall cost to the State. Some states chose to have more

[12] Ibid. Page 28.
[13] Ibid. Page 30.

generous income and resource limits that resulted in high utilization and costs. Other states imposed unearned income and earned income limits, which resulted in fewer participants.

The following describes the Medicaid Buy-In programs in the states of South Carolina, Iowa, and Minnesota. These states used different participation requirements and had different results. These experiences show how participation criteria affect utilization and budget projections. These examples record tangible components of the individual state MBI programs. DMAS does not have information detailing each state's MBI education and outreach programs. The greater the states' publication and consumer promotion, the more likely the program will enroll larger numbers of participants. Similarly, if the state does not publicize within the disability community and within state government, the less likely people will know that a MBI program exists.

The State of South Carolina has not enrolled MBI participants as forecast. South Carolina originally thought participation would reach 1,200 people, but the program has enrolled relatively few individuals. This program has no cost share and only has one income limit which is that participants must have less than 250% FPL. These two factors would seem to encourage participation in the MBI. However, the $2,000 resource level may have kept many potential participants from enrolling. This $2,000 resource level means that as a person approaches full employment, the individual must be careful not to save more than $2,000. The individual will need to spend earned income and must be careful to invest in approved resources. If the individual exceeds the resource level, that person will be removed from the MBI program and lose access to medical insurance through Medicaid. Public outreach in Virginia (in the form of the surveys, listening tour, focus groups, and the advisory committee) stated that access to medical care was the most important requirement for maintaining health and being able to return to work. In South Carolina, an MBI participant could return to work, gain access to Medicaid, and then potentially lose Medicaid and be unable to maintain employment because of the resource limit. Exceeding approved resource levels appears to be enough disincentive to keep South Carolinians with disabilities from participating in the MBI.

South Carolina (A model that resulted in under-utilization)

Income	Up to 250% Federal Poverty Limit (FPL)	
Resources	$2,000 exclude value of life estate interest in real property and car	
Cost-Share	none	
Enrollment	Projected: 1,200	Actual: 73
Budget	Projected:	Actual: $200,000
Result	Under-utilization	

Enrollment in Iowa's MBI has greatly exceeded State estimates. Iowa credits its large enrollment to extensive outreach. The program serves many people and provides many Medicaid services, but the program greatly exceeds its budget forecast. Data from Iowa shows that 57% of participants have monthly earnings of less than $250 and over 60% received unearned income

exceeding $600 per month. The lack of a required earned or unearned income level appears to have contributed to the under-forecasting of enrollment and over-spending of the MBI program.

Iowa (A model that resulted in over-utilization)

Income	Up to 250% FPL. Excludes all Unearned Income	
Resources	$12,000. Retirement account, medical savings, and assistive technology	
Cost-Share	$20 premium starting at 150% FPL gross income up to a premium of $201.	
Enrollment	2002 Projected: 700	2002 Actual: 4,134
Budget	2002 Projected: $900,000	2002 Actual: $28,000,000
Result	Over-utilization	

Minnesota underestimated how many people would enroll in its MBI. As a consequence, Minnesota reached its third year enrollment projection in the first year and under-budgeted for the program. Costs and enrollment outpaced forecasts because Minnesota has no upper income limit. The State allows resources up to $20,000, in addition to excluding retirement plans and medical savings accounts. Originally, participants began paying premiums when the individual's gross income exceeded 200% FPL. At that point the individual paid a premium of 10% of the difference. In 2002, Minnesota changed this income level to begin at 100% FPL which appears to have caused enrollment to level off. Minnesota's MBI costs were much higher than forecast.[14]

Minnesota (A model that was under budgeted)

Income	No limit. All earned and unearned income ignored.	
Resources	$20,000. Excludes retirement & medical expense accounts, spousal assets	
Cost-Share	Premiums of 10% of amount over 200% FPL	
Enrollment	2001 Projected: 4,300	2002 Actual: 5,657
Budget	Projected: $19,000,000	Actual: $27,000,000
Result	Over-utilization. Achieved third year expenditures ($27,000,000) in first year.	

[14] Source of State information: Comprehensive Person-Centered State Work Incentive Initiative: A Resource Center for Developing and Implementing Medicaid Buy-In Programs and Related Employment Initiatives for Persons with Disabilities.
www.uiowa.edu/~lhpdc/work/States.html

MEDICAID BUY-IN COST PROJECTIONS AND OPTIONS FOR VIRGINIA

Cost Projections

A key component to proposing a Virginia Medicaid Buy-In program is to determine the potential number of participants and the associated costs to the State. Several other states have implemented Buy-In programs and several other states are in the planning stages. Some of these states used state specific information to forecast costs, which can not be replicated for Virginia's purposes. The Medicaid Infrastructure Grant (MIG) staff at the Department of Medical Assistance Services (DMAS) acquired a study that the State of Nevada used to predict its MBI enrollment and costs. The following describes how DMAS utilized the Nevada MBI study to create cost projections for a Virginia MBI program. This information also provides the reference material that DMAS used to forecast costs.

Reference information was developed and provided by the Nevada Ticket to Work and Work Incentives Improvement Act (TWWIIA) MIG Program Manager, John Alexander. In developing their cost projection model, Mr. Alexander received guidance from representatives at the American Public Human Services Association's (APHSA) Center for Workers with Disabilities and Allen Jensen, Project Director, Work Incentives Project at George Washington University.

Nevada used an easily identifiable Social Security Disability Insurance (SSDI) population in their cost projection model. Specifically, the Nevada and Virginia projections utilize $100 increments of unearned income that are consistent with Social Security Administration (SSA) data classification of SSDI recipients. This data is from a 2001 SSA publication15 and represents the 2000 Virginia SSDI population.

To project MBI participation, the State of Nevada used actual participation data from the State of Iowa, which had already enacted a MBI. These Iowa figures represent the percent of SSDI participants in each $100 range of unearned income that participated in the Iowa MBI program. The proportion of employed SSDI recipients varies from 1% - 8% in the Iowa SSDI ranges and is listed in row five of the projection spreadsheet. Virginia used these calculations to estimate the number Virginia SSDI recipients that would probably utilize a MBI option in Virginia. Some other states have similar data but Iowa is a 209(b) state like Virginia and technical advisor Allen Jensen recommended the Iowa statistics because Virginia's Medicaid eligibility requirements are like Iowa's Medicaid criteria. The 209(b) status can represent an additional barrier to initially qualifying for Medicaid and it is important that Virginia can incorporate another 209(b) state's experience into Virginia projections. Please see Appendix L for the spreadsheet illustrating the above methodology and further explanation of the projections.

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[15] Source: Social Security Bulletin, Annual Statistical Supplement 2001 (2000 OASDI Current Pay-Benefits: Geographic Data) page 238

Options for Virginia

Several Medicaid Buy-In Options for Virginia based on the above methodology are shown below:

- Option 1: Unearned income limit @ 81.2% Federal Poverty Level
  1,391 projected participants
  $4.0 million projected General Fund expense
- Option 2: Unearned income limit @ 94.7% Federal Poverty Level
  2,820 projected participants
  $8.1 million projected General Fund costs
- Option 3: Unearned income limit @ 108.3% Federal Poverty Level
  4,004 projected participants
  $11.5 million projected General Fund expense
- Option 4: No unearned income limit
  5,261 projected participants
  $15.1 million projected General Fund costs

Administrative costs associated with a MBI could be significant based upon the amount of staff and information systems development that would be necessary. Only expected staffing costs have been factored into the above projections. Projected General Fund expenditures do not include any offset from potential premium collections, several examples of which are included on the cost projection spreadsheet in Appendix L.

Meeting of the Disability Commission on October 30, 2002

As requested during a previous meeting with the Disability Commission, the Department of Medical Assistance Services provided a presentation on the activities undertaken in development of a Medicaid Buy-In (MBI) program for Virginia and on budgetary requirements necessary to support several MBI options. Following the presentation, Lieutenant Governor Kaine requested a MBI model and budget be prepared based on recommendations gathered from the Listening Tour that DMAS conducted in the summer of 2002. Original recommendations from the Listening Tour were as follows:

- Income limit of 250% of Federal Poverty Limit
- Resources – $4,000 to $10,000
- Cost-sharing – premiums at 5% of income

At a subsequent meeting with State staff on November 8, 2002, the Lieutenant Governor revised his request for the above MBI design. He instead asked staff to develop a limited Medicaid waiver to enable Medicaid coverage for approximately 200 individuals with disabilities, based on appropriations of approximately $400,000 for the second half of SFY 2004. The waiver design requested was:

- Income limit of 175% of Federal Poverty Limit
- Resources – $7,500
- Cost-sharing – premiums at 5% of income

State staff will be attending the Disability Commission meeting on December 6, 2002, to further discuss the above options for a MBI program. Further study of these and other MBI options as requested by Lieutenant Governor Kaine and the Disability Commission will continue with the goal of removing barriers that prevent individuals with disabilities from maximizing their employment, earning potential and independence.

APPENDICES

Appendix

Appendix A

Senate Joint Resolution #128
House Joint Resolution #219

SENATE JOINT RESOLUTION NO. 128

Requesting the Department of Medical Assistance Services, in collaboration with the Department of Rehabilitative Services and the Department for the Rights of Virginians with Disabilities, to proceed with the development of Medicaid Buy-In opportunity for working Virginians with disabilities.

Agreed to by the Senate, February 4, 2002
Agreed to by the House of Delegates, March 5, 2002

WHEREAS, the Department of Medical Assistance Services has recently been awarded a Medicaid Infrastructure Grant from the Centers for Medicare and Medicaid Services for $2,000,000 ($500,000 over the next four years) to provide resources to the Commonwealth to identify the barriers to employment for individuals with disabilities; and

WHEREAS, health care is important to all Americans, but particularly so to individuals with disabilities who have special health care needs who often cannot afford insurance available to them through the private market, are uninsurable by the plans available in the private sector and are at risk of incurring high and economically devastating health care costs; and

WHEREAS, health care services allow Americans with significant disabilities to live independently and rejoin the workforce; and

WHEREAS, coverage for many of these services, as well as for prescription drugs and durable medical equipment, enables persons with disabilities to obtain and retain employment; and

WHEREAS, the fear of losing health care and related services is one of the greatest barriers keeping individuals with disabilities from maximizing their employment, earning potential and independence; and

WHEREAS, despite the many opportunities for employment made possible by the Americans with Disabilities Act and innovations in technology, medical treatment, and rehabilitation, fewer than one-half of one percent of Social Security Disability Insurance and Supplemental Security Income beneficiaries leave the disability rolls and return to work; and

WHEREAS, Congress enacted the "Ticket to Work and Work Incentives Improvement Act of 1999" to amend the Social Security Act to, among other things, expand the availability of health care coverage for working individuals with disabilities and to provide such individuals with meaningful opportunities to work; and

WHEREAS, the purposes of the Act are to (i) provide health care and employment preparation and placement services to individuals with disabilities that will enable those individuals to reduce their dependency on cash benefit programs; (ii) encourage states to adopt the option of allowing individuals with disabilities to purchase Medicaid coverage that is necessary to enable such individuals to maintain employment; (iii) provide individuals with disabilities the option of maintaining Medicare coverage while working; and (iv) establish a return to work ticket program

that will allow individuals with disabilities to seek the services necessary to obtain and retain employment and reduce their dependency; and

WHEREAS, in order to evaluate the feasibility of implementation of a Medicaid Buy-In program that supports working persons with disabilities within the Commonwealth, it is imperative that certain research be conducted to survey potential recipients, educate stakeholders, and assess employment barriers; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Department of Medical Assistance Services, in collaboration with the Department of Rehabilitative Services and the Department for the Rights of Virginians with Disabilities be requested to proceed with the development of Medicaid Buy-In opportunity for working Virginians with disabilities.

In developing the opportunity, the Department of Medical Assistance Services shall utilize the Medicaid Infrastructure grant to identify the steps needed to implement an effective Medicaid Buy-In Program for Virginia, with the goal of utilizing data to develop initial legislation and budgetary recommendations that will be necessary to implement the Buy-In. Specifically, the Department shall use the Medicaid Infrastructure grant to survey potential population, delineate financing for the program, and assess the cost-effectiveness, availability of funding, and economic benefits, in order to make recommendations as to the effective implementation of a Medicaid Buy-In program for the Commonwealth under the federal "Ticket to Work and Work Incentives Improvement Act of 1999."

The Department of Medical Assistance Services shall seek the participation of the Department for the Blind and Vision Impaired, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department for the Deaf and Hard-of-Hearing, the Virginia Board for People with Disabilities, and establish an advisory committee of consumers, advocates, and stakeholders. During its examination, the Department of Medical Assistance Services shall solicit the input from stakeholders, disability advocates, business employers, and others deemed to have valuable information for the benefit of the study, including the Business Leadership Forum with the purpose of unveiling the Buy-In as an economic and workforce opportunity for business.

All agencies of the Commonwealth shall provide assistance to the Department for this study, upon request.

The Department shall complete its work by November 30, 2002, and shall submit its written findings and recommendations to the Disability Commission, the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 219

Requesting the Department of Medical Assistance Services, in collaboration with the Department of Rehabilitative Services and the Department for Rights of Virginians with Disabilities, or its successor in interest, to proceed with the development of a Medicaid Buy-In opportunity for working Virginians with disabilities.

Agreed to by the House of Delegates, March 6, 2002
Agreed to by the Senate, March 5, 2002

WHEREAS, the Department of Medical Assistance Services has recently been awarded a Medicaid Infrastructure Grant from the Centers for Medicare and Medicaid Services for $2,000,000 ($500,000 over the next four years) to provide resources to the Commonwealth to identify the barriers to employment for individuals with disabilities; and

WHEREAS, health care is important to all Americans, but particularly so to individuals with disabilities who have special health care needs who often cannot afford insurance available to them through the private market, are uninsurable by the plans available in the private sector and are at risk of incurring high and economically devastating health care costs; and

WHEREAS, health care services allow Americans with significant disabilities to live independently and rejoin the workforce; and

WHEREAS, coverage for many of these services, as well as for prescription drugs and durable medical equipment, enables persons with disabilities to obtain and retain employment; and

WHEREAS, the fear of losing health care and related services is one of the greatest barriers keeping individuals with disabilities from maximizing their employment, earning potential and independence; and

WHEREAS, despite the many opportunities for employment made possible by the Americans with Disabilities Act and innovations in technology, medical treatment, and rehabilitation, fewer than one-half of one percent of Social Security Disability Insurance and Supplemental Security Income beneficiaries leave the disability rolls and return to work; and

WHEREAS, Congress enacted the "Ticket to Work and Work Incentives Improvement Act of 1999" to amend the Social Security Act to, among other things, expand the availability of health care coverage for working individuals with disabilities and to provide such individuals with meaningful opportunities to work; and

WHEREAS, the purposes of the Act are to (i) provide health care and employment preparation and placement services to individuals with disabilities that will enable those individuals to reduce their dependency on cash benefit programs; (ii) encourage states to adopt the option of allowing individuals with disabilities to purchase Medicaid coverage that is necessary to enable such individuals to maintain employment; (iii) provide individuals with disabilities the option of maintaining Medicare coverage while working; and (iv) establish a return to work ticket program

that will allow individuals with disabilities to seek the services necessary to obtain and retain employment and reduce their dependency; and

WHEREAS, in order to evaluate the feasibility of implementation of a Medicaid Buy-In program that supports working persons with disabilities within the Commonwealth, it is imperative that certain research be conducted to survey potential recipients, educate stakeholders, and assess employment barriers; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Department of Medical Assistance Services, in collaboration with the Department of Rehabilitative Services and the Department for Rights of Virginians with Disabilities, or its successor in interest, be requested to proceed with the development of a Medicaid Buy-In opportunity for working Virginians with disabilities.

In developing the opportunity, the Department of Medical Assistance Services shall utilize the Medicaid Infrastructure grant to identify the steps needed to implement an effective Medicaid Buy-In Program for Virginia, with the goal of utilizing data to develop initial legislation and budgetary recommendations that will be necessary to implement the Buy-In. Specifically, the Department shall use the Medicaid Infrastructure grant to survey potential population, delineate financing for the program, and assess the cost-effectiveness, availability of funding, and economic benefits, in order to make recommendations as to the effective implementation of a Medicaid Buy-In program for the Commonwealth under the federal "Ticket to Work and Work Incentives Improvement Act of 1999."

The Department of Medical Assistance Services shall seek the participation of the Department for the Blind and Vision Impaired, the Department of Mental Health, Mental Retardation and Substance Abuse Services, the Department for the Deaf and Hard-of-Hearing, the Virginia Board for People with Disabilities, and establish an advisory committee of consumers, advocates, and stakeholders. During its examination, the Department of Medical Assistance Services shall solicit the input from stakeholders, disability advocates, business employers, and others deemed to have valuable information for the benefit of the study, including the Business Leadership Forum with the purpose of unveiling the Buy-In as an economic and workforce opportunity for business.

All agencies of the Commonwealth shall provide assistance to the Department for this study, upon request.

The Department shall complete its work by November 30, 2002, and shall submit its written findings and recommendations to the Disability Commission, the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Medicaid Buy-In Work Group

MEDICAID BUY-IN/1619(B) WORKGROUP
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Appendix C

2001 Consumer Forum

Medicaid Buy-In	Forum Participants
Sponsor:	**DBVI Rehab Council**
Mary McMann	Va Assoc. Of DeafBlind
Sevelia Allen	DBVI Rehab Council
Linda Broady-	Amer. Coun. Blind (ACB)
Larry Povinelli	Nat. Fed. Blind (NFB)
Allen "Chris" Smith	Roanoke All for Vis. Enabled
James Taylor	DBVI Rehab Council
Jane Chandler	Va Assoc. of DeafBlind
Sponsor:	**Mental Health Planning**
John Schartzer	VA IAPSRS
Ray Bridge	Mental Health Planning
Beverly Ball	Mental Health Planning
Cynthia Power	VOCAL
Valerie Marsh	NAMI-VA
Sponsor:	**VBPD**
Elin Doval	VBPD
Brian Parsons	VBPD
Donna Gassie	VBPD
Scheronne Dunham	Partners Program
Christine Bryant-	Central Va Chapter MS
Sponsor:	**DRS Rehab Council**
Amy Fitzgerald	Va. Brain Injury Coun.(VBIC)
Christine Baggini	Brain Injury Assoc. of Va
Warren King	DRS Rehab Council
Quincy Dedes	DRS Rehab Council/VSCIC
John Favret	DRS Rehab Council
Katherine Lawson	DRS Rehab Council
Sponsor:	**VACIL**
Marcia Dubois	Harrisonburg CIL
Kim Shick	Winchester CIL
Gwen Gillenwater	Pennington Gap CIL
Michael Cooper	Arlington CIL
Betty Bevins	Grundy CIL
Bill Ward	Manassas CIL
Sponsor:	**SILC**
Steve Johnson	SILC
Karen Michalski	SILC
WorkGroup	
Allen Jensen	GWU
Kathy Hayfield	DRS
Kathy Kotula	DMAS
Cindy Olson	DMAS
Susan O'Mara	VCU RRTC
Catherine Harrison	DMAS
Pat Sykes	DMAS
Kirsten Rowe	DRS

Jim Rothrock	SILC
Michael Shank	DMHMRSAS
Sharon Koehler	DMHMRSAS
Sterling Deal	MHPC
Joe Bowman	DBVI
Heidi Lawyer	DRVD
Mary Nunnally	DRS
Ronald Lanier	DDHH
Liz Smith	DRS
Joe Ashley	DRS
Roy Grizzard	DBVI

DRS Advisory

Karen Brown	Va. Alliance of BISP
Pat Lovell	VSCIC
Genni Sasnett	
Gayle Harding	DSB
Nita Grignol	ARC
Ray Roberson	ARC
Caryn Willwiggins	CVA HIV Care Consortium

Miscellaneous

Attendant for	Donna Bowden to provide
Attendant for	Ernest Gordon
Attendant for Lovell	bringing her own
Attendant for Ward	Bringing his own
Facilitator	
Interpreters	confirmed
LaDonna	
Shelley	

Barriers to Employment
Identified at the Medicaid Buy-In Consumer Forum
February 27, 2001

Broad Categories Identified (see attached page for details)

- Public policy issues
- Limitations in community and support services/infrastructures
- Perceptions and attitudes that create barriers
- Questions of job readiness
- Barriers related to the economic impact of becoming employed
- Communication problems
- Limited employer involvement

Data from the Red Dot Group

Issues & Barriers	Data and Information Needs	People who need to be included in processes around Medicaid Buy-In
• No Plan for moving people from institutional setting (like nursing homes) to work • Employment situation for general population in a geographic area (High unemployment = Low Opportunity for the disabled (3) • Misinformation in professional network • Part Time Employment = No Benefits (5) • Employment means "I lose"—no incentive to risk my life style and support systems. • Timing of employment related to needs issues of disability • Small step entry into workplace by the seriously mentally ill • "Good enough" job attitude • Misperceptions of employers (i.e. assumptions on limitations) • Transportation (access, personal assistance, cost, dependability) (8) • Discrimination • Education limitations (1) • Fear of the disabled (1) • Entry-level salaries... limited range of potential to grow salaries (1) • Overly complicated and hidden work incentives (3) • Stigma • Affordable Housing (5) • Transition Services (1) • Personal Services (1) • Motivation and Preparation of the public (1) • Equipment cost and training (2) • Ignorance (3) • Independent Living Supports (1)	• True cost of keeping disabled out of work force • Benefits for getting disabled into the workforce • Statistics on the Disabled in the workforce ... quality/ value of service (DRS survey—cost/benefit analysis) • Other state data • Survey to SSI recipients (DMAS with mailing list)	• Legislators • Insurance providers • State Policy Makers • Employers • Transportation • Advocates • Disability community representatives • Those who fall between the cracks • At Risk • Service Providers • "Money Controllers"

Data from the Blue Dot Group

Issues & Barriers	Data and Information Needs	People who need to be included in processes around Medicaid Buy-In
• Fear of losing income and benefits if employed (Fear of having a lower income, fewer benefits, and fewer services if you work) (8) • Eligibility for Medicaid (6) • Limited ability to save financially for the future (5) • Need better employer incentives (5) • Lack of affordable and accessible housing (initially and as income increases) (4) • Financially in between services and self support (earn too much income to receive benefits, but do not earn enough income for self sustainability) (4) • Social discrimination and attitudes – a lack of acceptance in the workplace (4) • Long-term employment support for developmental disabilities (other than mental retardation), brain injury, and adults with mental illness (3) • Prescription drugs (3) • Employee and employer fear of drip in/drop out capacity – need continual system support (2) • Self-esteem and confidence (2) • Public transportation (2) • Limited or no accessibility to specialist care (dental, eye, hearing) (2) • Limitation of health care (1) • Flexibility to work from home or own your own business (1) • Inadequate rehabilitation (Rehabilitation has been reduced so much that customers only reach a point for nursing home living, not self sufficiency.) (1) • Employment options do not match employees skill sets – underemployment (1) • Mental health funding is prioritized for treatment, not for employment • Limitations on HIV/AIDS being recognized as a disability • Information not reaching people (opportunities for employment, opportunities to employ, skill and training opportunities, services and benefit details) • Blind people feel differentiated from disability community • Time of "unknown," with finances, health care, and housing, during the waiting period for qualification – waiting period policy needs review Fragmentation of services and benefits (They are often different from locality to locality.)	• Models and learnings from other states, particularly southeast and mid Atlantic states • Percentage of people who want to work –obtain through a survey • What makes working worthwhile to people – obtain through a survey • DMH and DMAS know who is in the system now • Forecasting the cost of different models (eligibility thresholds) and compare it to resources to implement program • Set a time constraint to end collection of data and start moving to implementation • Details about Governor's priorities and legislative agenda • Information about the current Medicaid system • Details of DRS/SSA/DSS (government agencies) policies	• Disability advocacy groups • Legislators • Gubernatorial candidates • Joint Commission on Health Care • Joint Commission of Behavioral Health Care • Disability Commission • Chamber of Commerce • Business Leadership Network (BLN) • Consumers • Medicaid and Non-Medicaid service providers • Disability Services Board Chairs • Social Security Administration • Private healthcare insurance companies • State Corporation Commission • Decision makers and middle management of all • Department of Planning and Budget • Secretary of Health and Human Resources • Association of Professional Supportive Employers (APSE) – group was unsure exactly what acronym stands for

Data from the Yellow Dot Group

Issues & Barriers	Data and Information Needs	People who need to be included in processes around Medicaid Buy-In
• Transportation (8) • Availability of adaptive technologies • Loss of health insurance coverage & other benefits (11) • Fear & attitudes of some employers • Inadequate supportive services to get people to the point of employment (4) • Language barrier/ on-going communication access (2) • PBS plans for behavioral issues in a work setting (Positive Behavior Support) (1) • Lack of Marketable skills • Lack of readiness after high school for employment (3) • Failure to provide a forum to educate employers • Complexity of programs related to employment of the disabled • (10) • Education for future employers • Pigeon-holing	• We have data but its not yet useful information – numbers not connected (Federal/ State Incompatibility, No set criteria of data across agencies) • Look at other state programs for what has been usable/ useful • How much do disability workers know about options for the disabled • Interagency working group looking at how to work with existing data • Disability commission recommends in-depth survey	• More consumers • SSA • Regional meetings (town hall, closer to home, informal) • Get businesses involved—be a part of the process • Use a facilitated process • Support service providers • Focus group of consumers • Stakeholders include families • Personal experience based education of legislators • Draw in benefit planning specialists

Employment Opportunities for the Disabled
Issues and Barriers

Capacity of Community and Support Services Infrastructure	Public Policy	Job Readiness	Economic Impact	Perceptions & Attitudes	Communication	Employer Education
Affordable Housing (9) High Unemployment = Low Opportunity for the Disabled (3) Availability of adaptive technologies Equipment cost and training (2) Independent Living Supports (6) Limitation of health care Limited or no accessibility to specialist care (2) Personal services Transition services Transportation (20)	Complexity of programs related to employment of the disabled (2) Eligibility for Medicaid (6) Flexibility to work from home or own your own business Fragmentation of services anhd benefits from locality to locality Limitation on HIV/AIDS being recognized as a disability Long Term employment support (3) Mental Health funding is prioritized for treatment, not employment No plan for moving people from institutional settings to work Waiting period policy	Education limitations (2) Employment options do not match skill sets (2) Small step entry into workplace Timing of employment—related to needs of disability	Entry Level Salaries with limited range for growth (1) Limited ability to save for future (5) Loss of health care coverage and other benefits (32)	"Good Enough" job attitude Assumption of limitations Blind people feel differentiated from disability community Discrimination (3) Fears and attitudes of some employees Fear of the disabled Ignorance (3) Employee and employer fear of drop in/ drop out capacity Motivation and preparations of the public (1) Self-Esteem and Confidence	Information not reaching people Language barriers/ on-going communication access (2) Mis-information in professional network	Education for employers (2) Employer incentives (5)

Medicaid Buy-In Consumer Forum
Tuesday, February 27, 2001
Break-out Session Summary

Following general session presentations in the morning, meeting participants formed three subgroups in the afternoon, each of which addressed the following three questions:

1. What are the issues and barriers that impede the competitive employment of people with disabilities?
2. In developing a Medicaid Buy-In Program for Virginia, what kinds of data and information should be gathered, and from whom?
3. Who else should be involved in the development of the Medicaid Buy-In Program? In other words, who else should be at the table?

The issues and barriers identified by each subgroup in response to the **first question** are summarized in the table titled "Employment Opportunities for People with Disabilities: Issues and Barriers" on page 2. Seven broad categories of issues were identified, including:

- public policy issues,
- limitations in community and support services/infrastructures,
- perceptions and attitudes that create barriers,
- questions of job readiness,
- barriers related to the economic impact of becoming employed,
- communication problems, and
- limited employer involvement.

A summary of the subgroups' answers to the **second question**, about the kinds of data and information that are needed for development of a Medicaid Buy-In Program, is provided in the table titled "Medicaid Buy-In Data and Information Needs" on page 3. Across all three subgroups, information needs were identified in five broad areas:

- data from consumers on their experiences and needs,
- analysis of cost issues,
- information about current policy issues and priorities in Virginia,
- information on the experiences of other states, and
- coordination of data sources at both the state and federal levels.

The people and organizations that should be included in developing a Medicaid Buy-In program, as identified by each subgroup in response to the **third question**, are summarized in the table titled "Stakeholders for Medicaid Buy-In Development" on page 4. Key groups to be involved included:

- state legislators and other state and federal policy makers,
- more consumers and advocacy groups,
- service providers,
- employers and
- insurance providers.

Employment Opportunities for People with Disabilities: Issues and Barriers

Public Policy	Community and Support Services Infrastructures	Perceptions & Attitudes	Job Readiness	Economic Impact	Communication	Employer Involvement
• Eligibility for Medicaid • Long Term employment support • Complexity of programs related to employment of the disabled • Lack of flexibility to work from home or own your own business • Limitation on HIV/AIDS being recognized as a disability • Mental Health funding prioritized for treatment, not employment • No plan for moving people from institutional settings to work • Waiting period policy	• Transportation • Affordable Housing • Independent Living Supports • Equipment cost and training • Limited or no accessibility to specialist care • Personal services • Transition services • Availability of adaptive technologies • Limitation of health care • Fragmentation of services and benefits from locality to locality	• Discrimination • Ignorance • "Good Enough" job attitude • Assumption of limitations • Blind people feel differentiated from disability community • Fears and attitudes of some employees/Fear of the disabled • Employee and employer fear of drop in/ drop out capacity • Motivation and preparations of the public • Self-esteem and Self-confidence of people with disabilities	• Education limitations • Employment options do not match skill sets • Small step entry into workplace • Timing of employment - related to needs of disability	• Loss of health care coverage and other benefits • Limited ability to save for future • High Unemployment = Low Opportunity for the Disabled • Entry Level Salaries with limited range for growth	• Language barriers/ on-going communication access • Information not reaching people • Misinformation in professional network	• Employer incentives • Education for employers

Medicaid Buy-In Data and Information Needs

Experiences & needs of consumers	Cost issues	Current policy priorities & issues	Other state's models/experiences	Coordination of data sources
• Survey to SSI recipients (DMAS with mailing list) • Percentage of people who want to work –obtain through a survey • What makes working worthwhile to people – obtain through a survey • Disability commission recommends in-depth survey • Statistics on people with disabilities in the workforce	• True cost of keeping disabled out of work force • Benefits for getting disabled into the workforce • Quality/value of service (DRS survey—cost/benefit analysis) • Forecasting the cost of different models (eligibility thresholds) and compare it to resources to implement program	• Details about Governor's priorities and legislative agenda • Information about the current Medicaid system • Details of DRS/SSA/DSS (government agencies) policies • How much do disability workers know about options for the disabled	• Other state data • Models and learnings from other states, particularly southeast and mid Atlantic states • Look at other state programs for what has been usable/ useful	• We have data but its not yet useful information – numbers not connected (Federal/ State Incompatibility, No set criteria of data across agencies) • Interagency working group looking at how to work with existing data • DMH and DMAS know who is in the system now

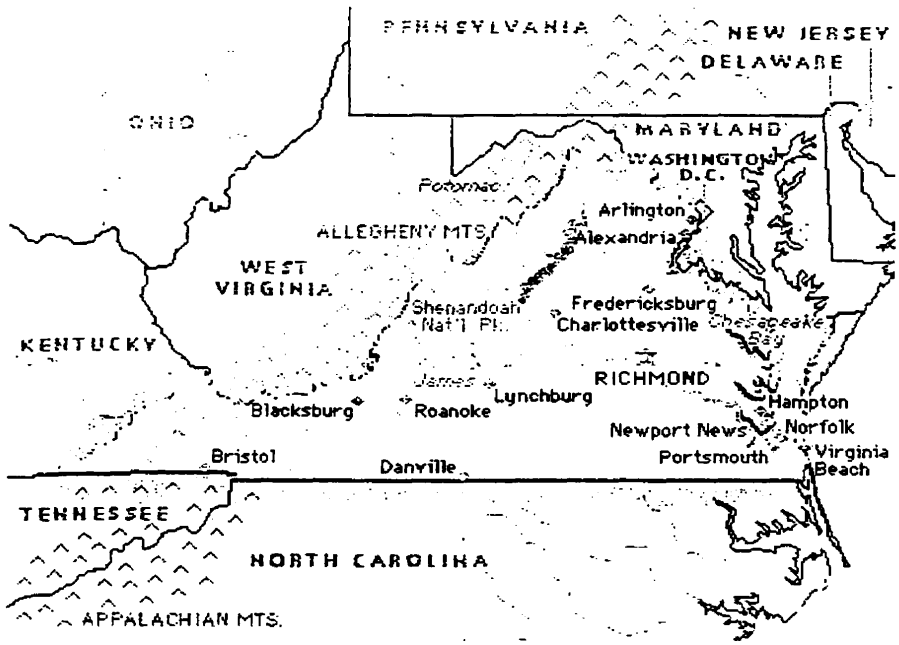
Stakeholders for Medicaid Buy-In Development

Legislators and Policy Makers	Consumers and Advocacy Groups	Service Providers	Employers	Insurance Providers
• Legislators • State Policy Makers • "Money Controllers" • Gubernatorial candidates • Joint Commission on Health Care • Joint Commission on Behavioral Health Care • Disability Commission • State Corporation Commission • Department of Planning and Budget • Secretary of Health and Human Resources • Social Security Administration • Decision makers and middle management of all • Draw in benefit planning specialists • Personal experience-based education of legislators	• More consumers • Advocates • Disability community representatives • Disability advocacy groups • Disability Services Board Chairs • Those who fall between the cracks/at-risk • Stakeholders include families	• Service Providers • Support service providers • Medicaid and Non-Medicaid service providers • Association for Persons in Supported Employment (APSE) • Transportation	• Employers • Chamber of Commerce • Business Leadership Network (BLN) • Get businesses involved—be a part of the process	• Insurance providers • Private healthcare insurance companies

Appendix D

Virginia Commonwealth University
Survey and Evaluation Research Laboratory
1619(b) Survey

Medicaid Work Incentive Survey: Report of Findings



Prepared for:

Virginia Department of Medical Assistance Services

May 2002

Prepared by:

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Virginia Commonwealth University
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Executive Summary

Since the Supplemental Security Income (SSI) program was implemented in 1974, work incentive provisions have been included in the Social Security Act for persons with severe disabilities. Under Section 1619(b) of the Social Security Act there is a work incentive program that allows individuals to work *and* maintain their Medicaid coverage after their cash payments have ceased. To be eligible, the person's earnings must remain below a certain threshold amount. If Virginia had a Medicaid buy-in program, 1619(b) eligible individuals that exceed the earnings threshold could opt to purchase Medicaid as their source of health insurance. In other words, they could buy in to Medicaid. The Virginia Department of Medical Assistance Services (DMAS) contracted with the Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University to survey individuals eligible for continued Medicaid coverage under 1619(b).

The *Medicaid Work Incentive Survey* was developed by SERL and used to gather information from individuals with disabilities about their employment status, their health insurance coverage, their Medicaid status, and their knowledge of 1619(b) and work incentives such as Medicaid buy-in programs. A total of 730 of 1,430 surveys were completed and returned to yield a response rate of 51%. Of the 730 respondents, 63% were currently receiving Medicaid in Virginia, 25% were past Medicaid recipients, and 12% had never received Medicaid.

Survey respondents were distributed across all five regions of the Commonwealth with the greatest representation being in the northern region and the least representation being in the western region. The average age of respondents was 38 years with a range from 19 years to 82 years. Approximately one-half were male and one-half were female. Slightly less than one-half reported having a high school education or equivalent.

Fifty-one percent of the respondents reported having one disability, 28% reported two disabilities and 13% reported three disability categories. Across all three Medicaid groups (current, cancelled, and never), the three most frequently cited disability categories were consistent. They were mental health impairment, physical disability, and developmental

disability. The least frequently cited disabilities included HIV/AIDS, drug/alcohol dependency, spinal cord injury, respiratory impairment and hearing impairment.

The following are key findings from the survey with regard to employment, health insurance, Medicaid status, awareness of Medicaid buy-in programs, and knowledge of 1619(b).

Employment:

- Eighty-four percent of the respondents reported currently having a job for which they receive pay. Little difference was seen in employment status based on current Medicaid status.
- Earnings ranged from less than $100 per month to greater than $1,099 per month. Forty-six percent (n=264) reported earning between $100 to $499 per month and 32% (n=185) reported earning between $500 and $1,099 per month.
- Respondents currently on Medicaid reported earning less money per month than their counterparts that had either had their Medicaid cancelled or had never been on Medicaid.
- Nearly one half of the respondents reported working 31 to 40 hours per week. Past Medicaid recipients and those who never received Medicaid in Virginia reported working more hours than those currently receiving Medicaid. Further, 35% of those currently on Medicaid reported limiting their work hours in order to continue receiving certain benefits as compared to 20% of past Medicaid recipients and 15% of those never on Medicaid.
- Seventy percent of respondents indicated that they had no desire to work more hours per week.
- With regard to ancillary services that make work feasible, transportation was cited most frequently and interpreter services was cited least frequently.

Health Insurance

- Eighty-four percent of the respondents reported currently having health insurance (n=602). The vast majority indicated that their coverage was either through Medicaid or Medicare.

Health Insurance (con't)

- Of those that reported currently having health insurance, slightly less than one-half (n=252) knew the amount of their monthly health insurance premium. Approximately 50% (n=125) reported having a monthly premium of less than $50 per month. Thirty-two percent (n=79) reported monthly premiums between $50 and $75 per month. The remainder reported monthly premiums over $75 per month.

- Most respondents reported that their current health insurance plan covers, at least partially, doctor visits and prescription medications. Fewer respondents reported at least partial coverage for services such as medical supplies and equipment, transportation to and from medical appointments, and dental care.

Medicaid Status

- Of all respondents, 70% reported currently receiving Medicaid (n=489). Of those not currently receiving Medicaid, 76% reported having applied for Medicaid in Virginia in the past (n=152).

- Those that reported not currently receiving Medicaid *and* having applied for Medicaid in Virginia in the past, were asked if they had been denied Medicaid in Virginia. Thirty-seven percent reported having been denied (n=53). Of these 53, approximately 20% had been denied because their income exceeded the threshold amount required for Medicaid consideration.

Awareness of Medicaid Buy-In Programs

- Only 31 of the 677 respondents reported having heard of Medicaid buy-in programs. That is a mere 4% of all survey respondents. The most frequent source of information cited by the 31 respondents was their case manager / social worker.

Knowledge of 1619(b)

- When asked if they had ever heard of 1619(b), only 9% of the respondents indicated that they had (n=65); 91% of respondents indicated they had not (n=646). Only slight variations were noted in awareness based on the respondents Medicaid status.

- Those that had heard of 1619(b) were asked to select, from 4 choices, the one that best described 1619(b). Of the 54 respondents answering this question, 65% selected the most accurate definition of 1619(b) that was provided.

The Medicaid Work Incentive Survey yielded interesting findings across a range of topics. For many demographic, employment, Medicaid, and health insurance questions, respondents were strikingly similar in their responses across all three Medicaid categories. This was the case for questions related to education, disability type, employment status, knowledge of 1619(b), and awareness of Medicaid buy-in programs.

Differences were seen between respondents based on Medicaid status for questions related to hours worked per week, earnings, and limitation of work hours. Those currently on Medicaid tended to work less hours per week, earn less money, and limit their hours to a greater degree than their counterparts who had their Medicaid cancelled or had never been on Medicaid.

I. BACKGROUND & PURPOSE:

Since the Supplemental Security Income (SSI) program was implemented in 1974, work incentive provisions have been included in the Social Security Act for persons with severe disabilities. Under Sections 1619(a) and 1619(b) of the Social Security Act, SSI beneficiaries have had the opportunity to earn higher incomes while retaining Medicaid eligibility. 1619(a) allows an individual to increase earnings which, in turn, causes a gradual reduction in their SSI cash benefit. With continued increased income, the SSI cash benefit eventually reaches zero and then Medicaid coverage is also lost unless the individual is eligible for continued coverage under the 1619(b) provision. Under 1619(b), eligibility for Medicaid coverage can be retained if the individual continues to: (1) meet all SSI eligibility criteria except for earnings (i.e., serious disabling condition); (2) needs Medicaid services to maintain employment (e.g., coverage for medication or therapy); and (3) has gross earnings below the state-specific threshold. The current threshold amount in Virginia is $21,319 (FY 2002).

During the course of researching disabled populations that could potentially benefit from a Medicaid buy-in program[1], the Department of Medical Assistance Services (DMAS) obtained a listing of all 1619(b) eligible individuals residing in Virginia as per the Social Security Administration (SSA).[2] Medicaid recipients in this category could eventually exceed the state's earnings threshold and, therefore, could potentially benefit from a Medicaid buy-in option. The SSA data was matched against Medicaid files to determine if these individuals were: (1) currently receiving Medicaid; (2) previously enrolled in Medicaid in Virginia; or (3) never enrolled in Medicaid in Virginia. DMAS found that the majority of these individuals (57%) were currently enrolled in Medicaid. Twenty-seven percent had been on Medicaid previously but were canceled and the remaining 16% had never been enrolled in Medicaid in Virginia.

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[1] A Medicaid buy-in program is one that would allow otherwise eligible persons who exceed the threshold amount for earnings and/or resources to purchase continued Medicaid coverage. In other words, persons ineligible for Medicaid based on income and/or resources would have an option to buy Medicaid coverage.

[2] In September 2001, the Social Security Administration reported that a total of 1,781 SSI recipients in Virginia were 1619(b) eligible.

DMAS sought assistance from the Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University to gain information directly from 1619(b) eligible individuals about how the development of a Medicaid Buy-In program could further enhance their participation in competitive employment. SERL agreed to conduct a survey of the 1619(b) eligible individuals within each of the following sub-groups: currently receiving Medicaid, previously received Medicaid in Virginia, and never received Medicaid in Virginia. The purpose of the survey was to compare these groups to gain knowledge of demographics and other characteristics, including employment status, health care needs, and health care insurance. The findings of this research are intended to provide guidance to DMAS in their effort to develop a Medicaid buy-in program that addresses the insurance needs of the seriously disabled that are seeking or are engaged in competitive employment.

II. RESEARCH METHODOLOGY:[3]

Survey Development and Design

The *Medicaid Work Incentive Survey* was developed to gather information from individuals with disabilities about their employment status, their health insurance coverage, their Medicaid status, and their knowledge of 1619(b) and work incentives such as Medicaid buy-in programs. DMAS provided SERL with a number of core questions to which answers were sought. These core questions were transformed into closed-ended survey questions that fit into one of the following broad categories: demographics, employment, health insurance coverage, Medicaid status, or knowledge of 1619(b).

[3] The VCU Institutional Review Board (IRB) reviewed and approved the study protocol prior to the initiation of data collection.

The survey was reviewed by key stakeholders at DMAS, Department of Rehabilitative Services (DRS), and other state agencies and organizations. In addition, DMAS, DRS and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) arranged for pilot testing of the survey with a number of individuals with disabilities[4] These test completions generated valuable feedback with regard to survey design elements such as question wording and clarity, question order, and skip patterns.

Survey Distribution

The survey was sent via first class mail to 1,692 individuals that were designated by the Social Security Administration as 1619(b) eligible and were either currently receiving Medicaid (n=986), had received Medicaid in the past (n=438), or never received Medicaid (n=268).[5] This represented the entire population of 1619(b) eligible individuals in the Commonwealth of Virginia. The names and addresses for the mailing were provided to SERL from DMAS.

SERL sent a pre-notification postcard to the entire sample ten days prior to the mailing of the survey. The postcard alerted individuals to the fact that they would be receiving a survey from SERL, on behalf of DMAS, within 10 to 14 days. The pre-notification postcard was signed by a DMAS official. Seven days thereafter, the mail survey was sent to the entire sample. A three dollar incentive was included in the first mailing along with a postage paid, return envelope. Two weeks after the mailing of the survey, a reminder postcard was mailed. Seven days thereafter, all non-responders were sent a second survey packet. This was identical to the first with the exception of a re-worded cover letter and the exclusion of the three dollar incentive.

[4] Data from these individuals were not included in the analyses.
[5] Name, address and Medicaid status file based on a query conducted by DMAS in September 2001. Prenotification postcards that were returned non-deliverable triggered exclusion of that case from the mailing database for the survey. Thus, the total number of surveys sent (n=1,692) is smaller than the initial population of 1619(b) eligible individuals (n=1,781).

A copy of the prenotification postcard, cover letter, survey, reminder postcard, and second-wave mailing cover letter can be found in Appendix 1.[6]

Response Rate

As mentioned previously, a total of 1,692 surveys were mailed, first-class, to the population of 1619(b) eligible individuals. Of these, 1,430 were deliverable. Table 1 provides summary information about the survey population by Medicaid group.

Table 1 – Survey Population by Medicaid Group

Medicaid Group	*Original Population*	*Bad Addresses*	*True Population*	*% in Medicaid Group*
♦ Currently receiving Medicaid in Virginia	986	81	905	63%
♦ Previously received Medicaid in Virginia	438	81	357	25%
♦ Never received Medicaid in Virginia	268	100	168	12%
TOTAL	1,692	262	1,430	100%

A total of 730 of 1,430 surveys were completed to yield a response rate of 51%. Of these, 718 were completed by mail, 10 were completed by phone (voice), and two were completed via TTY. Three cases were excluded from the analyses because the respondents were under the age of 18. Table 2 provides summary information about the distribution of the 727 respondents across the three different Medicaid groups.

[6] A toll-free phone line and a TTY line were made available for survey respondents who were unable to complete the survey by mail.

Table 2 - Respondents by Medicaid Group

Medicaid Group	*True Sample*	*Number of Respondents*	*% in Medicaid Group*
♦ Currently receiving Medicaid in Virginia	905	503	69%
♦ Previously received Medicaid in Virginia	357	155	21%
♦ Never received Medicaid in Virginia	168	69	10%
TOTAL	1,430	727	100%

As can be seen by comparing the far right-hand columns in Tables 1 and Table 2, the distribution of survey respondents across the Medicaid categories was similar to the distribution seen in the entire study population.

III. DESCRIPTION OF THE SURVEY RESPONDENTS

Regional Distribution

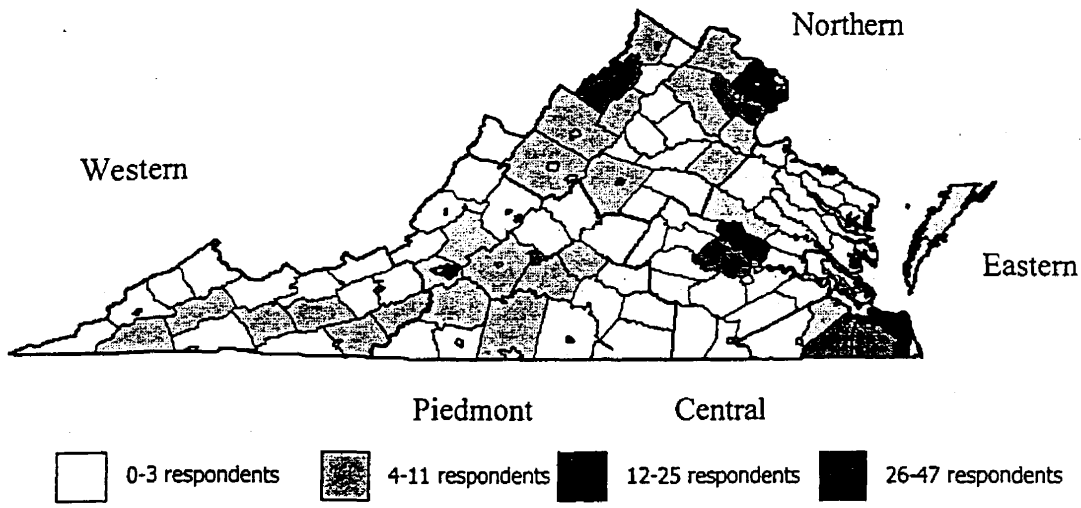
Respondents were distributed across all five regions of the Commonwealth with the greatest representation being in the northern region and the least representation being in the western region. Representation of respondents in the different Medicaid groups was similar across regions. Table 3 highlights the number of respondents per region by Medicaid group. Figure 1 provides a geographic representation of respondents by region.

Table 3 - Regional Distribution of Respondents by Medicaid Group

		Medicaid Group			
Region	*Total N*	*% of Regional Total: Current*	*% of Regional Total: Cancelled*	*% of Regional Total: Never*	*% of ALL Respondents*
Northern	233	74%	14%	12%	32%
Eastern	179	65%	28%	7%	25%
Central	127	71%	21%	8%	17%
Piedmont	122	67%	21%	12%	17%
Western	62	66%	29%	5%	9%
Total[7]	723	69%	21%	10%	100%

[7] FIPS missing for four respondents.

Figure 1 - Distribution of Respondents by Region



Age

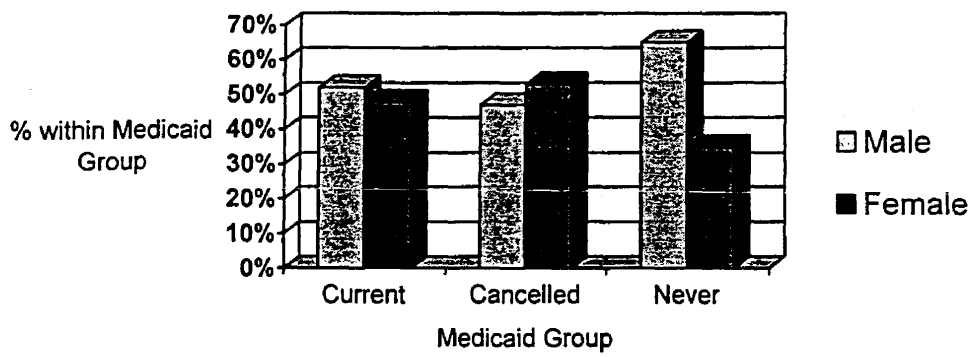
The average age of respondents was 38 years with a range from 19 years to 82 years. Respondents that were never on Medicaid were, on average, younger than those currently on Medicaid or those that had been on Medicaid in the past.[8]

[8] Mean age for those never on Medicaid was 35 years old. Mean age for those currently on Medicaid was 39 years old. Mean age for those previously on Medicaid was 37 years old. An ANOVA with Tukey's post-hoc analysis indicates that the difference between the ages of those who were never on Medicaid and those who are currently on Medicaid approached statistical significance (p=.057). However, the difference was only four years between these two groups.

Gender

Respondents were equally distributed with regard to gender. Variations were seen in the gender distribution within the three different Medicaid groups.[9] There was a slightly higher number of males in the "currently on Medicaid" group and significantly higher number of males in the "never on Medicaid" group. The number of females slightly exceeded the number of males in the "previously on Medicaid" group. Figure 2 highlights these findings.

Figure 2 - Gender of Respondents by Medicaid Group



Marital Status

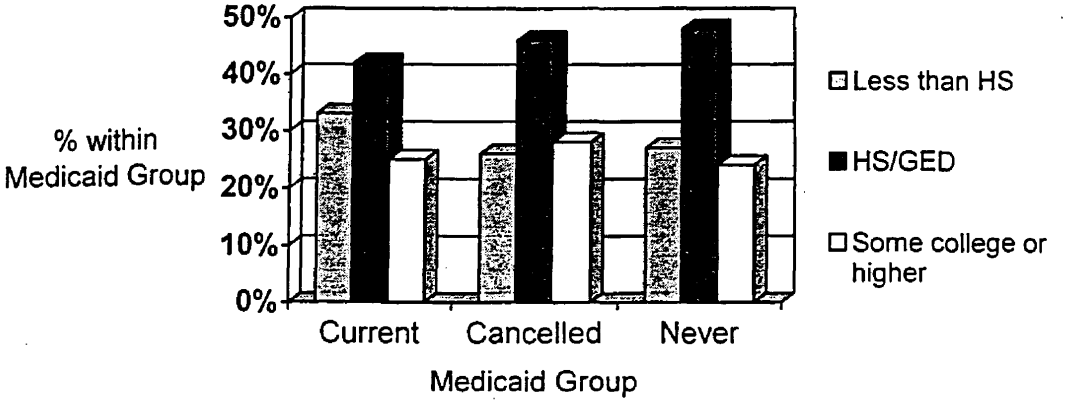
The vast majority of the respondents, 87%, reported being "single / widowed / divorced / separated" (n=622). The remainder, 13%, reported being married (n=92). Variations were seen in the marital status of respondents based on the Medicaid group that they were in. Those that had their Medicaid cancelled were more likely to report being married as compared to those currently receiving Medicaid and those having never received Medicaid in Virginia (X^2=10.63, 2, n=714, p=.005).

[9] Chi-square value is statistically significant suggesting that there is an association between gender and Medicaid status (X^2=6.35, 2, n=716, p=.04). The adjusted residuals suggest that the primary contribution to this finding is related to the distribution of males and females in the "never on Medicaid" group.

Educational Attainment

Approximately 31% of all respondents reported having less than a high school education (n=217), 44% reported a high school education or equivalent (n=303), and 25% had some college education or a college degree (n=175). Chi-square analyses suggest that there is no significant association between education and Medicaid status (X^2=14.30, 10, n=695, p=.16). In other words, educational level does not appear to differ significantly between respondents in different Medicaid groups. Figure 3 provides a graphic representation of this finding. Within each of the different Medicaid groups (current, cancelled, and never), the educational level reported by the respondents followed a similar distribution.

Figure 3 - Educational Attainment by Medicaid Group



Disability Type

Each respondent was asked to identify which disability category pertained to him/her from a list that was provided. Respondents were instructed to check all of the disability categories that applied. Options included, but were not limited to, physical disability, hearing impairment, mental health impairment, and developmental disabilities. Fifty-one percent of the respondents checked one disability category only (n=356), 28% checked two disability categories (n=195), and 13% checked three disability categories (n=89). The remaining 8% checked between four to seven disability categories (n=54).[10]

Within each of the three Medicaid groups (current, cancelled, and never), the three most frequently cited disability categories were consistent. They were mental health impairment, physical disability, and developmental disability. The least frequently cited disabilities were consistent for respondents that were currently receiving Medicaid and those previously on Medicaid. These were HIV/AIDS, drug/alcohol dependency, and spinal cord injury. Those that never received Medicaid in Virginia varied slightly. The three least frequently cited disabilities for this group was HIV/AIDS, spinal cord injury, and respiratory impairments.

IV. DATA ANALYSIS & FINDINGS:

As mentioned previously, the survey instrument contained five sections. The demographic characteristics of the respondents have been described previously. The remaining four sections of the survey were focused on employment-related questions, health insurance, Medicaid status, and knowledge of 1619(b). The remainder of this report highlights the findings within each of these sections. When appropriate, comparisons between those currently on Medicaid, those previously on Medicaid, and those never on Medicaid are made. Detailed charts for each of the major content areas, comparing respondents by Medicaid group, are available in the Appendix 2.

[10] Thirty-three respondents failed to check any of the 12 disability categories on the survey. These respondents, along with those under the age of 18, are excluded from the analyses related to disability type.

Employment-Related Questions

Respondents were asked a series of questions related to their current employment status. This included questions about current employment status, type of occupation, tenure at current job, hours worked per week, earnings, number of different jobs within the past two years, desire to work more hours, and support services that make work possible.

Type of Work

Eighty-four percent of the respondents (n=604) reported currently having a job for which they receive pay. Table 4 highlights the jobs that respondents reported having.

Table 4 - Type of Work

Type of Work	*Number of Respondents*	*% of Total*
Other[11]	222	38%
Sheltered work	149	25%
Service, maintenance	74	13%
Sales and related work	40	7%
Secretarial, clerical	29	5%
Professional	25	4%
Skilled craft	17	3%
Technical, paraprofessional	15	2%
Executive, administrative, managerial	10	2%
Farming, fishing, forestry, and related work	4	1%
TOTAL	585	100%

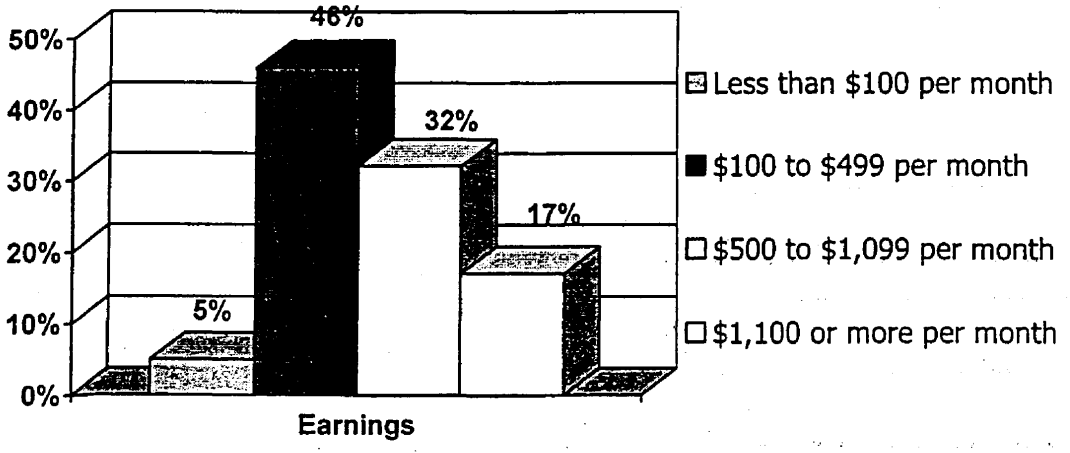
Employment Tenure and Income

Approximately one-half of the respondents (n=308) reported being at their current job for more than two years. Twenty-five percent reported being at their current job for one to two years. The remainder reported tenure at their current job of less than one year.

[11] Many respondents wrote in their job title / job activity rather than selecting one of the defined categories provided. The verbatim responses for those that reported "other" are provided in Appendix 4.

Earnings ranged from less than $100 per month to greater than $1,099 per month. Five percent reported earning less than $100 per month, 46% (n=264) reported earning $100 to $499 per month, 32% (n=185) reported earning between $500 and $1,099 per month, and 17% (n=99) reported earning over $1,100 per month. Figure 4 illustrates the findings with regard to earnings.

Figure 4 - Respondent Earnings



Yearly income is an important consideration with regard to Medicaid buy-in programs. Much attention has been paid to the income threshold that, if exceeded, precludes an employed individual from receiving Medicaid benefits. As mentioned previously, this threshold amount in Virginia is $21,319 (FY 2002). There were 549 respondents who were employed and reported earning less than $1,699 a month (approximately $20,388/year). Presumably, these are respondents that *based on income alone* would currently be eligible for Medicaid. However, only 71% were on Medicaid (n=392). This suggests that attention be paid not only to the needs of those who exceed the threshold income but also to those with earnings that fall below the threshold amount but are not receiving Medicaid benefits.

Comparisons were also made between those that reported earning $1,700 or more per month and those earning less than $1,700 per month. Since an income of $1,700 per month would equate to a yearly income of $20,400, respondents in this category would likely be targets for a Medicaid buy-program as their income approximates and may well exceed the threshold amount of $21,319 (FY 2002). Interestingly, of the 27 respondents that earned greater than $1,700 per month, 37% (n=10) reported currently receiving Medicaid. These 10 respondents may be earning between $20,400 and $21,319.

Work Hours

Tables 5, 6, and 7 provide information with regard to number of hours worked per week, desire to work more hours per week, and limitation of work hour to maintain benefits.

Table 5 - Hours of Work per Week

Question: *How many hours do you currently work per week?*		
	N	Percent
01-10 hours per week	47	8%
11-20 hours per week	150	25%
21-30 hours per week	144	24%
31-40 hours per week	253	43%
TOTAL	594	100%

Table 6 - Desire to Work More Hours

Question: *Do you want to work more hours per week than you do right now?*		
	N	Percent
Yes	176	30%
No	405	70%
TOTAL	581	100%
Question: *If yes to above, how many more hours per week do you want to work?*		
	N	Percent
01 to 10 hours	67	38%
11 to 20 hours	24	14%
21 to 30 hours	17	10%
31 to 40 hours	39	22%
Over 40 hours	29	16%
TOTAL	176	100%

Table 7 - Limitation of Work Hours to Maintain Certain Benefits

Question: *Do you limit the number of hours you work per week so that you can receive certain benefits (e.g., Supplemental Security Income, Medicaid, etc)?*		
	N	Percent
Yes	178	30%
No	410	70%
TOTAL	588	100%

Ancillary Services and Work

Respondents were asked to identify the types of services that they receive that make it possible for them to work. Respondents were able to select multiple services. Table 8 highlights these findings.

Table 8 - Ancillary Services and Work

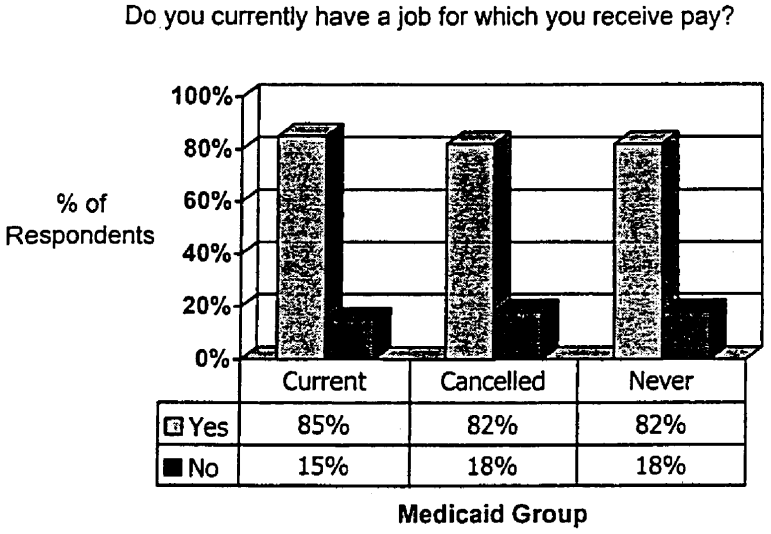
Question: *Which of the following do you receive that helps make it possible for you to work?*		
	N	Percent
Transportation	253	42%
Ability to obtain prescription medications	194	32%
Personal assistance services	79	13%
Adaptation of physical environment	32	5%
Interpreter	13	2%

NOTE: Respondents were asked to check all that applied. Thus, counts within categories are unique and counts across categories are duplicated.

Responses to Questions by Medicaid Group

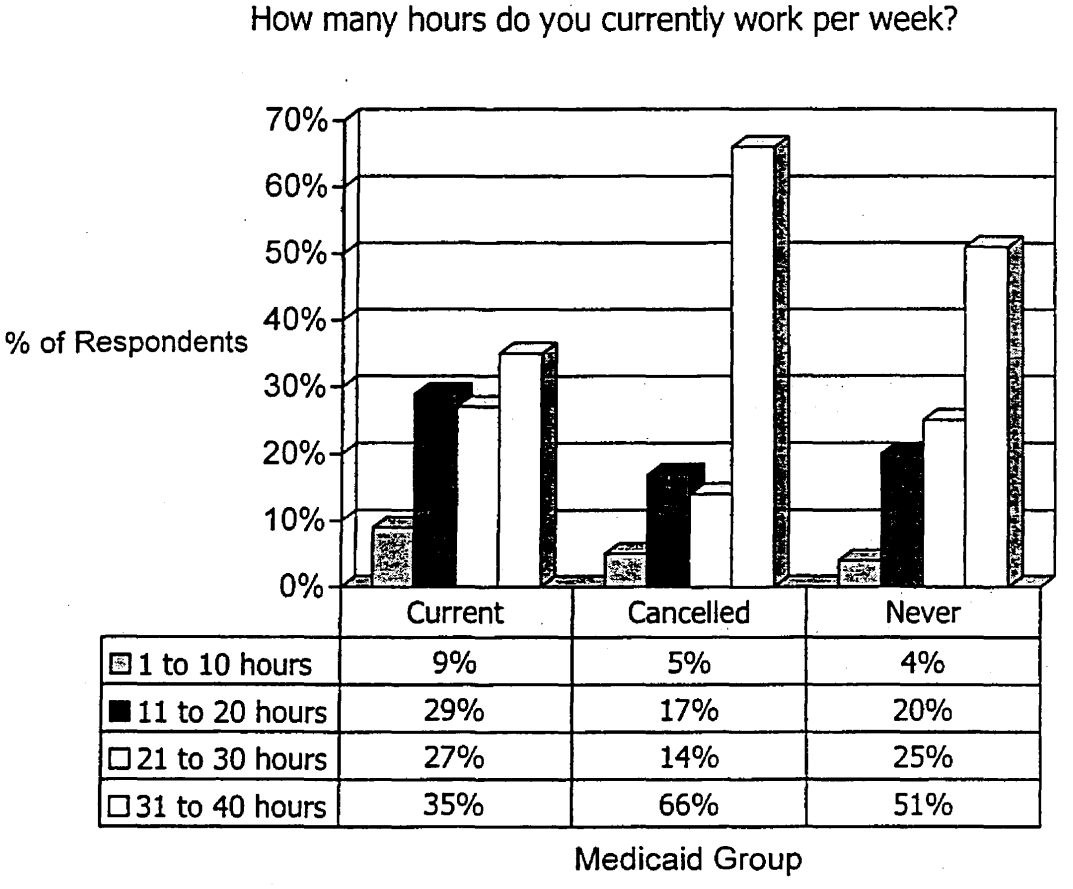
One of the core areas of interest in conducting this survey was to identify if differences existed between respondents based on their Medicaid status (current, cancelled, or never). Figures 5, 6, 7 and 8 provide a graphic comparison of respondents in the different Medicaid groups for the employment-related questions.

Figure 5 - Work Status by Medicaid Group



Of those currently receiving Medicaid, 85% reported having a job for which they received pay. Of those who have had their Medicaid cancelled, 82% reported having a job for which they received pay. Similarly, 82% of those who have never had Medicaid in Virginia reported having a job for which they receive pay. Little difference was seen in current employment status based on Medicaid group.

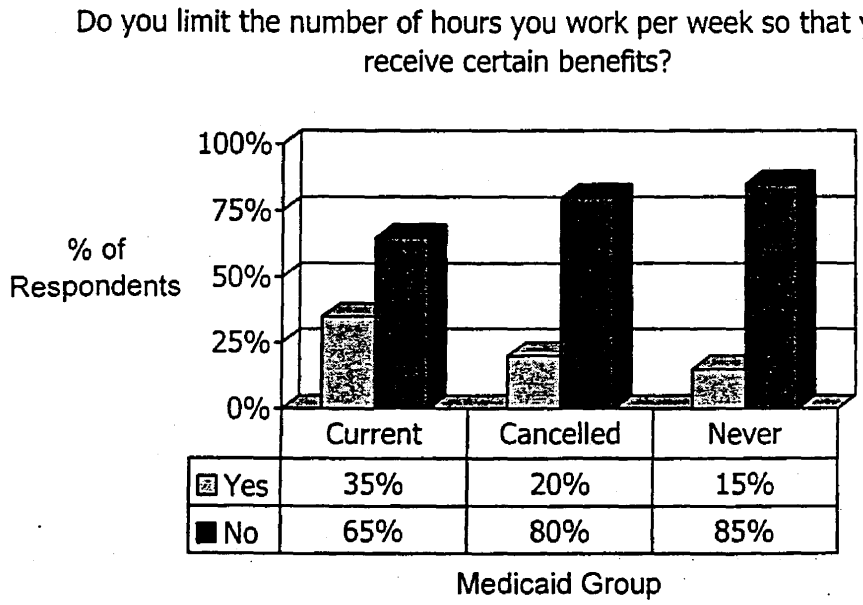
Figure 6 - Hours of Work per Week by Medicaid Group



	Current	Cancelled	Never
1 to 10 hours	9%	5%	4%
11 to 20 hours	29%	17%	20%
21 to 30 hours	27%	14%	25%
31 to 40 hours	35%	66%	51%

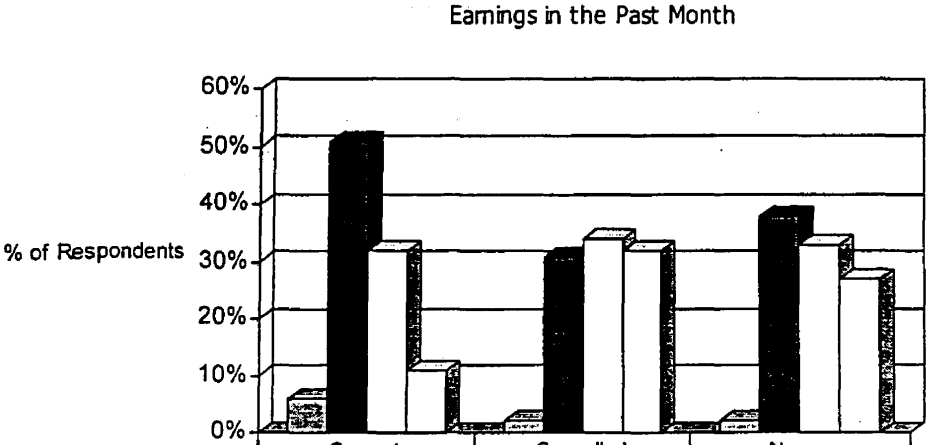
As can be seen from Figure 6, those in the cancelled and never on Medicaid in Virginia groups reported working more hours than those in the currently on Medicaid group. In other words, respondents currently on Medicaid reported working fewer hours than those in the other two Medicaid groups.

Figure 7 - Work Hour Limitations by Medicaid Group



The findings reflected in Figure 7 support the notion that at least some current Medicaid recipients opt to work fewer hours than desired in order to continue to receive benefits. The findings indicate that respondents currently on Medicaid reported limiting their hours more often than those in the cancelled and never on Medicaid in Virginia groups. Thirty-five percent of those currently on Medicaid limited their work hours as compared to 20% in the cancelled group and 15% in the never on Medicaid group.

Figure 8 Monthly Earnings by Medicaid Group



	Current	Cancelled	Never
Less than $100	6%	2%	2%
$100 to $499	51%	31%	38%
$500 to $1,099	32%	34%	33%
$1,100 of greater	11%	32%	27%

Medicaid Group

Figure 8 indicates that respondents currently on Medicaid, in general, reported earning less money per month than their counterparts that had either had their Medicaid cancelled or had never been on Medicaid. This is not unexpected since those currently on Medicaid reported working fewer hours than their counterparts in the other two groups.

Health Insurance

Health Insurance Coverage

Eighty-four percent of the respondents reported currently having health insurance (n=602). Of these, 18% reported that their health insurance was through their employer (n=105). The remaining 494 respondents were asked if their health insurance was through their spouse, through Medicaid, through Medicare, through a private insurance plan, through parent's health insurance, or through a military-related entity. The vast majority indicated that their health insurance was through Medicaid (76%) or Medicare (59%).[12]

[12] A number of respondents indicated having health insurance through more than one source.

Those that reported they currently have health insurance were asked about their monthly premium and coverage of selected health-related services. Slightly less than one-half of the respondents (n=252) knew the amount of their monthly health-insurance premium.[13] Approximately 50% (n=125) of the respondents reported having a monthly premium of less than $50 per month. Thirty-two percent (n=79) reported monthly premiums between $50 and $75 per month. The remainder reported monthly premiums of over $75 per month. Figure 9 illustrates the findings with regard to current health insurance premiums.

Figure 9 - Reported Health Insurance Premium

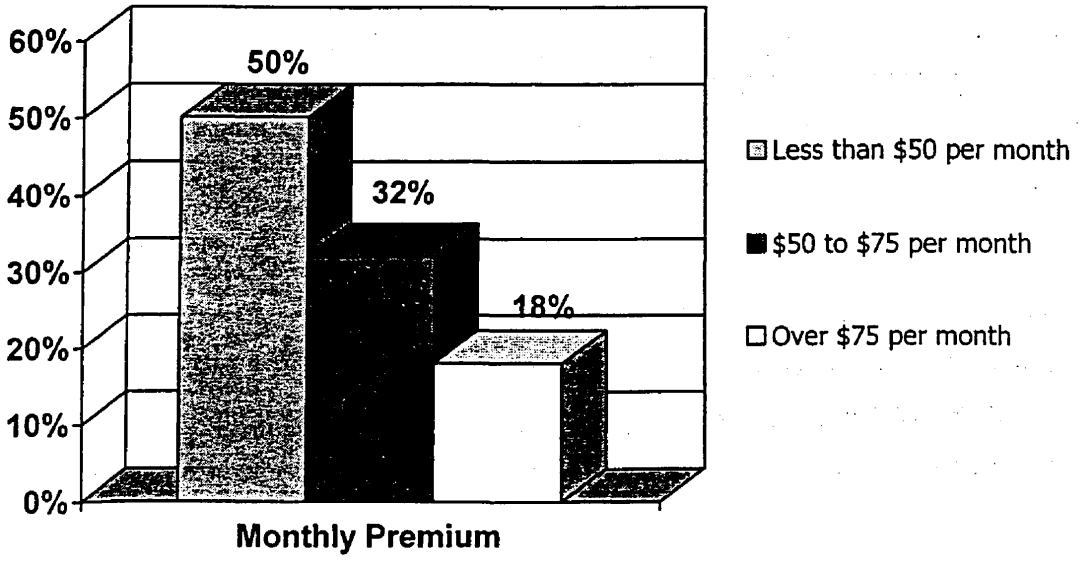


Table 9 below outlines the findings with regard to coverage, at least in part, for a range of services including prescription medications, doctor visits, personal assistance services, and transportation to medical appointments.

[13] Based on 540 respondents (62 of the 602 respondents with health insurance did not answer the question related to health insurance premiums).

Table 9 - Services Covered by Current Health Insurance

	Question: *Does your current health insurance plan cover, at least partially, the following?*		
	Yes	No	Don't know
Doctor visits	93%	4%	3%
Prescription medications	85%	10%	5%
Vision care	43%	43%	14%
Medical supplies and equipment	42%	22%	36%
Transportation to and from medical appointments	32%	41%	28%
Dental care	29%	60%	11%
Personal assistance services	21%	36%	44%
Family members	13%	73%	14%

Medicaid Status and Awareness of Medicaid Buy-In Programs

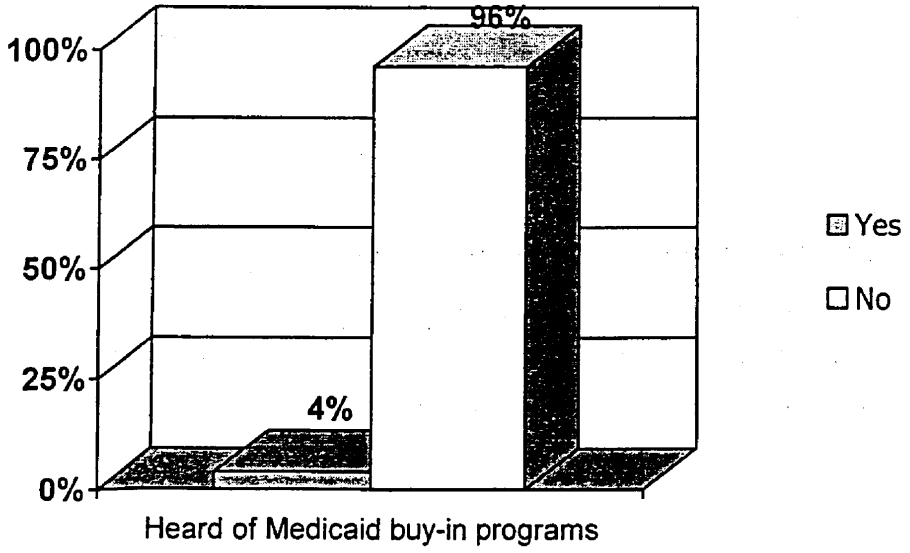
Respondents were asked about their current Medicaid status, past behaviors in terms of applying for Medicaid, and awareness of Medicaid buy-in programs. Of all respondents, 70% reported currently receiving Medicaid (n=489).[14] Of those that reported not currently receiving Medicaid, 76% reported having applied for Medicaid in Virginia in the past (n=152).[15]

Those that reported not currently receiving Medicaid *and* having applied for Medicaid in Virginia in the past were then asked if they had been denied Medicaid in Virginia. Thirty-seven percent reported having been denied (n=53), 49% were not denied, and 14% did not know their status with regard to Medicaid denial.[16] Of the 53 that had been denied, 23 selected "other" as the reason. In reviewing the verbatim responses associated with these 23 respondents, approximately one-half reported that their income exceeded the threshold amount required for Medicaid consideration.

[14] This self-reported Medicaid status is consistent with the percent of respondents who were identified as current Medicaid recipients in the mailing database.
[15] The percentage is based on 199 respondents. Seven of those who reported not currently being on Medicaid did not answer this question.
[16] The percentages with regard to denial are based on 144 respondents. Eight of those who reported not currently being on Medicaid *and* having had applied for Medicaid in Virginia in the past elected not to answer this question.

Interesting findings were generated with regard to awareness of Medicaid buy-in programs. Respondents were asked if they had ever heard of Medicaid buy-in programs. Only 31 of the 677 respondents reported having heard of such programs. That is a mere 4% of all survey respondents. Figure 10 illustrates this finding. The most frequent source of information cited by the 31 respondents was their case manager / social worker.[17]

Figure 10 - Awareness of Medicaid Buy-In Programs



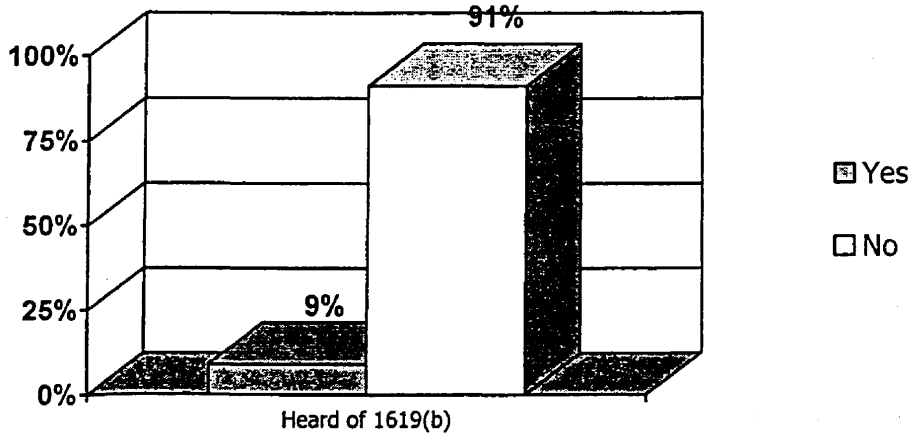
Knowledge of 1619(b)

Since 1619(b) eligible individuals represent a probable target population for a future Medicaid buy-in program, it was of interest to determine how knowledgeable they were about their 1619(b) eligible status. Respondents were asked if they had ever heard of 1619(b) and, if so, how they heard about it and what they understood it to mean.

[17] Since Virginia has not yet developed a Medicaid buy-in program, respondents were not asked questions that addressed understanding or knowledge about such a program.

When asked if they had ever heard of 1619(b), only 9% of the respondents indicated that they had (n=65); 91% of respondents indicated they had not (n=646). Figure 11 illustrates this finding.

Figure 11 - Have you heard of 1619(b)?



Only slight variations were noted in awareness based on the respondents Medicaid status. Approximately 50% of those who had reported hearing about 1619(b) reported having first heard about it through the Social Security Administration.[18]

Knowledge of 1619(b) was assessed by asking respondents to select, from 4 choices, the one that best described 1619(b). The definition that was deemed correct read, "1619(b) allows a person who goes to work to keep their Medicaid coverage as long as their income stays below a certain level." Of the 54 respondents answering this question, 65% selected the most accurate definition of 1619(b) that was provided. These findings with regard to awareness and knowledge indicate a need for targeted educational efforts.

[18] The percentage is based on 60 respondents. Five of those who had reported hearing about 1619(b) did not answer this question).

IV. Summary

The Medicaid Work Incentive Survey yielded interesting findings across a range of topics. For many demographic, employment, Medicaid, and health insurance questions, respondents were strikingly similar in their responses across all three Medicaid categories. This was the case for questions related to education, disability type, employment status, awareness of Medicaid buy-in programs, and knowledge of 1619(b).

Differences were seen between respondents based on Medicaid status for questions related to hours worked per week, earnings, and limitation of work hours. Those currently on Medicaid tended to work less hours per week, earn less money, and limit their hours to a greater degree than their counterparts who had previously been on Medicaid or had never been on Medicaid.

Interesting findings were generated with regard to income. It was anticipated that most respondents that earned less than $1,700 per month would currently be on Medicaid because of earnings that were below the current yearly $21,319 threshold amount (FY 2002). However, only 71% were currently on Medicaid. Further, it was anticipated that those that earned $1,700 or more per month would likely have had their Medicaid cancelled or never had been on Medicaid. However, 37% of these respondents reported currently being on Medicaid. These findings suggest the need for further research to clarify the relationship between income and Medicaid status and to identify other factors that allow or disallow persons with disabilities from receiving Medicaid.

Knowledge of 1619(b) was strikingly low among respondents. This is critical as the entire study population was 1619(b) eligible based on data provided be the Social Security Administration. These findings warrant further inquiry as to why there is an apparent lack of knowledge and how 1619(b) recipients can be made aware of benefits for which they may be eligible. An additional educational need was identified with regard to Medicaid buy-in programs. The vast majority of respondents had never heard of such programs. In order for an effective Medicaid buy-in program to be developed in the Commonwealth, it will be imperative to educate potential consumers and other key stakeholders about the characteristics of the program and its implications.

VI. Limitations

The Medicaid Work Incentive Survey was administered through the mail. Incentives and a second-wave mailing to non-responders were used to minimize non-response bias that is inherent in mail survey methodology. It is not known if those who responded are characteristically different than those who did not. However, a 51% response rate is encouraging along with the fact that there was representation across all regions of the Commonwealth. Additionally, the percent of respondents in each of the Medicaid groups closely approximated that of the entire population.

A self-developed survey was utilized because an instrument did not exist that adequately captured information relative to the research questions posed. Further refinement of the instrument is recommended based on the results of this study. Recommendations include refining selection options for the question pertaining to employment type. Many respondents selected "other." Also, when asked how many *more* hours per week one would like to work, some respondents reported wanting to work 40 additional hours per week or more. The wording of this question should be considered for revision in the future. Finally, some of the skip patterns can be simplified in future iterations of the survey.

APPENDIX 1

CONTENT OF THE PRE-NOTIFICATION POSTCARD

The Virginia Department of Medical Assistance Services (DMAS) has received a grant that will allow for the development of a Medicaid medical insurance program. This program will help meet the needs of working individuals with disabilities. In order to create a good program, DMAS needs to hear from you.

DMAS has contracted with the Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University to get your input. In the near future, you will receive a survey in the mail from the SERL. It will contain questions about your work, your health insurance, and Medicaid. We hope that you take the time to complete the survey. Your input will be crucial to helping DMAS develop a Medicaid medical insurance program that meets the needs of working individuals with disabilities in Virginia.

Sign with Kathryn T. Kotula
Director, Division of Policy & Research
Department of Medical Assistance Services

COVER LETTER

SERL LETTER HEAD

November [insert], 2001

Dear [insert],

The Virginia Department of Medical Assistance Services (DMAS) has received a grant that allows for an evaluation of the work incentives available to individuals with disabilities in Virginia. As part of this grant, DMAS will design a Medicaid medical insurance program to help meet the needs of working individuals with disabilities. In order to create a good program, DMAS needs to hear from you. To this end, the Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University has been contracted by DMAS to get your input.

The enclosed survey can be completed in about fifteen minutes. It contains questions about your work, your health insurance, and your Medicaid status. When completing the survey, you can leave questions blank that you do not want to answer. The $3 we have enclosed is a small token of our appreciation for your taking the time and energy to complete the survey.

The survey has an identification number. This number allows us to re-send the survey to people who do not respond initially. Information that is shared as a result of this study ***will not*** allow you to be identified to DMAS or anyone else. In other words, information will be kept strictly confidential. **Also, if you currently receive Medicaid benefits, nothing contained in this letter or survey will affect those benefits.**

If it is difficult for you to complete the survey by mail, you can call the SERL at 1-800-304-9402 / Voice or [INSERT #] / TTY and complete it over the phone. SERL staff is available to receive your call between 10:30am and 8:00pm Monday through Friday, between 11:00am and 4:00pm on Saturday, and between 4:00pm and 9:00pm on Sunday.

If you have any questions about this survey, please contact Kirsten Barrett, Ph.D., SERL Project Director, at 804-828-8813 or via e-mail at kbarrett@saturn.vcu.edu.

It is very important that you return your completed survey. The input you provide is crucial to building a new Medicaid program for working individuals with disabilities in Virginia. Thank you in advance for your time and effort!!

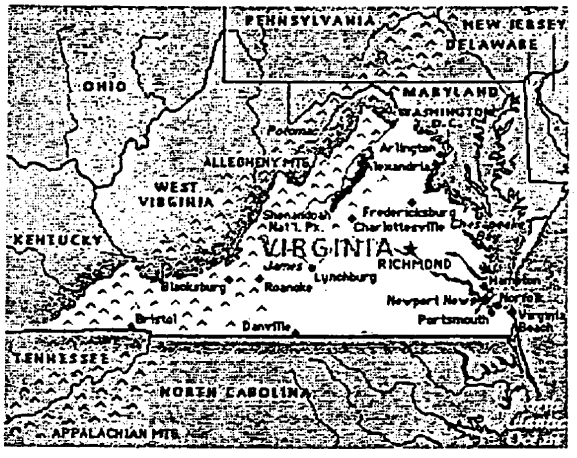
Sincerely,

Kirsten A. Barrett, Ph.D., Project Director
Survey and Evaluation Research Laboratory

CODE:_____

Department of Medical Assistance Services

Medicaid Work Incentive Survey



Fall 2001

Section I: Employment-Related Questions

1. Do you currently have a job for which you receive pay?

☐[1] Yes

Are you self-employed?

☐[1] Yes

☐[2] No

Please continue

☐[2] No

a. How many months has it been since you last worked? _____(number of months)

b. In general, how many hours per week were you working at the time? Check one only:

☐[1] 0 to 10 hours per wk ☐[3] 21-30 hours per wk

☐[2] 11-20 hours per wk ☐[4] 31-40 hours per wk

Please skip to Section II, Question 11

2. What type of job do you currently have? Check one only:

☐[1] Executive, administrative, managerial (executives, small business owners, office managers)
☐[2] Professional (teacher, nurse, doctor, engineers, computer programmer, etc.)
☐[3] Secretarial, clerical (typists, bookkeepers, tellers, clerks, secretaries)
☐[4] Technical, paraprofessional (drafter, teachers aide, nurse aide)
☐[5] Skilled craft (mechanic, carpenter, electrician)
☐[6] Service, maintenance (child care worker, janitor, truck driver)
☐[7] Sales and related work (telemarketer, real estate sales, cashiers)
☐[8] Farming, fishing, forestry and related work (agricultural workers, loggers, fisherman)
☐[9] Sheltered work (jobs reserved by those with disabilities)
☐[10] Other:_____(please specify)

3. How long have you been at your current job? Check one only:

☐[1] 3 months or less ☐[2] 4 to 6 months ☐[3] 7 to 11 months ☐[4] 1 to 2 yrs. ☐[5] More than 2 yrs.

4. How many hours do you currently work per week? Check one only:

☐[1] 0 to 10 hours ☐[2] 11 to 20 hours ☐[3] 21 to 30 hours ☐[4] 31 to 40 hours

5. Do you want to work more hours per week than you do right now? ☐[1] Yes ☐[2] No

How many more hours per week do you want to work?_____(number)

Section I: Employment-Related Questions (con't)

6. Do you limit the number of hours you work per week so that you can receive certain benefits (e.g., social security income, social security disability income, Medicaid)? Check one only:

☐[1] Yes ☐[2] No

7. How many different jobs have you had in the past two years? _____(number of jobs)

8. How much money did you earn from your job **this past month**? Check one only:

☐[1] Less than $100
☐[2] $100 to $199
☐[3] $200 to $499
☐[4] $500 to $799
☐[5] $800 to $1,099
☐[6] $1,100 to $1,399
☐[7] $1,400 to $1,699
☐[8] $1,700 to $1,999
☐[9] $2,000 or greater

9. Which of the following do you receive that helps make it possible for you to work? Check all that apply:

☐[1] Transportation
☐[2] Adaptation of physical environment
☐[3] Personal assistance services
☐[4] Ability to obtain prescription medications
☐[5] Interpreter
☐[6] Other:_____

10. What types of medical services would allow you to work more effectively?_____
_____
_____

Section II: Health Insurance

11. Do you currently have health insurance?

☐[1] Yes

☐[2] No → Please indicate why not in the space provided and then skip to question #16 on the next page

Why not? _____
_____
_____

12. Is your health insurance through your employer?

☐[1] Yes

☐[2] No →

- Who is your health insurance through?

☐[1] Spouse
☐[2] Medicaid
☐[3] Medicare
☐[4] Private insurance plan
☐[5] Parents health insurance
☐[6] Military-related (VA, Tricare)
☐[7] Other:_____

- Could you get health insurance through your employer if you wanted to? Check one only:

☐[1] Yes ☐[2] No ☐[3] Don't know

Next Page →

Section II: Health Insurance (con't)

13. Does your current health insurance plan cover, at least partially, the following:

Your prescription medications?	☐[1] Yes	☐[2] No	☐[3] Don't know
Your doctor visits?	☐[1] Yes	☐[2] No	☐[3] Don't know
Your dental care?	☐[1] Yes	☐[2] No	☐[3] Don't know
Your vision care?	☐[1] Yes	☐[2] No	☐[3] Don't know
Your medical supplies and equipment?	☐[1] Yes	☐[2] No	☐[3] Don't know
Personal assistance services?	☐[1] Yes	☐[2] No	☐[3] Don't know
Transportation to medical appointments?	☐[1] Yes	☐[2] No	☐[3] Don't know
Any family members?	☐[1] Yes	☐[2] No	☐[3] Don't know

14. Do you know the amount of the premium that you pay each month for your health insurance?

☐[1] Yes → ☐[2] No

- ☐[1] Less than $50 / month
- ☐[2] $50 to $75 / month
- ☐[3] $76 to $100 / month
- ☐[4] $101 to $125 / month
- ☐[5] More than $125 / month

15. Do you have any health care needs that are currently not being addressed by your health insurance plan?

☐[1] Yes → ☐[2] No

Describe:_____

_____

_____

_____

_____

_____

_____

Section III: Knowledge about 1619.B

16. Have you ever heard of 1619B? ☐[1] Yes ☐[2] No → Skip to question #20

17. How did you **first** hear about 1619B? Check one only:

- ☐[1] Social Security Administration
- ☐[2] Virginia Department of Social Services
- ☐[3] Virginia Department of Rehabilitative Services
- ☐[4] Other state agency_____
- ☐[5] Other: _____
- ☐[6] Case manager
- ☐[7] Vocational rehabilitation counselor
- ☐[8] During job training activities
- ☐[9] Advocacy group:_____

_____

Section III: Knowledge about 1619.B (con't)

18. What *BEST* describes 1619.B? Check one only:

☐[1] 1619.B allows a person to keep their Medicaid coverage if they agree to work less than 32 hours a week.
☐[2] 1619.B allows a person who goes to work to keep their Medicaid coverage as long as their income stays below a certain level.
☐[3] 1619.B allows a person to apply for Medicaid once they are employed if doing so would help them stay employed.
☐[4] 1619.B allows a person to keep their Medicaid coverage and to also be covered by a health insurance plan through their work.

19. Are you classified as 1619.B by the Social Security Administration? Check one only:

☐[1] Yes ☐[2] No ☐[3] Don't know

Section IV: Medicaid Status

20. Are you currently receiving Medicaid? ☐[1] Yes → Skip to question # 22 ☐[2] No → Go to question # 21

21. Have you applied for Medicaid in Virginia in the past?

☐[1] Yes →

- Were you denied Medicaid in Virginia? Check one:

☐[1] Yes ☐[2] No ☐[3] Don't know

☐[2] No →

Why not?_____

_____

- If you were denied Medicaid, what was the reason? Check all that apply:

☐[1] Did not meet Social Security Administration's definition of having a disability
☐[2] Did not complete the required Medicaid application
☐[3] Did not provide needed verifications for Medicaid
☐[4] Did not meet Virginia's resource requirements for Medicaid
☐[5] Other:_____
☐[6] Don't know

22. Were you ever on Medicaid in a state other than Virginia?

☐[1] Yes →

Which state?_____

- At the time you moved to Virginia after being on Medicaid in this other state, did you know that you would have to apply for Medicaid in Virginia? ☐[1] Yes ☐[2] No

☐[2] No → Go to question # 23

Next Page →

Section IV: Medicaid Status (con't)

23. Have you heard of the Medicaid Buy-In Programs?

☐[1] Yes → How did you hear about it? Check all that apply

☐[1] Employer
☐[2] Case manager / social worker
☐[3] Newspaper or public announcement
☐[4] Other:_____

_____

☐[2] No →

Go to question # 24

Section VI: General Information

24. What is your birth date? ___ ___ / ___ ___ / 1 9 ___ ___
(month) (day) (year)

25. Gender: ☐[1] Male ☐[2] Female

26. What is your legal marital status? ☐[1] Married ☐[2] Single / Widowed / Divorced/Separated

27. What is your highest level of education? Check one only:

☐[1] Less than high school
☐[2] Some high school
☐[3] High school / GED
☐[4] Some college / associates degree
☐[5] Bachelors degree
☐[6] Graduate study or degree

28. This survey has been mailed to people who have are classified as having disabilities according to the Social Security Administration. The information from the survey will help the Department of Medical Assistance Services develop programs that make it easier for people with disabilities to work. **Please check all of the disability categories that apply to you:**

☐[1] Physical disability
☐[2] HIV/AIDS
☐[3] Drug/alcohol dependency
☐[4] Brain injury
☐[5] Hearing impairment
☐[6] Visual impairment
☐[7] Speech impairment
☐[8] Spinal cord injury
☐[9] Developmental disability
☐[10] Mental health impairment
☐[11] Respiratory impairment
☐[12] Other:_____

Thank you for completing this survey. Please return it in the enclosed, pre-stamped envelope as soon as possible.

REMINDER POSTCARD CONTENT

Last week, the Survey and Evaluation Research Laboratory (SERL) at VCU mailed a survey to you on behalf of the Virginia Department of Medical Assistance Services. The survey contained questions about your work, your health insurance coverage, and Medicaid. In order for the results to be meaningful, it is very important that your information be included. If you have already completed and returned the survey, please accept our sincere thanks. If not, please do so immediately.

Also, the TTY phone number that was indicated on the cover letter that was with the survey was not correct. If you would like to complete the survey over the telephone and require TTY, please access the SERL through the Virginia Relay by dialing 711 and requesting a connection to 1-800-304-9402. We apologize for the error.

If you did not receive the survey, please call Michael Otley, SERL Mailroom Manager at 804-827-4320 (Voice) or email him at has5mjo@mail1.vcu.edu and he will get another in the mail for you. For TTY service, please access the SERL through the Virginia Relay by dialing 711 and requesting a connection to 1-800-304-9402. Thanks!

APPENDIX 2

Table 1: Characteristics of Survey Respondents by Medicaid Status

		Medicaid Status						Total	
		Current		Cancelled		Not found			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Gender:	Male	255	52%	72	47%	45	65%	372	52%
	Female	239	48%	81	53%	24	35%	344	48%
Total		494	100%	153	100%	69	100%	716	100%
Age (Grouped)	20 or younger	7	1%	4	3%	6	9%	17	2%
	21-30 years old	130	26%	52	34%	25	36%	207	28%
	31-40 years old	152	30%	51	33%	17	25%	220	30%
	41-50 years old	126	25%	29	19%	9	13%	164	23%
	51-60 years old	61	12%	13	8%	10	14%	84	12%
	Over 60 years old	27	5%	6	4%	2	3%	35	5%
Total		503	100%	155	100%	69	100%	727	100%
What is your legal marital status?	Single / Widowed / Divorced / Separated	439	89%	123	79%	60	90%	622	87%
	Married	53	11%	32	21%	7	10%	92	13%
Total		492	100%	155	100%	67	100%	714	100%
What is your highest level of education?	Less than high school	97	20%	18	12%	12	18%	127	18%
	Some high school	62	13%	22	14%	6	9%	90	13%
	High school / GED	201	42%	70	46%	32	48%	303	44%
	Some college / associates degree	85	18%	30	20%	7	11%	122	18%
	Bachelors degree	17	4%	9	6%	6	9%	32	5%
	Graduate study or degree	15	3%	3	2%	3	5%	21	3%
Total		477	100%	152	100%	66	100%	695	100%

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Table 2: Knowledge of 1619.B

		Medicaid Status						Total	
		Current		Cancelled		Not found			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Have you ever heard of 1619B?	Yes	50	10%	13	8%	2	3%	65	9%
	No	443	90%	140	92%	63	97%	646	91%
Total		493	100%	153	100%	65	100%	711	100%
How did you first hear about 1619B?	Social Security Administration	20	43%	10	77%	0	0%	30	50%
	Other	7	15%	2	15%	0	0%	9	15%
	Virginia Department of Social Services	6	13%	0	0%	0	0%	6	10%
	Case manager	6	13%	1	8%	0	0%	7	12%
	Vocational rehabilitation counselor	3	7%	0	0%	0	0%	3	5%
	Virginia Department of Rehabilitative Services	2	4%	0	0%	0	0%	2	3%
	Other state agency	1	2%	0	0%	1	100%	2	3%
	Advocacy group	1	2%	0	0%	0	0%	1	2%
Total		46	100%	13	100%	1	100%	60	100%
What BEST describes 1619.B? 1619.B allows a person to keep or apply for Medicaid coverage...	as long as their income stays below a certain level	29	71%	5	45%	1	50%	35	65%
	and also be covered by health insurance through work	5	12%	2	18%	1	50%	8	15%
	if they agree to work less than 32 hours a week	4	10%	1	9%	0	0%	5	9%
	if doing so would help them stay employed	3	7%	3	27%	0	0%	6	11%
Total		41	100%	11	100%	2	100%	54	100%
Are you classified as 1619.B by the Social Security Administration?	Yes	31	69%	8	62%	0	0%	39	65%
	No	0	0%	2	15%	0	0%	2	3%
	Don't know	14	31%	3	23%	2	100%	19	32%
Total		45	100%	13	100%	2	100%	60	100%

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Table 3: Employment Characteristics by Medicaid Status

		Medicaid Status						Total	
		Current		Cancelled		Not found			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Do you currently have a job for which you receive pay?	Yes	423	85%	125	82%	56	82%	604	84%
	No	72	15%	28	18%	12	18%	112	16%
Total		495	100%	153	100%	68	100%	716	100%
Are you self-employed?	Yes	19	5%	5	5%	2	4%	26	5%
	No	360	95%	102	95%	49	96%	511	95%
Total		379	100%	107	100%	51	100%	537	100%
What type of job do you currently have?	Other	145	35%	55	46%	22	42%	222	38%
	Sheltered work	126	31%	14	12%	9	17%	149	25%
	Service, maintenance	53	13%	16	13%	5	9%	74	13%
	Sales and related work	29	7%	6	5%	5	9%	40	7%
	Secretarial, clerical	23	6%	6	5%	0	0%	29	5%
	Skilled craft	11	3%	3	3%	3	6%	17	3%
	Professional	9	2%	10	8%	6	11%	25	4%
	Technical, paraprofessional	8	2%	7	6%	0	0%	15	3%
	Executive, administrative, managerial	5	1%	3	3%	2	4%	10	2%
	Farming, fishing, forestry and related work	3	1%	0	0%	1	2%	4	1%
Total		412	100%	120	100%	53	100%	585	100%
How long have you been at your current job?	3 months or less	24	6%	13	10%	6	11%	43	7%
	4 to 6 months	24	6%	8	6%	3	6%	35	6%
	7 to 11 months	41	10%	15	12%	8	15%	64	11%
	1 to 2 yrs.	101	24%	37	30%	12	22%	150	25%
	More than 2 yrs.	232	55%	51	41%	25	46%	308	51%
Total		422	100%	124	100%	54	100%	600	100%

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Table 4: Employment Characteristics by Medicaid Status

		Medicaid Status						Total	
		Current		Cancelled		Not found			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
How many hours do you currently work per week?	1 to 10 hours per wk	39	9%	6	5%	2	4%	47	8%
	11-20 hours per wk	118	29%	21	17%	11	20%	150	25%
	21-30 hours per wk	114	28%	16	13%	14	25%	144	24%
	31-40 hours per wk	143	35%	82	66%	28	51%	253	43%
Total		414	100%	125	100%	55	100%	594	100%
Want to work more hrs per wk than you do right now?	Yes	118	29%	41	34%	17	32%	176	30%
	No	288	71%	81	66%	36	68%	405	70%
Total		406	100%	122	100%	53	100%	581	100%
How many more hours would you like to work? (grouped)	1 to 10 hours	47	40%	13	32%	7	41%	67	38%
	11 to 20 hours	17	14%	5	12%	2	12%	24	14%
	21 to 30 hours	12	10%	4	10%	1	6%	17	10%
	31 to 40 hours	26	22%	8	20%	5	29%	39	22%
	Over 40 hours	16	14%	11	27%	2	12%	29	16%
Total		118	100%	41	100%	17	100%	176	100%
Limit hours so that you can receive certain benefits?	Yes	146	35%	24	20%	8	15%	178	30%
	No	267	65%	96	80%	47	85%	410	70%
Total		413	100%	120	100%	55	100%	588	100%
Earnings in the Past Month (grouped)	Less than $100	24	6%	3	2%	1	2%	28	5%
	$100 to $499	205	51%	39	31%	20	38%	264	46%
	$500 to $1,099	126	32%	42	34%	17	33%	185	32%
	$1,100 or greater	45	11%	40	32%	14	27%	99	17%
Total		400	100%	124	100%	52	100%	576	100%

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Table 5: Health Insurance by Medicaid Status

		Medicaid Status						Total	
		Current		Cancelled		Not found			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Do you currently have health insurance?	Yes	441	89%	107	69%	54	79%	602	84%
	No	54	11%	47	31%	14	21%	115	16%
Total		495	100%	154	100%	68	100%	717	100%
Is your health insurance through your employer?	Yes	35	8%	44	41%	26	48%	105	18%
	No	403	92%	63	59%	28	52%	494	82%
Total		438	100%	107	100%	54	100%	599	100%
Health insurance through spouse?	Checked	0	0%	4	6%	1	4%	5	1%
	Not checked	403	100%	59	94%	27	96%	489	99%
Total		403	100%	63	100%	28	100%	494	100%
Health insurance through Medicaid?	Checked	347	86%	22	35%	8	29%	377	76%
	Not checked	56	14%	41	65%	20	71%	117	24%
Total		403	100%	63	100%	28	100%	494	100%
Health insurance through Medicare?	Checked	242	60%	36	57%	12	43%	290	59%
	Not checked	161	40%	27	43%	16	57%	204	41%
Total		403	100%	63	100%	28	100%	494	100%
Health insurance through private insurance plan?	Checked	5	1%	6	10%	2	7%	13	3%
	Not checked	398	99%	57	90%	26	93%	481	97%
Total		403	100%	63	100%	28	100%	494	100%
Health insurance through parents health insurance?	Checked	23	6%	3	5%	10	36%	36	7%
	Not checked	380	94%	60	95%	18	64%	458	93%
Total		403	100%	63	100%	28	100%	494	100%
Health insurance through military-related entity?	Checked	6	1%	0	0%	3	11%	9	2%
	Not checked	397	99%	63	100%	25	89%	485	98%
Total		403	100%	63	100%	28	100%	494	100%
Health insurance through other source?	Checked	13	3%	1	2%	2	7%	16	3%
	Not checked	390	97%	62	98%	26	93%	478	97%
Total		403	100%	63	100%	28	100%	494	100%
Could you get health insurance through your employer if you wanted to?	Yes	43	12%	14	25%	2	8%	59	13%
	No	216	60%	33	59%	16	64%	265	60%
	Don't know	102	28%	9	16%	7	28%	118	27%
Total		361	100%	56	100%	25	100%	442	100%

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Table 6: Health Insurance Coverage by Medicaid Status

		Medicaid Status						Total	
		Current		Cancelled		Not found			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Cover prescription medications?	Yes	365	90%	66	67%	41	82%	472	85%
	No	23	6%	26	26%	6	12%	55	10%
	Don't know	18	4%	7	7%	3	6%	28	5%
Total		406	100%	99	100%	50	100%	555	100%
Cover doctor visits?	Yes	391	95%	91	88%	43	86%	525	93%
	No	10	2%	10	10%	4	8%	24	4%
	Don't know	11	3%	3	3%	3	6%	17	3%
Total		412	100%	104	100%	50	100%	566	100%
Cover dental care?	Yes	87	22%	43	44%	27	54%	157	29%
	No	258	66%	47	48%	16	32%	321	60%
	Don't know	43	11%	7	7%	7	14%	57	11%
Total		388	100%	97	100%	50	100%	535	100%
Cover vision care?	Yes	164	43%	41	42%	21	45%	226	43%
	No	165	43%	41	42%	21	45%	227	43%
	Don't know	56	15%	15	15%	5	11%	76	14%
Total		385	100%	97	100%	47	100%	529	100%
Cover medical supplies and equipment?	Yes	165	44%	32	34%	16	38%	213	42%
	No	72	19%	32	34%	9	21%	113	22%
	Don't know	140	37%	29	31%	17	40%	186	36%
Total		377	100%	93	100%	42	100%	512	100%
Cover personal assistance services?	Yes	82	22%	14	15%	7	17%	103	21%
	No	114	31%	46	49%	18	43%	178	36%
	Don't know	169	46%	33	35%	17	40%	219	44%
Total		365	100%	93	100%	42	100%	500	100%
Cover transportation to medical appointments?	Yes	146	38%	15	16%	3	7%	164	32%
	No	129	34%	57	60%	26	59%	212	41%
	Don't know	106	28%	23	24%	15	34%	144	28%
Total		381	100%	95	100%	44	100%	520	100%
Cover any family members?	Yes	40	11%	19	20%	8	18%	67	13%
	No	271	74%	64	67%	32	73%	367	73%
	Don't know	55	15%	12	13%	4	9%	71	14%
Total		366	100%	95	100%	44	100%	505	100%

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Table 7: Health Insurance Premiums by Medicaid Status

		Medicaid Status						Total	
		Current		Cancelled		Not found			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Do you know the amount of the premium that you pay each month for your health insurance?	Yes	147	38%	68	67%	37	77%	252	47%
	No	244	62%	33	33%	11	23%	288	53%
Total		391	100%	101	100%	48	100%	540	100%
Amount of monthly premium	Less than $50 / month	87	60%	25	37%	13	36%	125	50%
	$50 to $75 / month	42	29%	29	43%	8	22%	79	32%
	$76 to $100 / month	2	1%	6	9%	3	8%	11	4%
	$101 to $125 / month	3	2%	1	1%	2	6%	6	2%
	More than $125 / month	11	8%	6	9%	10	28%	27	11%
Total		145	100%	67	100%	36	100%	248	100%
Any unmet health care needs?	Yes	122	30%	44	44%	14	30%	180	33%
	No	281	70%	57	56%	32	70%	370	67%
Total		403	100%	101	100%	46	100%	550	100%

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Table 8: Medicaid Status

		Medicaid Status						Total	
		Current		Cancelled		Not found			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Are you currently receiving Medicaid?	Yes	444	93%	34	23%	11	17%	489	70%
	No	35	7%	116	77%	55	83%	206	30%
Total		479	100%	150	100%	66	100%	695	100%
Have you applied for Medicaid in Virginia in the past?	Yes	30	88%	106	95%	16	30%	152	76%
	No	4	12%	6	5%	37	70%	47	24%
Total		34	100%	112	100%	53	100%	199	100%
Were you denied Medicaid in Virginia?	Yes	14	50%	33	33%	6	40%	53	37%
	No	11	39%	54	53%	6	40%	71	49%
	Don't know	3	11%	14	14%	3	20%	20	14%
Total		28	100%	101	100%	15	100%	144	100%
Denied - Did not meet SSA definition of disability	Checked	0	0%	2	2%	1	6%	3	2%
	Not checked	30	100%	104	98%	15	94%	149	98%
Total		30	100%	106	100%	16	100%	152	100%
Denied - Did not complete application	Checked	2	7%	2	2%	1	6%	5	3%
	Not checked	28	93%	104	98%	15	94%	147	97%
Total		30	100%	106	100%	16	100%	152	100%
Denied - Did not provide verifications for Medicaid	Checked	0	0%	1	1%	1	6%	2	1%
	Not checked	30	100%	105	99%	15	94%	150	99%
Total		30	100%	106	100%	16	100%	152	100%
Denied - Did not meet resource requirements	Checked	4	13%	13	12%	2	13%	19	13%
	Not checked	26	87%	93	88%	14	88%	133	88%
Total		30	100%	106	100%	16	100%	152	100%
Denied - Other reason	Checked	5	17%	24	23%	1	6%	30	20%
	Not checked	25	83%	82	77%	15	94%	122	80%
Total		30	100%	106	100%	16	100%	152	100%
Denied - Don't know why	Checked	6	20%	14	13%	1	6%	21	14%
	Not checked	24	80%	92	87%	15	94%	131	86%
Total		30	100%	106	100%	16	100%	152	100%
Ever on Medicaid in a state other than Virginia?	Yes	67	14%	30	20%	12	18%	109	16%
	No	415	86%	119	80%	53	82%	587	84%
Total		482	100%	149	100%	65	100%	696	100%
Know that you'd have to apply for Medicaid in Virginia?	Yes	44	72%	21	78%	5	45%	70	71%
	No	17	28%	6	22%	6	55%	29	29%
Total		61	100%	27	100%	11	100%	99	100%

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Table 9: Awareness of Medicaid Buy-In Programs

		Medicaid Status						Total	
		Current		Cancelled		Not found			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Have you heard of the Medicaid Buy-In Programs?	Yes	20	4%	10	7%	1	1%	31	4%
	No	470	96%	140	93%	67	99%	677	96%
Total		490	100%	150	100%	68	100%	708	100%
Heard through employer	Checked	4	20%	0	0%	0	0%	4	13%
	Not checked	16	80%	10	100%	1	100%	27	87%
Total		20	100%	10	100%	1	100%	31	100%
Heard through case manager / social worker	Checked	14	70%	3	30%	0	0%	17	55%
	Not checked	6	30%	7	70%	1	100%	14	45%
Total		20	100%	10	100%	1	100%	31	100%
Heard through newspaper or public announcement	Checked	2	10%	2	20%	0	0%	4	13%
	Not checked	18	90%	8	80%	1	100%	27	87%
Total		20	100%	10	100%	1	100%	31	100%
Heard through other source	Checked	3	15%	4	40%	1	100%	8	26%
	Not checked	17	85%	6	60%	0	0%	23	74%
Total		20	100%	10	100%	1	100%	31	100%

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Table 10: Self-Reported Disability Type

		Medicaid Status						Total	
		Current		Cancelled		Not found			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Disability Types	Mental health impairment	219	46%	57	38%	26	39%	302	44%
	Physical disability	167	35%	52	35%	19	29%	238	34%
	Developmental disability	141	29%	27	18%	15	23%	183	26%
	Other	110	23%	44	29%	18	27%	172	25%
	Speech impairment	70	15%	12	8%	9	14%	91	13%
	Visual impairment	55	12%	11	7%	6	9%	72	10%
	Hearing impairment	43	9%	14	9%	3	5%	60	9%
	Brain injury	33	7%	8	5%	4	6%	45	6%
	Respiratory impairment	30	6%	6	4%	3	5%	39	6%
	Spinal cord injury	18	4%	3	2%	1	2%	22	3%
	Drug/alcohol dependency	14	3%	2	1%	4	6%	20	3%
	HIV/AIDS	8	2%	4	3%	2	3%	14	2%
Total		478	100%	150	100%	66	100%	694	100%

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APPENDIX 3

Table 1: Characteristics of Survey Respondents by Income

		Earnings Per Month				Total	
		Less than $1,700 / month		$1,700 / month or more			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Gender:	Male	275	51%	17	63%	292	51%
	Female	269	49%	10	37%	279	49%
Total		544	100%	27	100%	571	100%
Age (Grouped)	20 or younger	10	2%	0	0%	10	2%
	21-30 years old	163	30%	12	44%	175	30%
	31-40 years old	167	30%	8	30%	175	30%
	41-50 years old	120	22%	5	19%	125	22%
	51-60 years old	65	12%	2	7%	67	12%
	Over 60 years old	24	4%	0	0%	24	4%
Total		549	100%	27	100%	576	100%
What is your legal marital status?	Single / Widowed / Divorced / Separated	480	88%	22	81%	502	88%
	Married	63	12%	5	19%	68	12%
Total		543	100%	27	100%	570	100%
What is your highest level of education?	Less than high school	103	20%	0	0%	103	19%
	Some high school	62	12%	2	7%	64	12%
	High school / GED	233	44%	10	37%	243	44%
	Some college / associates degree	92	18%	4	15%	96	17%
	Bachelors degree	17	3%	9	33%	26	5%
	Graduate study or degree	17	3%	2	7%	19	3%
Total		524	100%	27	100%	551	100%
Medicaid Status	Current	392	71%	8	30%	400	69%
	Cancelled	110	20%	14	52%	124	22%
	Not found	47	9%	5	19%	52	9%
Total		549	100%	27	100%	576	100%

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Table 2: Knowledge of 1619.B

		Earnings Per Month				Total	
		Less than $1,700 / month		$1,700 / month or more			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Have you ever heard of 1619B?	Yes	53	10%	3	11%	56	10%
	No	486	90%	24	89%	510	90%
Total		539	100%	27	100%	566	100%
How did you first hear about 1619B?	Social Security Administration	23	46%	3	100%	26	49%
	Virginia Department of Social Services	5	10%	0	0%	5	9%
	Virginia Department of Rehabilitative Services	2	4%	0	0%	2	4%
	Other state agency	2	4%	0	0%	2	4%
	Other	9	18%	0	0%	9	17%
	Case manager	5	10%	0	0%	5	9%
	Vocational rehabilitation counselor	3	6%	0	0%	3	6%
	Advocacy group	1	2%	0	0%	1	2%
Total		50	100%	3	100%	53	100%
What BEST describes 1619.B? 1619.B allows a person to keep or apply for Medicaid coverage...	if they agree to work less than 32 hours a week	5	11%	0	0%	5	11%
	as long as their income stays below a certain level	30	68%	1	33%	31	66%
	if doing so would help them stay employed	4	9%	0	0%	4	9%
	and also be covered by health insurance through work	5	11%	2	67%	7	15%
Total		44	100%	3	100%	47	100%
Are you classified as 1619.B by the Social Security Administration?	Yes	32	64%	1	33%	33	62%
	No	1	2%	1	33%	2	4%
	Don't know	17	34%	1	33%	18	34%
Total		50	100%	3	100%	53	100%

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Table 3: Employment Characteristics by Income

		Earnings Per Month				Total	
		Less than $1,700 / month		$1,700 / month or more			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Do you currently have a job for which you receive pay?	Yes	549	100%	27	100%	576	100%
Total		549	100%	27	100%	576	100%
Are you self-employed?	Yes	23	5%	2	8%	25	5%
	No	463	95%	24	92%	487	95%
Total		486	100%	26	100%	512	100%
What type of job do you currently have?	Other	207	39%	6	22%	213	38%
	Sheltered work	144	27%	0	0%	144	26%
	Service, maintenance	68	13%	3	11%	71	13%
	Sales and related work	35	7%	2	7%	37	7%
	Secretarial, clerical	27	5%	1	4%	28	5%
	Professional	17	3%	7	26%	24	4%
	Technical, paraprofessional	14	3%	0	0%	14	2%
	Skilled craft	12	2%	5	19%	17	3%
	Executive, administrative, managerial	7	1%	3	11%	10	2%
	Farming, fishing, forestry and related work	3	1%	0	0%	3	1%
Total		534	100%	27	100%	561	100%
How long have you been at your current job?	3 months or less	40	7%	2	7%	42	7%
	4 to 6 months	31	6%	2	7%	33	6%
	7 to 11 months	57	10%	5	19%	62	11%
	1 to 2 yrs.	135	25%	8	30%	143	25%
	More than 2 yrs.	282	52%	10	37%	292	51%
Total		545	100%	27	100%	572	100%

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Table 4: Employment Characteristics by Income

		Earnings Per Month				Total	
		Less than $1,700 / month		$1,700 / month or more			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
How many hours do you currently work per week?	0 to 10 hours per wk	46	8%	0	0%	46	8%
	11-20 hours per wk	143	26%	0	0%	143	25%
	21-30 hours per wk	137	25%	1	4%	138	24%
	31-40 hours per wk	218	40%	24	96%	242	43%
Total		544	100%	25	100%	569	100%
Want to work more hrs per wk than you do right now?	Yes	159	30%	4	15%	163	29%
	No	370	70%	22	85%	392	71%
Total		529	100%	26	100%	555	100%
How many more hours would you like to work? (grouped)	1 to 10 hours	64	40%	0	0%	64	39%
	11 to 20 hours	22	14%	0	0%	22	13%
	21 to 30 hours	16	10%	0	0%	16	10%
	31 to 40 hours	32	20%	1	25%	33	20%
	Over 40 hours	25	16%	3	75%	28	17%
Total		159	100%	4	100%	163	100%
Limit hours so that you can receive certain benefits?	Yes	166	31%	3	11%	169	30%
	No	369	69%	24	89%	393	70%
Total		535	100%	27	100%	562	100%
Earnings in the Past Month (grouped)	Less than $100	28	5%	0	0%	28	5%
	$100 to $499	264	48%	0	0%	264	46%
	$500 to $1,099	185	34%	0	0%	185	32%
	$1,100 or greater	72	13%	27	100%	99	17%
Total		549	100%	27	100%	576	100%

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Table 5: Health Insurance by Income

		Earnings Per Month				Total	
		Less than $1,700 / month		$1,700 / month or more			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Do you currently have health insurance?	Yes	461	84%	25	93%	486	85%
	No	86	16%	2	7%	88	15%
Total		547	100%	27	100%	574	100%
Is your health insurance through your employer?	Yes	83	18%	16	64%	99	20%
	No	377	82%	9	36%	386	80%
Total		460	100%	25	100%	485	100%
Health insurance through spouse?	Checked	2	1%	1	11%	3	1%
	Not checked	375	99%	8	89%	383	99%
Total		377	100%	9	100%	386	100%
Health insurance through Medicaid?	Checked	294	78%	6	67%	300	78%
	Not checked	83	22%	3	33%	86	22%
Total		377	100%	9	100%	386	100%
Health insurance through Medicare?	Checked	217	58%	1	11%	218	56%
	Not checked	160	42%	8	89%	168	44%
Total		377	100%	9	100%	386	100%
Health insurance through private insurance plan?	Checked	8	2%	0	0%	8	2%
	Not checked	369	98%	9	100%	378	98%
Total		377	100%	9	100%	386	100%
Health insurance through parents health insurance?	Checked	26	7%	2	22%	28	7%
	Not checked	351	93%	7	78%	358	93%
Total		377	100%	9	100%	386	100%
Health insurance through military-related entity?	Checked	8	2%	0	0%	8	2%
	Not checked	369	98%	9	100%	378	98%
Total		377	100%	9	100%	386	100%
Health insurance through other source?	Checked	13	3%	1	11%	14	4%
	Not checked	364	97%	8	89%	372	96%
Total		377	100%	9	100%	386	100%
Could you get health insurance through your employer if you wanted to?	Yes	48	14%	2	22%	50	14%
	No	212	60%	5	56%	217	60%
	Don't know	95	27%	2	22%	97	27%
Total		355	100%	9	100%	364	100%

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Table 6: Health Insurance Coverage by Income

		Earnings Per Month				Total	
		Less than $1,700 / month		$1,700 / month or more			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Cover prescription medications?	Yes	374	86%	23	92%	397	86%
	No	40	9%	1	4%	41	9%
	Don't know	20	5%	1	4%	21	5%
Total		434	100%	25	100%	459	100%
Cover doctor visits?	Yes	407	93%	24	96%	431	93%
	No	19	4%	1	4%	20	4%
	Don't know	14	3%	0	0%	14	3%
Total		440	100%	25	100%	465	100%
Cover dental care?	Yes	116	28%	17	68%	133	30%
	No	258	62%	7	28%	265	60%
	Don't know	45	11%	1	4%	46	10%
Total		419	100%	25	100%	444	100%
Cover vision care?	Yes	176	43%	11	44%	187	43%
	No	178	43%	12	48%	190	43%
	Don't know	60	14%	2	8%	62	14%
Total		414	100%	25	100%	439	100%
Cover medical supplies and equipment?	Yes	158	39%	12	52%	170	40%
	No	88	22%	6	26%	94	22%
	Don't know	156	39%	5	22%	161	38%
Total		402	100%	23	100%	425	100%
Cover personal assistance services?	Yes	76	19%	5	22%	81	20%
	No	138	35%	10	43%	148	36%
	Don't know	178	45%	8	35%	186	45%
Total		392	100%	23	100%	415	100%
Cover transportation to medical appointments?	Yes	123	30%	3	13%	126	29%
	No	166	41%	12	52%	178	42%
	Don't know	116	29%	8	35%	124	29%
Total		405	100%	23	100%	428	100%
Cover any family members?	Yes	47	12%	8	33%	55	13%
	No	291	74%	16	67%	307	73%
	Don't know	57	14%	0	0%	57	14%
Total		395	100%	24	100%	419	100%

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Table 7: Health Insurance Premiums byIncome

		Earnings Per Month				Total	
		Less than $1,700 / month		$1,700 / month or more			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Do you know the amount of the premium that you pay each month for your health insurance?	Yes	198	47%	16	67%	214	48%
	No	222	53%	8	33%	230	52%
Total		420	100%	24	100%	444	100%
Amount of monthly premium	Less than $50 / month	102	52%	4	27%	106	50%
	$50 to $75 / month	64	33%	3	20%	67	32%
	$76 to $100 / month	5	3%	5	33%	10	5%
	$101 to $125 / month	5	3%	1	7%	6	3%
	More than $125 / month	19	10%	2	13%	21	10%
Total		195	100%	15	100%	210	100%
Any unmet health care needs?	Yes	137	32%	11	44%	148	33%
	No	288	68%	14	56%	302	67%
Total		425	100%	25	100%	450	100%

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Table 8: Medicaid Status

		Earnings Per Month				Total	
		Less than $1,700 / month		$1,700 / month or more			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Are you currently receiving Medicaid?	Yes	379	72%	10	37%	389	71%
	No	145	28%	17	63%	162	29%
Total		524	100%	27	100%	551	100%
Have you applied for Medicaid in Virginia in the past?	Yes	110	79%	12	71%	122	78%
	No	29	21%	5	29%	34	22%
Total		139	100%	17	100%	156	100%
Were you denied Medicaid in Virginia?	Yes	44	42%	2	18%	46	40%
	No	46	44%	8	73%	54	47%
	Don't know	14	13%	1	9%	15	13%
Total		104	100%	11	100%	115	100%
Denied - Did not meet SSA definition of disability	Checked	2	2%	0	0%	2	2%
	Not checked	108	98%	12	100%	120	98%
Total		110	100%	12	100%	122	100%
Denied - Did not complete application	Checked	4	4%	0	0%	4	3%
	Not checked	106	96%	12	100%	118	97%
Total		110	100%	12	100%	122	100%
Denied - Did not provide verifications for Medicaid	Checked	1	1%	0	0%	1	1%
	Not checked	109	99%	12	100%	121	99%
Total		110	100%	12	100%	122	100%
Denied - Did not meet resource requirements	Checked	16	15%	2	17%	18	15%
	Not checked	94	85%	10	83%	104	85%
Total		110	100%	12	100%	122	100%
Denied - Other reason	Checked	26	24%	1	8%	27	22%
	Not checked	84	76%	11	92%	95	78%
Total		110	100%	12	100%	122	100%
Denied - Don't know why	Checked	14	13%	1	8%	15	12%
	Not checked	96	87%	11	92%	107	88%
Total		110	100%	12	100%	122	100%
Were you ever on Medicaid in a state other than Virginia?	Yes	81	15%	7	27%	88	16%
	No	447	85%	19	73%	466	84%
Total		528	100%	26	100%	554	100%
Did you know that you would have to apply for Medicaid in Virginia?	Yes	50	69%	4	57%	54	68%
	No	22	31%	3	43%	25	32%
Total		72	100%	7	100%	79	100%

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Table 9: Awareness of Medicaid Buy-In Programs

		Earnings Per Month				Total	
		Less than $1,700 / month		$1,700 / month or more			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Have you heard of the Medicaid Buy-In Programs?	Yes	24	4%	3	12%	27	5%
	No	513	96%	23	88%	536	95%
Total		537	100%	26	100%	563	100%
Heard through employer	Checked	3	13%	0	0%	3	11%
	Not checked	21	88%	3	100%	24	89%
Total		24	100%	3	100%	27	100%
Heard through case manager / social worker	Checked	12	50%	1	33%	13	48%
	Not checked	12	50%	2	67%	14	52%
Total		24	100%	3	100%	27	100%
Heard through newspaper or public announcement	Checked	3	13%	1	33%	4	15%
	Not checked	21	88%	2	67%	23	85%
Total		24	100%	3	100%	27	100%
Heard through other source	Checked	7	29%	1	33%	8	30%
	Not checked	17	71%	2	67%	19	70%
Total		24	100%	3	100%	27	100%

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Table 10: Self-Reported Disability Type

		Earnings Per Month				Total	
		Less than $1,700 / month		$1,700 / month or more			
		Count	Percent of column total	Count	Percent of column total	Count	Percent of column total
Disability Types	Mental health impairment	229	43%	11	42%	240	43%
	Physical disability	173	33%	8	31%	181	33%
	Developmental disability	159	30%	1	4%	160	29%
	Other	134	25%	5	19%	139	25%
	Speech impairment	78	15%	1	4%	79	14%
	Visual impairment	55	10%	2	8%	57	10%
	Hearing impairment	42	8%	2	8%	44	8%
	Brain injury	27	5%	2	8%	29	5%
	Respiratory impairment	26	5%	0	0%	26	5%
	Spinal cord injury	14	3%	0	0%	14	3%
	Drug/alcohol dependency	13	2%	2	8%	15	3%
	HIV/AIDS	8	2%	2	8%	10	2%
Total		527	100%	26	100%	553	100%

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APPENDIX 4

2. What type of job do you currently have? [other, specify]

Warehouse
Dishwasher
Stocking shelves
Cleaning tables at W&M
Warehouse
Has job coach through CES, factory work
Security
Telephone and appointment making, also taking money for their services.
Work with mental retardation
Dishwasher / Service Worker
Unload trucks
Student Ambassador at NVCC (during school year)
Mental Health
Restaurant host
Bagger in grocery store
Warehouse helper
Courtesy Clerk, bagger
Grounds worker
Car Wash Attendant team member
Bagger, Reshopping
Excavation
Bagger, grocery store
Day Support Program-Contracts
Transport Railroad Conductors-Amtrak
Stock Clerk
Manufacturing
School bus driver

2. What type of job do you currently have? [other, specify]

Housekeeper
Fast Food / Job Coach involved
Laundry person-hotel
I work in a food pantry.
Lumber Handler
Cart attendant for Target
Title Examiner
Bagger for Kroger
Public Opinion Pollster
Construction of horse trailers
Mail order packer-pack out order in boxes for shipping
Production
Cleaning
Marketing assistant at a theatre
Deli
Overnight stocker at a department store
School cafeteria
Delivery man
Security Guard
House keeping
Fast Food
Warehouse (Load Trucks), Janitor
Warehouse
Drive Taxi - Part time
Video Store Clerk
Work in Cafeteria - Bedford Hospital - Vista Food - Bag person
Hardee's
Housekeeper
Restaurant-Ruby Tuesdays
Golf Course Maintenance
Mail Courier

2. What type of job do you currently have? [other, specify]

Library Assistant
Maid / Housekeeping
Hardee's
Factory
Deli Cook and Cashier
Dining room attendant / fast food
Food Service
Work in sheltered employment, but have worked my way up to a staff position.
Day Support Program-contracts
Staffing specialist
Chinese Food Delivery
Grocery Store Courtesy Clerk, porter
Dice Meat
Organist for two churches
Stock Clerk
CNA and Med Tech
I purchase items for my job
Parcel Pickup
Security Officer
Stocking for Commissary Oceana
Entertainment
Cosmetologist
Ukrops Courtesy Clerk
Stock, delivery and inventory at grocery store
Wal-Mart / Radio Grill
Bagger for grocery store
Utility work food service
Food service
Laborer for recycling company
Service Worker Housekeeping
Wal-Mart Customer Assistant

2. What type of job do you currently have? [other, specify]

Dietary
Grounds Keeper
Stock clerk, keep shelves full and neat at Wal-Mart
Bagger
Cleaning person for Shin Paco
Stock Clerk at discount store. Not a cashier.
Food service, feed children
Teacher's Aide
Deli Work
Tidewater Occupational Center for the handicap and disabled.
Enclave for people with disabilities-piece rate with enclave supervisor from Henrico County
Dietary Aide
Outreach worker
Waitress
Different job
Cook at Burger King
Machine Operator VA Industries for the Blind
Maintenance
Waitress
Bag boy at Food Lion
Laundry worker
Clerical and cashier
Food Service
Dispatcher
Custodial
Bagger for food city
Work at a detox
Waitress
Fast food
Cart pusher at Walmart
Stock Person

2. What type of job do you currently have? [other, specify]

Care Giver
Burger King Broiler
House Keeping
Busser and Kitchen Worker in a restaurant
Bagger
Food Service Dietary
VA. Visitor Center
Housekeeper at rest home
Used to work at Safeway, now I work at Outback Steakhouse as a bus boy
Cook
Switchboard Operator
Restaurant Worker
Chesapeake Lawnscapes, Inc
Security officer
Food Service, Restaurants
Food Service Worker
Cart Pusher
Laundress
Fairfax County p.s. food service
Laundry
Department Store fitting room-my job giving people ticket when changing clothes
Cleaning a laundry mat on weekends
Bakery
File Clerk through a temporary agency-no benefits
Bagger at Grocery Store
Radford Arsenal Plant finishing part
A mess attendant at Henderson Hall
Housekeeping
Clothes in the mall
Child Care
Temporary Flagger-VDOT

2. What type of job do you currently have? [other, specify]

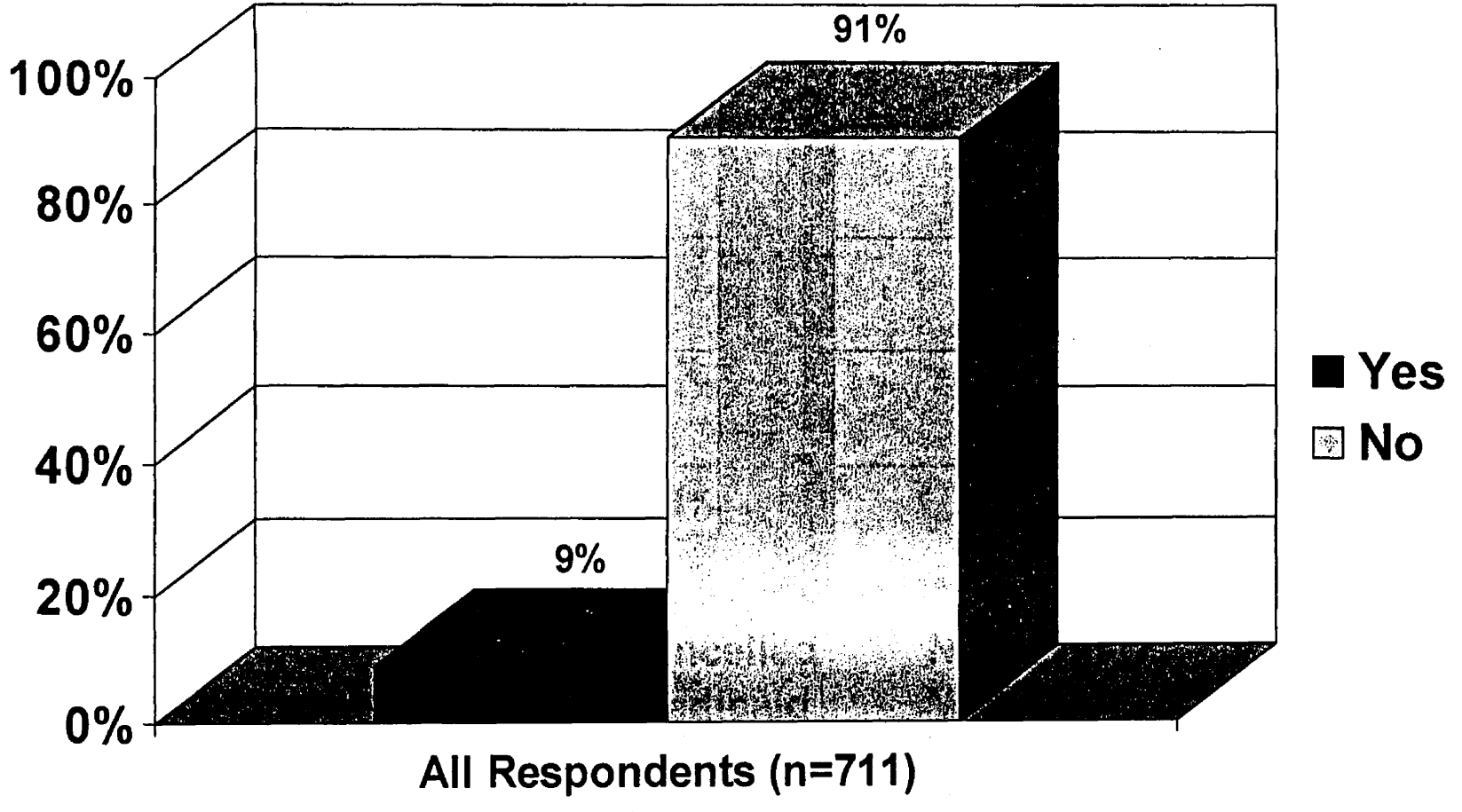
Greeter
Security Guard
Security Guard
Outside surface miner
Benefits Eligibility Worker for DSS
Labor
Red Lobster Restaurant
Operator/Packer
Dining Attendant
Dishwasher
Security
Center for Independent Living
Server
Dishwasher
Veterinary Assistant at Veterinary Hospital
Factory Work
Dish Washer
Mass helper
Restaurant Help Cook
Collections Representative
General Laborer
Collections Agent
Grocery Stocker
Material Handler (helper)
Dry Cleaner and Laundry
Grocery Store Bagger
Night Stockman
Waiters
Fast food
Manager at a fast food restaurant
Auto Cleaner

2. What type of job do you currently have? [other, specify]

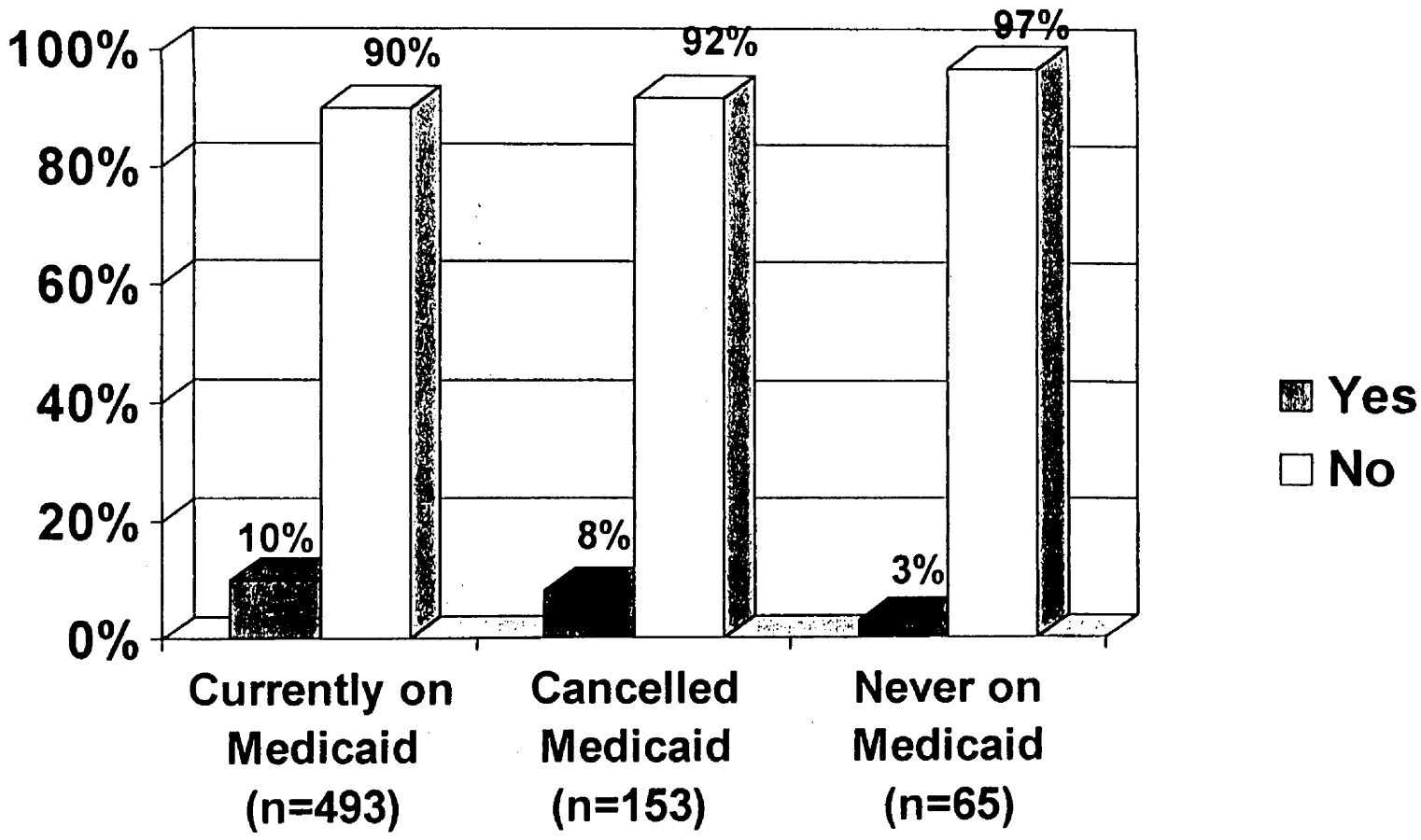
Lawn Care
Program Specialist
Work adjustment training
Landfield (with trash)
Fast Food Worker
Retail
McDonalds
Floor clerk-re-hang clothes in store
Certified Nursing Assistant
Food Lion Bagger
Cab Driver
School Bus Driver
Warehouse / Forklift operator
Waitress
Accountant/payroll
Cook at retirement home.
Work for Movie theaters
Manufacturing company
Working for Tyson
Janitor at rest area
Courtesy clerk: grocery store
Kitchen Helper
CNA
Service Technician
Clean Cabins
Fast food
Labor at a mulch plant
Deli Clerk
School Bus Aide
Load trucks-Kohl's Distribution
Clerk
Stock groceries
Poultry (Box Division)
Cook
Courtesy Clerk

APPENDIX 5

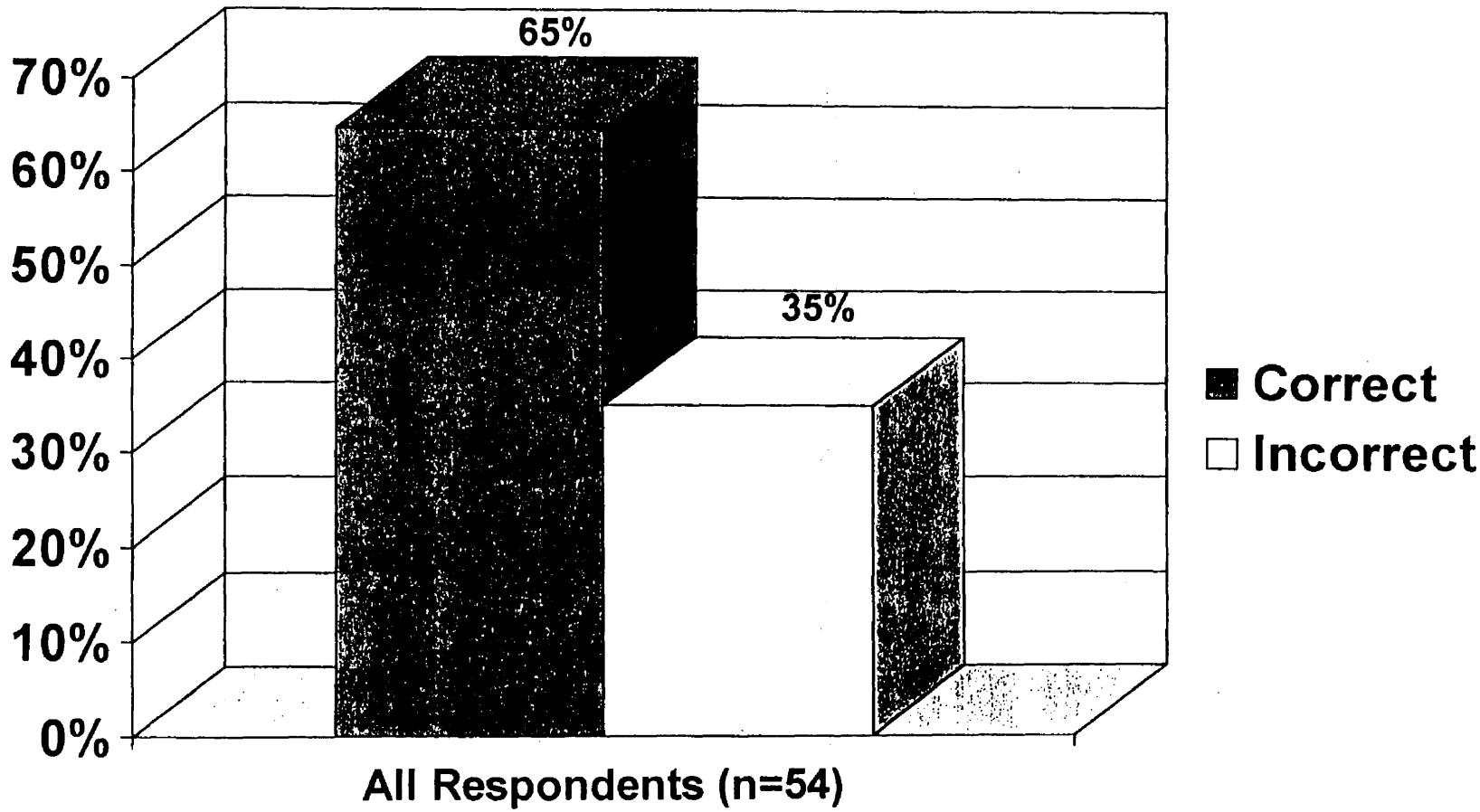
HAVE YOU EVER HEARD OF 1619.B?



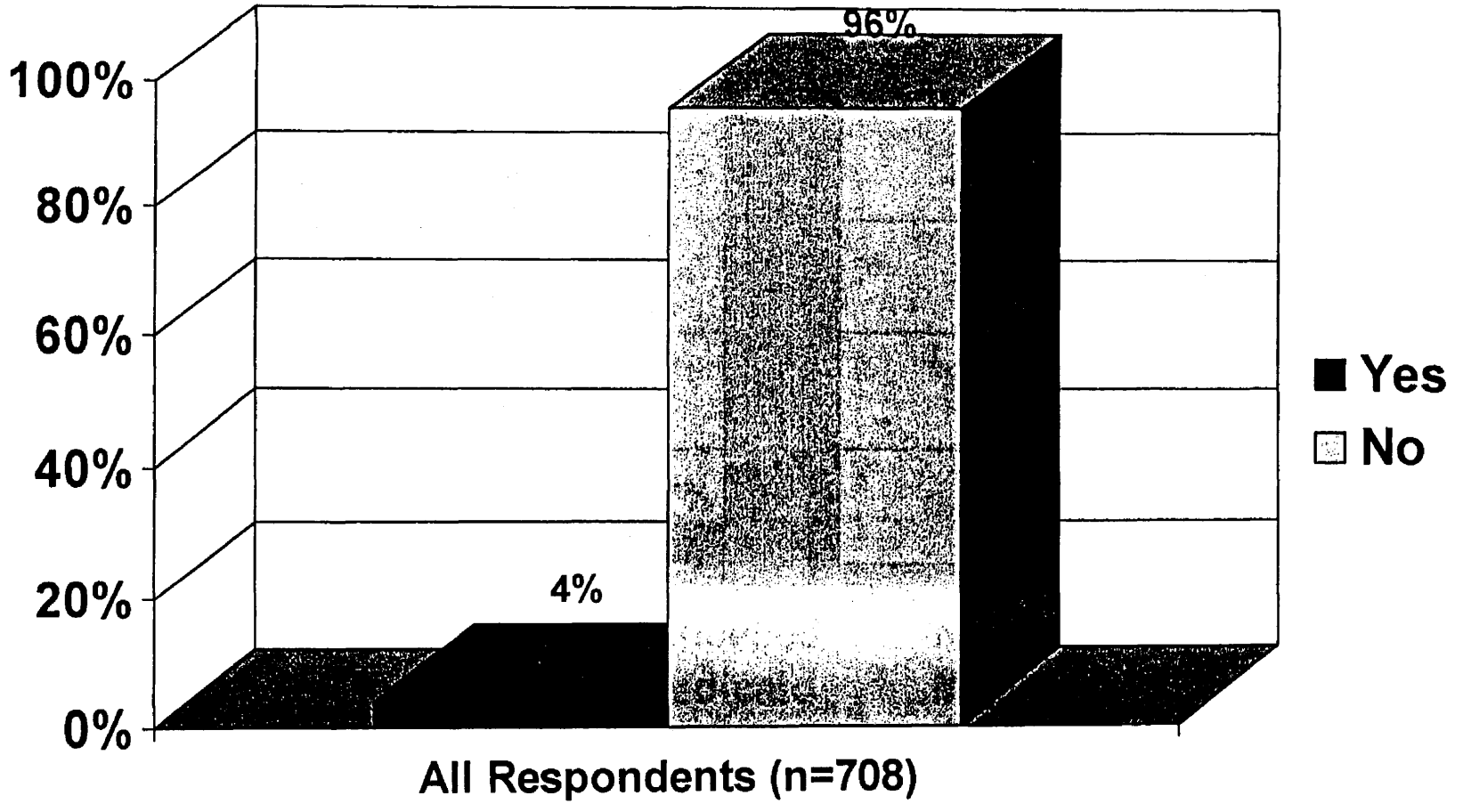
HAVE YOU EVER HEARD OF 1619.B?



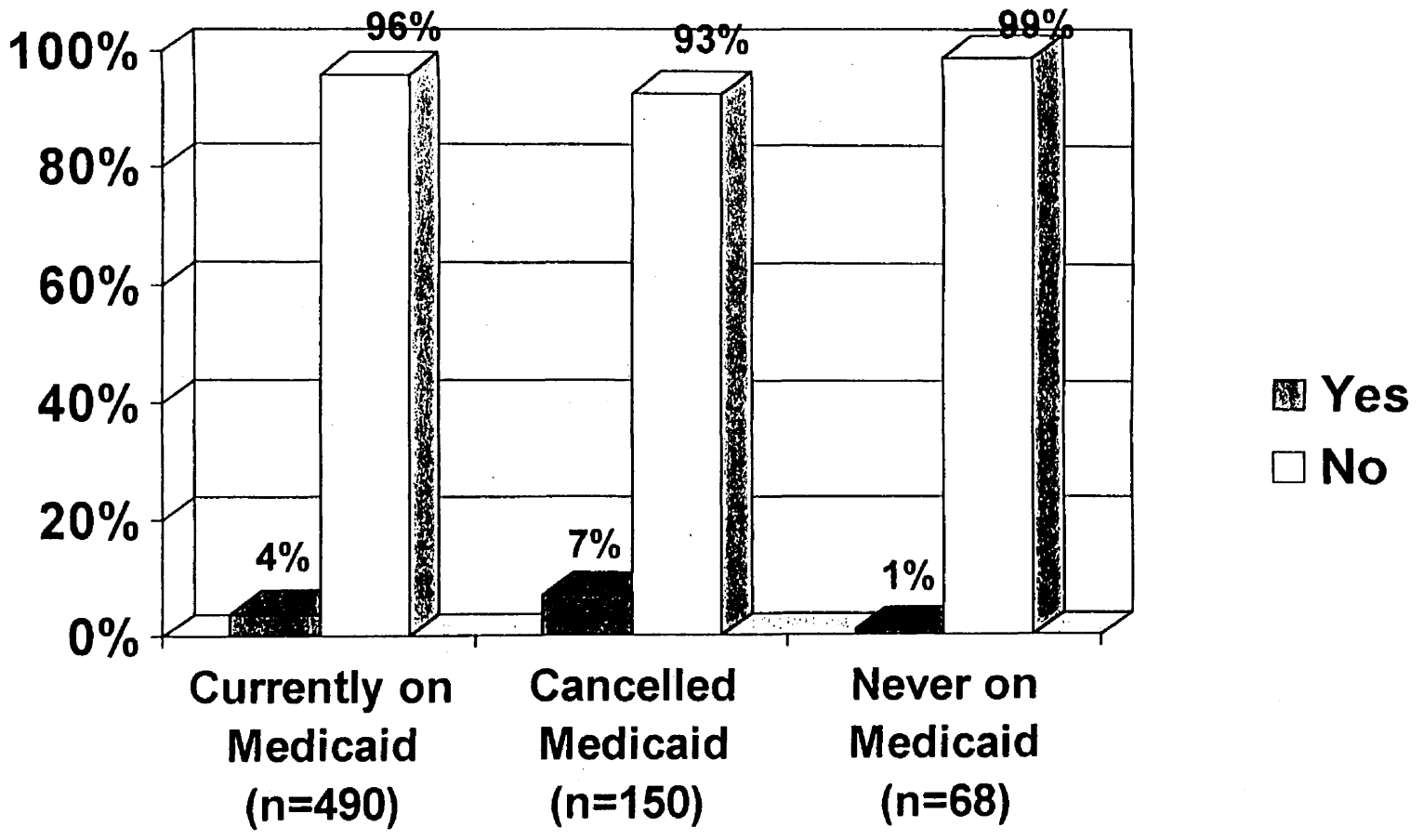
THOSE THAT INDICATED THEY HAD HEARD OF 1619.B WERE ASKED TO SELECT THE DEFINITION THAT BEST DESCRIBED 1619.B



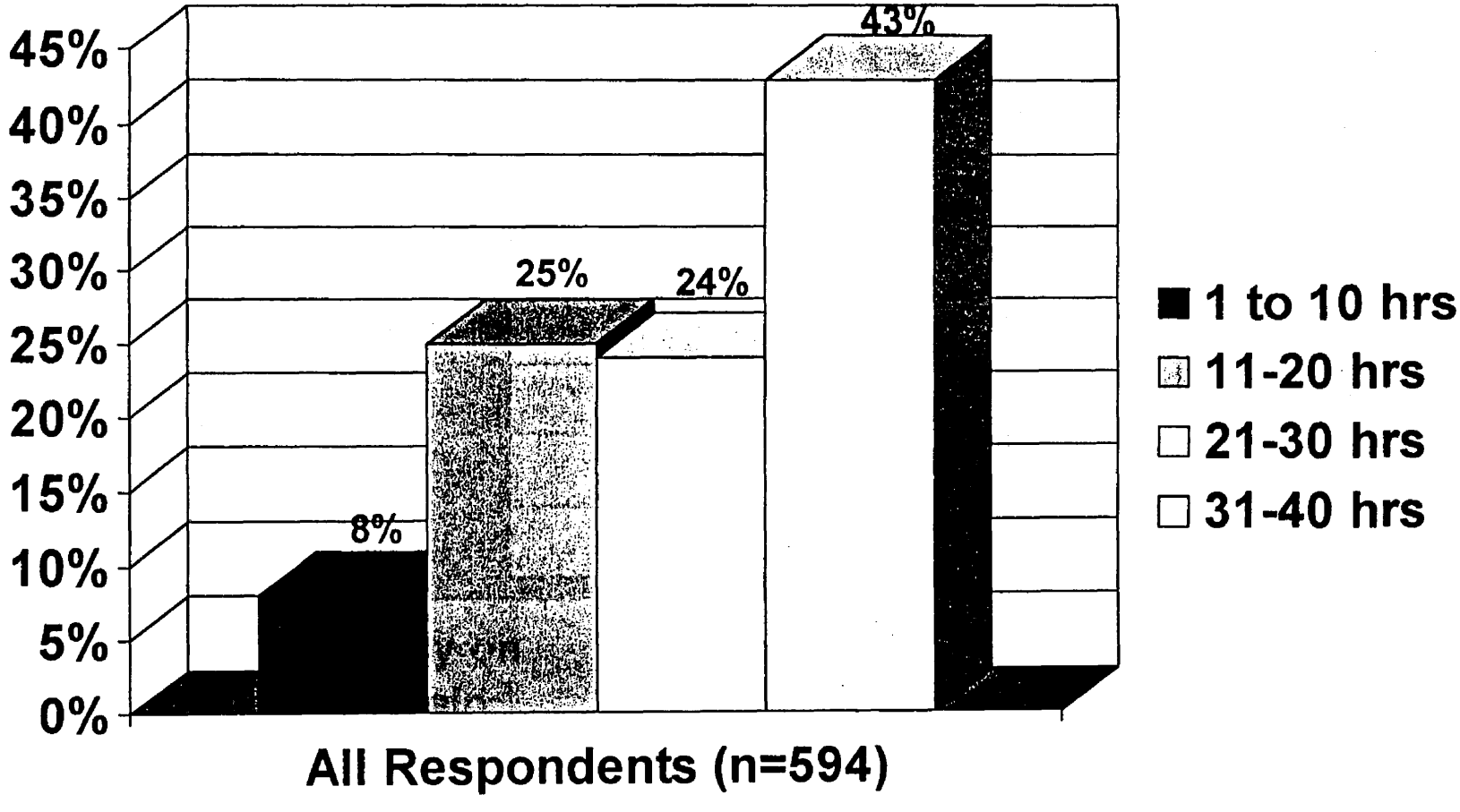
HAVE YOU HEARD OF MEDICAID BUY-IN PROGRAMS?



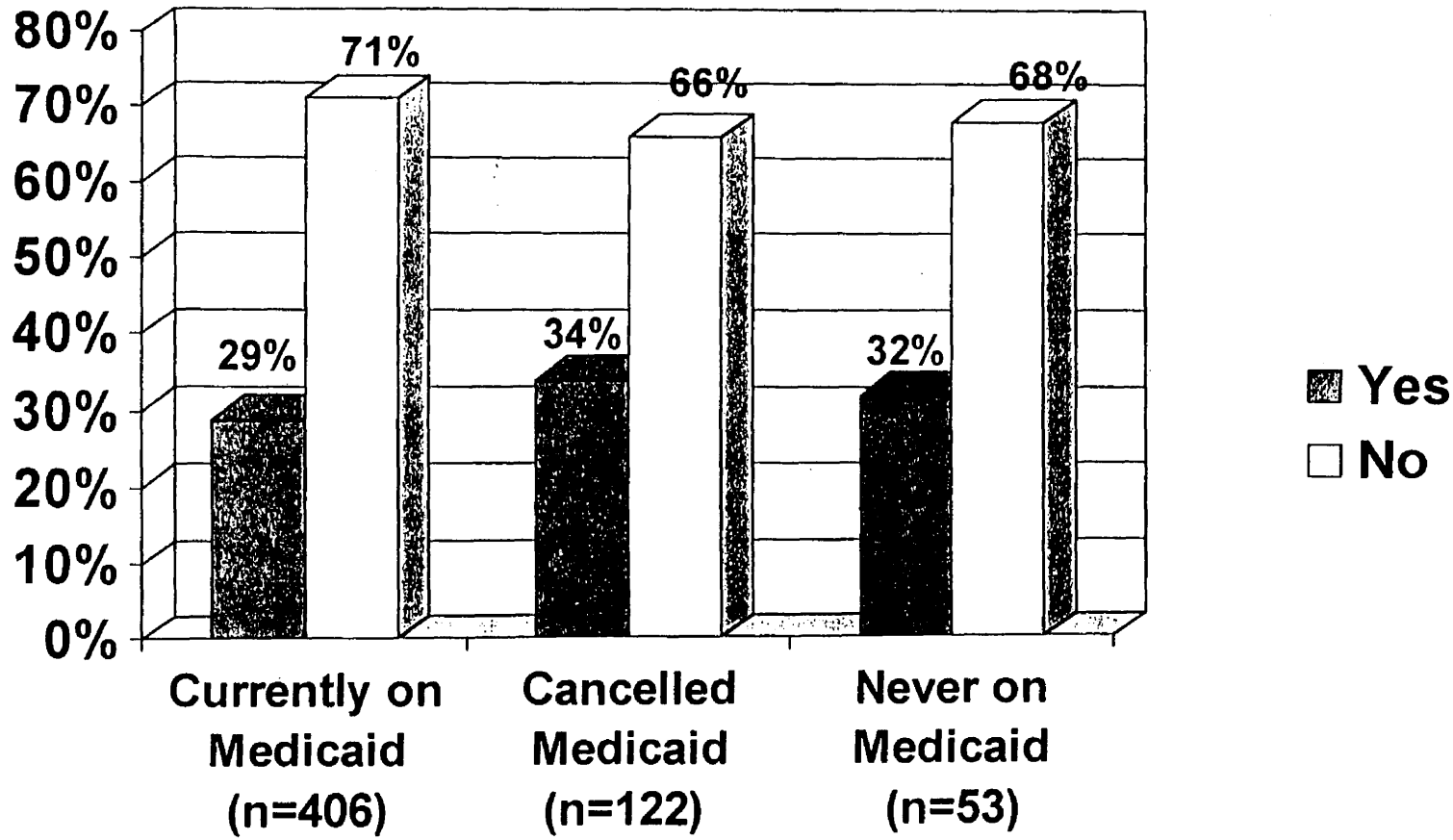
HAVE YOU HEARD OF MEDICAID BUY-IN PROGRAMS?



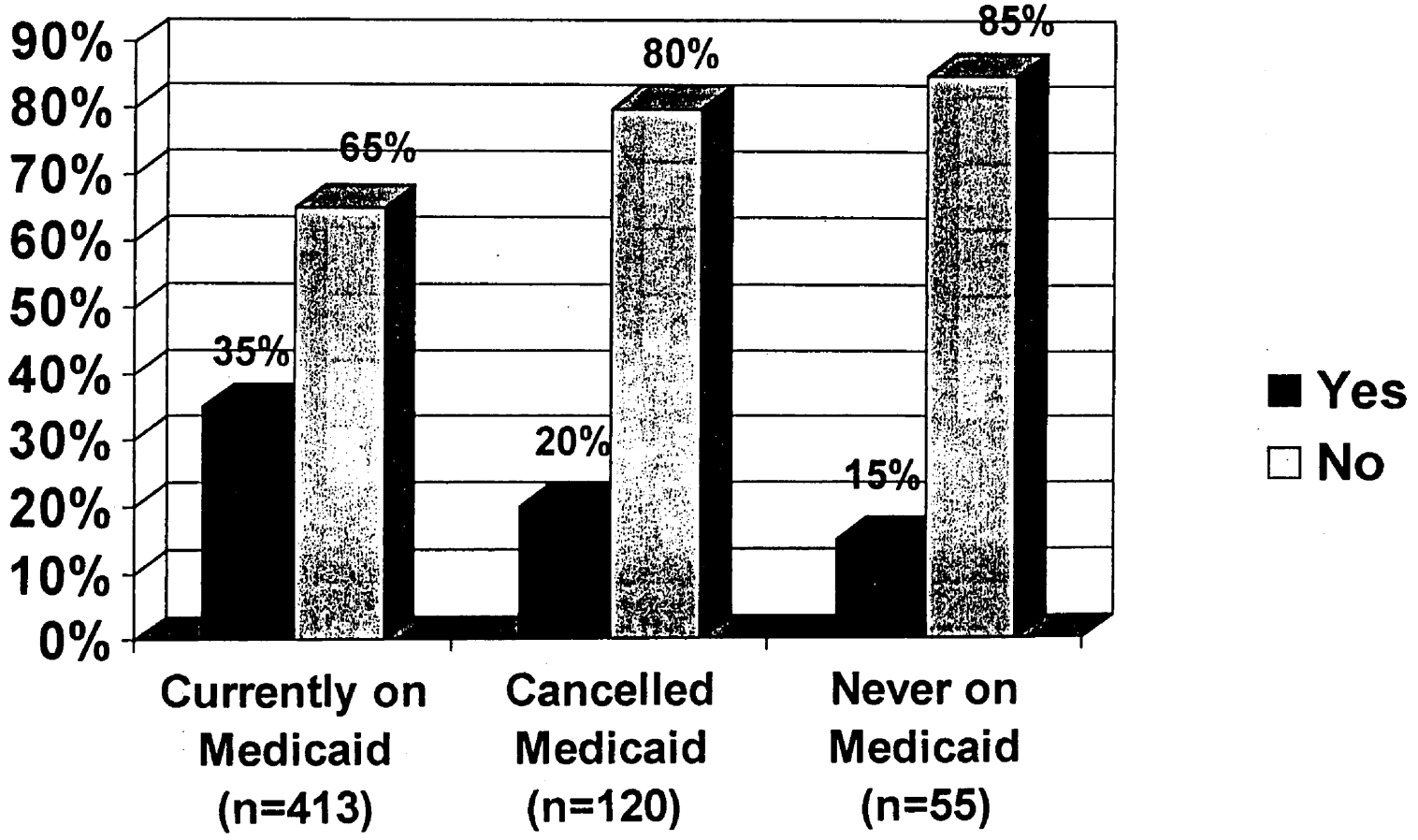
HOURS WORKED PER WEEK
(n=594)



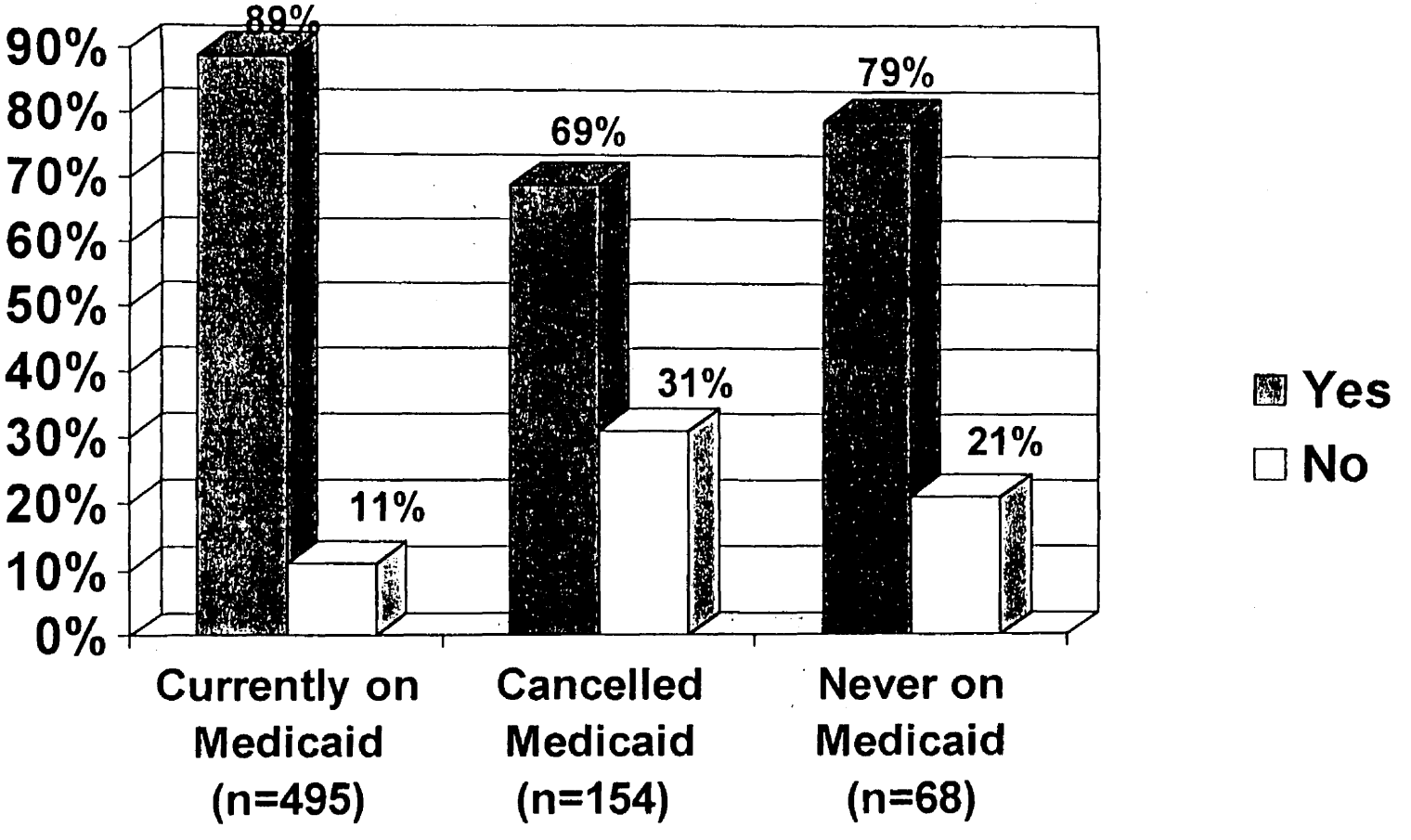
DO YOU WANT TO WORK MORE HOURS PER WEEK?



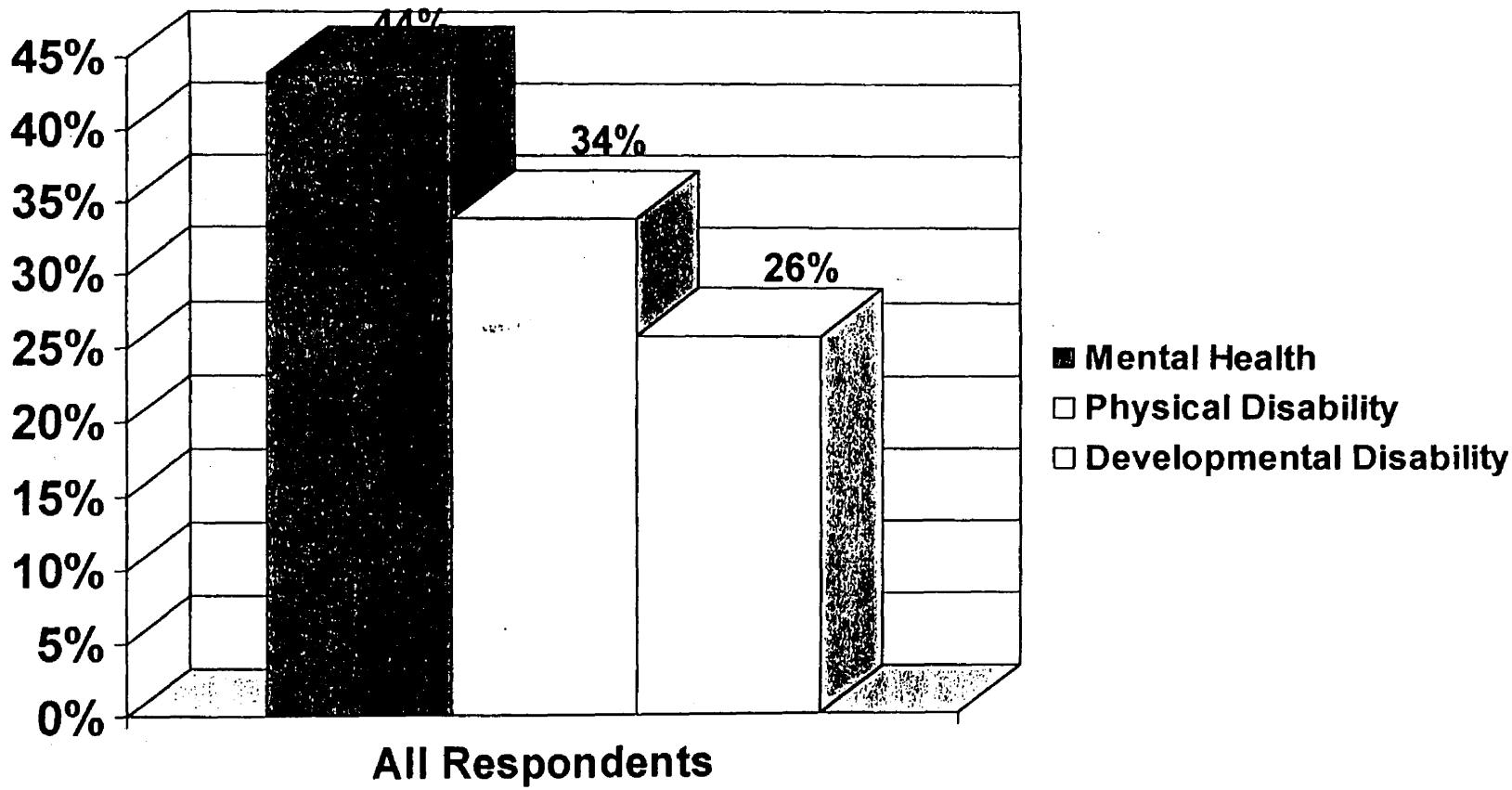
DO YOU LIMIT THE HOURS YOU WORK SO YOU CAN MAINTAIN CERTAIN BENEFITS (e.g., SSI, SSDI, MEDICAID)?



DO YOU CURRENTLY HAVE HEALTH INSURANCE?



DISABILITY TYPES – THREE MOST FREQUENTLY OCCURRING



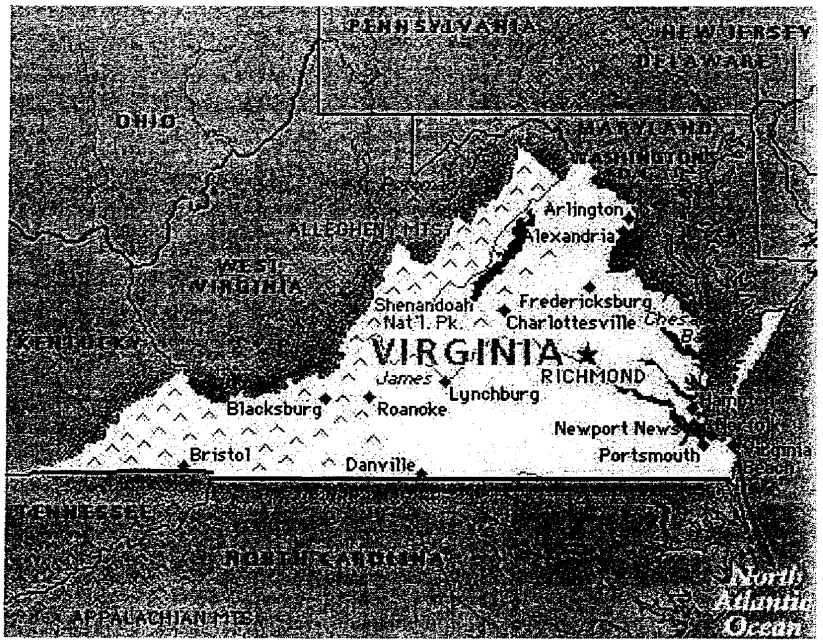
NOTE: Respondents were instructed to check all disability categories that applied. Respondents may be represented in more than one disability category.

Appendix E

Virginia Commonwealth University
Survey and Evaluation Research Laboratory
1619(b) Focus Groups

Medicaid Buy-In Focus Groups:

Report of Findings from 1619(b) Eligible Individuals



Prepared for the
Virginia Department of Medical Assistance Services

August 2002

Survey and Evaluation Research Laboratory and the
Rehabilitation and Research Training Center
Virginia Commonwealth University

Table of Contents

Executive Summary

Since the Supplemental Security Income (SSI) program was implemented in 1974, work incentive provisions have been included in the Social Security Act for persons with severe disabilities. Under Section 1619(b) of the Social Security Act there is a work incentive program that allows individuals to work *and* maintain their Medicaid coverage after their cash payments have ceased. To be eligible, the person's earnings must remain below a certain threshold amount. If Virginia had a Medicaid buy-in program, 1619(b) eligible individuals that exceed the earnings threshold could opt to purchase Medicaid as their source of health insurance. In other words, they could buy in to Medicaid.

The Virginia Department of Medical Assistance Services (DMAS) sought assistance from the Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University to gain information directly from 1619(b) beneficiaries about how the development of a Medicaid Buy-In program could further enhance their participation in competitive employment. This was done through mail survey and focus group methodology. Under a sub-award from SERL, the Rehabilitation Research and Training Center (RRTC) agreed to facilitate the focus groups. The purpose of the focus groups was to provide 1619(b) eligible individuals with an opportunity to provide input on the design of a Medicaid Buy-In program in Virginia. The findings from the focus groups are intended, in part, to provide guidance to DMAS in their effort to develop a Medicaid Buy-In program that addresses the health insurance needs of individuals with serious disabilities who are seeking or are engaged in competitive employment.

Key findings from two focus groups involving 11 individuals are as follows:[1]

- Health insurance is very important to working individuals with disabilities. However, participants had very little knowledge and understanding regarding existing health insurance options potentially available to them.
- There are a variety of strategies used by some workers with disabilities to assure that they do not exceed income threshold limits for eligibility for Medicaid coverage. These strategies include limiting work hours, turning down promotions, and taking periodic breaks from employment.
- The Medicaid Buy-In program, because it can protect health care coverage, offers the potential for employed persons with disabilities to expand their work hours and to take advantage of an expanded variety of employment opportunities.
- Limits should be set for earned income when establishing eligibility requirements for the Medicaid Buy-In. Opinion varies considerably among the focus group members on eligibility requirements for unearned income and the income of spouses.
- Money spent on work related expenses such as transportation, medications, and personal assistance services should be excluded when determining available resources.
- All focus group members recommended that the current resource limit of $2,000 for Medicaid eligibility be increased. A sliding scale was recommended for setting a resource limit that would allow for increased savings as earnings increased. Exclusions that should be allowed in resource determination included, for example, money for retirement or college and savings for a home.
- Premiums and co-pays should be set on a sliding scale based on an individual's resources and income.
- Reinstatement to Medicaid should be automatic if there is job loss.

[1] Despite the offering of a $50 incentive, the response rate for focus group participation was low and necessitated canceling planned sessions in Fredericksburg, Roanoke, and Harrisonburg.

In summary, the Medicaid Buy-In program offers working people with disabilities who exceed the Medicaid eligibility threshold amount for earnings and/or resources the opportunity to purchase Medicaid coverage. The 1619(b) eligible individuals who participated in the focus group process provided very helpful information and insight for use by DMAS in the development of Virginia's Medicaid Buy-In program. First, it is very clear that focus group members had very limited awareness of the existing health coverage opportunities potentially available to them and no awareness of the Medicaid Buy-In. Virginia's Medicaid Buy-In program needs to plan for an aggressive public awareness and education campaign to assure that information gets to potential users. Second, focus group members emphasized that the presence of the Buy-In would offer them greater flexibility in making choices about the intensity and nature of their employment. Third, the focus group members did vary in their recommendations regarding income limits for eligibility, treatment of resources, and premiums and co-payments. However, they consistently noted the importance of flexible rules that would allow, for example, for premium payments to be based on financial resources and income rather than on a fixed amount for everyone. Although the number of participants in the focus groups was small, the information they provided is very useful regarding the need and support that exists for the Medicaid Buy-In program, the importance of aggressive education and awareness regarding the Buy-In's implementation, and the importance of flexible guidelines in establishing eligibility and participation guidelines.

Introduction:

Since the Supplemental Security Income (SSI) program was implemented in 1974, work incentive provisions have been included in the Social Security Act for persons with severe disabilities. Under Sections 1619(a) and 1619(b) of the Social Security Act, SSI beneficiaries have had the opportunity to earn higher incomes while retaining SSI status and Medicaid eligibility for a longer period of time. 1619(a) allows an individual to increase earnings which, in turn, causes a gradual reduction in their SSI cash benefit. With continued increased income, the SSI cash benefit eventually reaches zero and then Medicaid coverage is also lost unless the individual is eligible for continued coverage under the 1619(b) provision. Under 1619(b), eligibility for Medicaid coverage can be retained if the individual continues to: (1) meet the SSA's disability standard, (2) meet all SSI eligibility criteria with the exception of having earned income above the allowable SSI limits, (3) needs Medicaid services to maintain employment (e.g., coverage for medication or therapy); and (4) has gross earnings below the state-specific threshold. The current threshold amount in Virginia is $21,319 (CY 2002).

During the course of researching populations of individuals with disabilities that could potentially benefit from a Medicaid Buy-In program[2], the Department of Medical Assistance Services (DMAS) obtained a listing of all 1619(b) eligible individuals residing in Virginia from the Social Security Administration (SSA).[3] Medicaid recipients in this category could eventually exceed the state's earnings threshold and, therefore, could potentially benefit from a Medicaid Buy-In option.

DMAS sought assistance from the Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University to gain information directly from 1619(b) eligible individuals about how the development of a Medicaid Buy-In program could further enhance their participation in competitive employment. This was done through mail survey and focus

[2] A Medicaid Buy-In program is one that would allow otherwise eligible persons with disabilities who exceed the threshold amount for earnings and/or resources to purchase continued Medicaid coverage. In other words, persons ineligible for Medicaid based on income and/or resources would have an option to buy Medicaid coverage.

[3] In September 2001, the Social Security Administration reported that a total of 1,781 SSI recipients in Virginia were 1619(b) eligible.

group methodology. Under a sub-award from SERL, the Rehabilitation Research and Training Center (RRTC) agreed to facilitate the focus groups. The purpose of the focus groups was to give 1619(b) eligible individuals an opportunity to provide input on the design of a Medicaid Buy-In program in Virginia. The findings from the focus groups are intended, in part, to provide guidance to DMAS in their effort to develop a Medicaid Buy-In program that addresses the health insurance needs of individuals with serious disabilities who are seeking or are engaged in competitive employment.

Methodological Overview:[4]

DMAS provided SERL with a list of 1619(b) eligible individuals. An invitation postcard was mailed, first class, to all individuals on the list (n= 1,692). The postcard contained general information about the Medicaid Buy-In program and the purpose of the focus group. The postcard also referenced a $50 incentive for participation. Interested individuals were asked to call SERL. A toll-free number and a TTY line were made available for this purpose. Research staff at SERL recorded contact information for each participant in a secure database. Participants requiring assistance with transportation were referred to Department of Rehabilitative Services to address this need. Three days prior to the focus group session, participants received a reminder phone call from SERL in an effort to minimize no-shows.

There were five focus groups scheduled across the state. Focus groups in Fredericksburg, Roanoke, and Harrisonburg were cancelled due to a low number of interested 1619(b) eligible individuals. Sessions were held at handicap-accessible venues in the cities of Richmond and Virginia Beach. A total of eleven 1619(b)-eligible individuals participated in the meetings, eight in Richmond and three in Virginia Beach.[5] Each session lasted approximately 2 ½ hours.

[4] The research protocol was reviewed and approved by the VCU Institutional Review Board.
[5] One Richmond participant arrived approximately one hour late.

Structure of the Focus Group Meeting:

At the opening of each focus group session, the facilitator explained to participants that Virginia had been awarded grant funding from the federal government to develop the infrastructure for a Medicaid Buy-In program. This included an explanation that the underlying premise of a Medicaid Buy-In program is to allow working people with disabilities to pay a premium to participate in their State's Medicaid program, like they were purchasing private health care coverage. Participants were told that the purpose of the focus group was to gather input on how to structure a Medicaid Buy-In program to best meet the needs of employed individuals with disabilities in Virginia. Participants were encouraged to share their opinions with the group and to speak up if they disagreed with someone else's opinion. Participants were encouraged to keep comments to each other positive so as not to alienate anyone.

At the start of the session, the staff obtained informed consent from all participants. Each section of the consent form was reviewed to ensure that it was clearly understood. The consent form covered issues such as the reason for the focus group, the intended use of the information, and any possible risks of benefits that the participants may be subject to. After this explanation was provided, participants were asked if they had any questions. After questions were answered, participants were asked to sign the document. As they turned in their signed consent forms, they were given the $50 incentive.

The roles of the two RRTC staff members were explained. One person was to serve as a process facilitator and her role would be to keep the group focused on the topic being discussed. The second RRTC staff person was to serve as a recorder for the meeting, and she was responsible for keeping a written and audiotape transcript of the session. She also reviewed the information from each section of the focus group to ensure that the recording accurately captured the important points of discussion. Permission to audiotape each session was obtained from all focus group participants in writing. Participants were assured that the verbatim transcript resulting from the focus group session would be devoid of any identifying information.

Topic Area 1 – Employment, Insurance Coverage and Knowledge of 1619(b):

Participants were asked about the type of employment they held and whether they worked full-time, part-time, or not at all. Table 1 details these findings.

Table 1 - Employment Demographics

Type of Employment	Employment Terms
Restaurant worker – Cook and Serve	Full-time
Transportation – Taxi Driver	Part-time (15-30 hrs/week)
Restaurant worker – Serve and Train	Part-time (hours varied according to need)
Richmond Times Dispatch	Part-time (hours varied)
Grocery Store – Bagger	Part-time (15 hours per week)
Grocery Store – Bagger	Part-time (15 hours per week)
Office Manager	Full-time
Unemployed	N/A
Unemployed	N/A
Daycare worker	Part-time (10-24 hours per week)
Unemployed	N/A

Participants were asked a series of questions about their current status with regard to health coverage. They were asked to identify their current source of health insurance and how satisfied they were with their current health insurance. Table 2 highlights these findings.

Table 2 - Health Insurance: Type, Years of Coverage and Satisfaction

Medical Insurance	Years of Coverage	Level of Satisfaction
Medicaid; Medicare	10 years on	Fairly Satisfied
Medicaid; Medicare	8 years on	Satisfied
Medicaid; 1619(b)	7 years on	Satisfied
Medicare	6 years on	Not Satisfied
Medicaid; Medicare	4 years on	Satisfied
Medicare; Employer provided	4 years on	Not Satisfied
Medicaid; Medicare	2 years on	Not Satisfied
No Coverage	3 years off	N/A
No Coverage	2 years off	N/A
No Coverage	Not eligible until 4 months ago	N/A

As can be seen from Table 2, the range of time on current health insurance programs was between two and 10 years, with a median of 5.9 years. Participants who were currently not covered by any health insurance program had a median of 2.5 years off health insurance. The two focus group members who were currently not covered had been on Medicaid previously for an average of 6.5 years. The third uncovered participant had only become eligible for Social Security benefits four months previously.

Participants made interesting comments about their attitudes toward medical insurance. The person who was covered by both her employer and Medicare was very concerned over the cost of prescription medication. She made the following comment, "That's why I was asking about the cost of the Medicaid Buy-In program. Just for some of my prescriptions. Most of my medicine I can get through my job, but it's going to cost me so much."

Participants who were not currently insured made comments about the difficulty they had in negotiating the Medicaid system. One participant stated, "...I lost the SSI – I wasn't all that smart, so I didn't realize [what I had to do] so I just kind of lost it all." Another participant stated that he had his Medicaid coverage cancelled because of a computer error and he further stated that, "it was a hassle to get reimbursed. The doctors are good, but the system is bad." The participant who had just become eligible for SSI stated that he was very concerned over how high his medical bills were and he felt he needed to be on insurance.

Knowledge of Health Insurance Options:

Next, participants were asked about opportunities for healthcare coverage that may be available to them. Surprisingly, no one was aware of other options. Participants were asked if they had heard of the 1619(b) work incentive program. Three participants had learned of the program while completing a recent mail survey administered by SERL. However, they stated that they did not have an understanding of what the program offered. One person had been informed of the 1619(b) program from the Social Security Administration (SSA) office. This person stated that the SSA representative told him why he likely qualified for 1619(b) and he

applied based on that information. No other participants had heard of the program until the focus group facilitator mentioned it.

Topic Area 2 – Medicaid Buy-In:

Participants were informed that Virginia has been awarded a federal grant known as the Medicaid Infrastructure Grant. Monies made available through this award will allow Virginia to evaluate the needs of the disability community with regard to employment and to develop a Medicaid Buy-In program that makes both gainful employment and health care coverage a reality.

Participants were asked if anyone had ever heard of a Medicaid Buy-In program before the focus group meeting, and no one had heard of it. Participants were then asked if their ability to retain Medicaid coverage while working would change how they worked. For example, would they work longer hours or accept a higher wage? When asked if the existence of a Medicaid Buy-In program would allow one to work more hours, all participants answered with an enthusiastic yes. When asked if they would be more likely to accept a raise if a Medicaid Buy-In Program was implemented, all participants said yes. One person stated that he was currently in the process of getting a raise, and he had considered turning it down for fear of losing medical benefits. Another participant stated that he had "taken breaks" from working in the past when he knew that he was approaching the threshold earnings amount. In addition, he stated that he knew a number of people who had similar strategies to maintain benefits. He further stated that he felt people who had worked for "a certain amount of time" should get Medicaid, "no matter what your income is."

A focus group member who was employed at a local restaurant made the following statement:

> "I've been at [the restaurant] for six or seven years now and I should be further along in the company than what I am now. I should already have been in management two years ago. I've had to not do that because of disability benefits, so its definitely stopped me from being able to progress any further along in the restaurant. I might get my four stars, but it's going to end at that point, just for the fear of losing my benefits."

Another participant stated that she had repeatedly turned down offers of more work hours for fear of losing Medicaid coverage. She further stated that, "For me to seek out better positions that require you to be in college for so many years, trying to get a degree, or have computer background or management, and all that stuff, but I don't stretch my neck out. If I can't handle that job, I'd lose everything." A second participant added that it was "easy to make up the money, it is difficult when you're in the hospital and you've got yourself a $30,000 bill." He added, "I've quit a lot of jobs. I had a lot of good jobs, but I quit because I can't afford to lose those benefits." The consensus in both the Richmond and Virginia Beach focus groups was that the Medicaid Buy-In program would allow for greater flexibility in the nature and intensity of work.

Topic Area 3 – Medicaid Buy-In Design Features:

Participants were asked to consider what features would be desirable in a Medicaid Buy-In Program. It was explained to participants that Virginia has the ability to set income limits for eligibility and to determine how different types of resources will be treated. They were provided with the following example: "In designing a Medicaid Buy-In program, some states have chosen to disregard income of an individual's spouse or unearned income that a person has from other sources, such as an SSDI benefit. Other states have opted to disregard a portion of other types of income, as well as income used to pay for disability related expenses necessary for work."

To begin this detailed discussion, focus group participants were asked to disclose their current earnings. The Richmond and Virginia Beach participants disclosed the following:

- 1 earned approximately $20,000;
- 2 earned approximately $15,000;
- 2 earned approximately $10,000;
- 2 earned between $5,000 and $10,000; and
- 3 were unsure of or chose not to disclose their current earnings.

Income and Resource Limits:

Participants were also asked if both earned (e.g., money from work) and unearned income (e.g., money from SSDI) should be considered with regard to resource limits. Participants had differing opinions about what income should be counted.

- 4 participants felt all income should be counted;
- 6 participants felt the only earned income should be counted; and
- 1 person stated that the income counted should be conditional based on the family's financial situation.

One focus group participant went so far as to say that she felt only net income should be counted because the remainder of the money goes to the government. Participants also shared their opinions about the inclusion of a spouse's income in countable resources: six thought it should be counted; four said it should not be counted; and one person said it should be conditional based on the family's financial situation.

Participants were then asked if they felt that money spent on certain work-related expenses should be counted if they were incurred solely because of a disability. One participant made a very clear statement when asked this question. He said, "You don't have it, so why should it be counted?" Richmond participants listed the following expenditures they felt should be excluded:

- transportation,
- medication (prescription and over-the-counter),
- personal assistant or certified nursing assistant,
- dental care,
- eye care, and
- medical equipment.

Virginia Beach participants did not go so far as to list items they felt should be excluded, but they agreed that disability related expenses necessary for work should be excluded from consideration when determining eligibility for 1619(b) or Medicaid Buy-In

A major disincentive to employment for individuals with disabilities is the fear of losing Medicaid benefits. Therefore, participants were asked if the existence of a Medicaid Buy-In program would encourage them to increase their earnings above the 1619(b) threshold limit. Ten of the 11 participants across both focus groups stated that they would be willing to increase their earnings if this program existed; the remaining participant had no opinion.

The next segment of the focus group was designed to gather information on the resource limit under the Medicaid Buy-In program. Participants were given the following example to help them to understand the resource limit and how it impacts savings and eligibility: "Tim is a person who receives Medicaid benefits through the state because of disability-related health problems that caused him to give up his job. When Tim returned to work, he limited his earnings so they stayed below the state threshold level for 1619(b). While he was confident in his ability to earn more money and was comfortable with giving up his SSI cash benefits, he limited his earnings so he could maintain Medicaid coverage. In addition to limiting his earnings, Tim also had to maintain his resources under $2,000 in order to continue to be eligible for 1619(b). This made it impossible for Tim to put anything aside for medical expenses, or to pursue his goal of establishing a retirement account for his future."

The facilitator also explained to participants that the state would have some flexibility in establishing a resource limit in the Medicaid Buy-In program. While it had not been determined what the resource limit would be, it could conceivably be above the current $2,000 limit. Participants were told that an increase to the resource limit might allow Tim to start a savings account, retirement savings, or to create a medical savings account. The question posed to the group was, "if Tim or one of you wanted to start saving, or set aside money for retirement or for a medical account, do you feel that you should be able to save above the $2,000 limit?"

All participants felt that the current resource limit of $2,000 should be increased. Participants expressed frustration at not being able to save for retirement or to send their children to college. The range of the limits cited by participants varied dramatically between the Richmond and Virginia Beach sites:

- 7 participants in Richmond established a range of $10,000-$21,000;
- 1 person in Richmond set an upward limit of $50,000;
- 2 participants in Virginia Beach set a range of $2,500 - $4,000; and
- 1 Virginia Beach participant had no opinion.

The Richmond participants defined a number of items that they felt should be excluded when setting resource limits, including:

- retirement accounts,
- college funds for the participant or their children,
- medical savings funds,
- savings for a home and home repair,
- vehicle valued up to $10,000, and
- life insurance programs.

Exclusions from Virginia Beach included:

- cars,
- life insurance,
- retirement accounts,
- savings for a house, and
- healthcare.

Different responses were elicited from Richmond and Virginia Beach participants when asked if there should be a higher resource limit established for married couples. The three Virginia Beach participants said that they didn't believe that a higher resource limit should be set for married couples; however the eight Richmond participants felt that the limit should be increased from $5,000 to $15,000 for married couples. Two participants were strongly opposed to having income other than spouses count when determining resources. One participant stated that, "My mother's income has nothing to do with what I make, so her income shouldn't count towards mine."

All 11 participants recommended that a sliding scale should be implemented to allow Medicaid recipients to save more as earnings increased. They also stated that they did not feel that they should have to spend down their resources in order to be eligible for Medicaid services in the event that they lost a job.

Premiums and Co-Payments:

Participants were asked about setting premiums for Medicaid services under the Medicaid Buy-In program. At the beginning of this discussion, the concepts of premiums and co-pays were explained to participants. Participants were asked how much of a premium they would expect to pay if they earned $21,000 per year. The majority of the Richmond participants initially set a range of $17 to $20; one participant set a range starting at $10 but not to exceed $30.

Participants were then asked if they were given a "raise" and began earning $25,000 a year, did they think they should contribute more money towards the premium for their health insurance. The consensus of the Richmond group was that the premium should be raised $5 for each $5,000 increase in earnings. As such, Richmond participants described that they would like to see a sliding scale established. Virginia Beach participants felt that the premium should depend on a person's financial situation and income, rather than being a set fee. One Virginia Beach participant stated that no unearned income should be counted toward setting the premium, and all three agreed that neither spouse's income nor medical expenses should be counted when setting a premium.

One participant brought up the following question, "Say you begin paying into the Medicaid Buy-In program and then all of the sudden you are no longer working...you're no longer able to do anything... because of a medical problem." After clarifying the comment with the group, another participant stated, "I guess that she was trying to find out if the money she had put into the Buy-In Program would be lost." The concept of the premium as a monthly fee for services for that month was explained to participants.

This exchange led to the following question, "Let's say that you're in the Medicaid Buy-In program and you lose your job. What do you think should happen as far as getting back into Medicaid? Should it be automatic?" The focus group participants agreed that reinstatement should be automatic. They further stated that there should be a 30 day grace period when entering and exiting the Medicaid Buy-In program during which no premium is paid. In Richmond, they decided that after this grace period premiums should start immediately as you earn over the threshold amount. In Virginia Beach, participants had varying opinions. One person stated that you should, "wait a little while after you reach the threshold", a second stated that the premium should only be charged after you pass the $25,000 earnings mark, and a third suggested a four to six month grace period as, "You many lose your job or have other problems." As with the resource limits, seven participants felt that premiums should be based on the individual's income alone and four participants felt that the premium should be based on the combined income of the individual and his/her spouse.

The next task of the focus group was to discuss co-payment amounts for the various services they would be eligible for under the Medicaid Buy-In program. The following co-payment amounts were recommended by the participants:

- Prescriptions:
  - 7 people set the co-payment at $5,
  - 3 people set a range of $5-$10, and
  - 1 person set the co-payment at $1.

- Doctor visits:
  - 7 people set the co-pay at $5,
  - 3 people set a range of $10-$15, and
  - 1 person set the co-pay at $15.

- Additional co-payments established in Richmond:
  - $15 for outpatient care, and
  - $25 for 24 hours of hospitalization.

- Additional co-payments established in Virginia Beach:
  - 10-30% of bill for outpatient care, and
  - 0-30% of bill for hospital stay.

Support Services:

During the last part of the focus group session, participants were asked about support services that they received or did not receive. When asked about access to specialized transportation services, seven replied that they had not accessed support for transportation, and one stated that although he had access to specialized transportation, he elected to use public transportation. One person had utilized DRS-provided bus passes when entering employment.

Participants were then asked if they had ever used vocational rehabilitation services. Six participants stated that they had used vocational rehabilitation services and five had not. Participants were further asked if DRS or an employment vendor had assisted them in finding a job. Four stated that supported employment vendors had assisted them in securing employment, and two had received assistance directly from DRS.

The final question regarding assistance in securing employment asked if participants used any other training programs to get a job. One person noted use of a temporary agency to secure employment. The Virginia Beach participants also commented on food stamps. One person stated that she was not currently using food stamps, but she did have access to them. Another stated that food stamps were "extremely inconvenient to obtain." The final support service used by a focus group participant was stress management classes through the Community Services Board. He stated that these classes "helped him to be a part of society again."

Conclusion:

The Medicaid Buy-In program offers working people with disabilities who exceed the threshold amount for earnings and/or resources the opportunity to purchase Medicaid coverage. The 1619(b) eligible individuals who participated in the focus group process provided very helpful information and insight for use by DMAS in the development of Virginia's Medicaid Buy-In program. First, it is very clear that focus group members had very limited awareness of the existing health coverage opportunities potentially available to them through 1619(b) and no awareness of the Medicaid Buy-In. Virginia's Medicaid Buy-In program needs to plan for an aggressive public awareness and education campaign to assure that information gets to potential users. Second, focus group members emphasized that the presence of the Buy-In would offer them greater flexibility in making choices about the intensity and nature of their employment. Third, the focus group members did vary in their specific recommendations regarding income limits for eligibility, treatment of resources, and premiums and co-payments. However, they consistently noted the importance of flexible rules that would allow, for example, for premium payments to be based on financial resources and income rather than on a fixed amount for everyone. Although the numbers of participants in the focus groups was small, the information

they provided to DMAS is very useful regarding the need and support that exists for the Medicaid Buy-In program, the importance of aggressive education and awareness regarding the Buy-In's implementation, and the importance of flexible guidelines in establishing eligibility and participation guidelines.

Limitations:

The majority of focus group participants were very willing to share opinions and ideas as related to Medicaid 1619(b) and the Medicaid Buy-In program. However, there did seem to be some group influence over individual opinions. In addition, there were a limited number of focus groups and, within each focus group session, there were a relatively small number of participants. The findings may have been different and/or more expansive if there were more focus groups held with more participants.

Appendix F

Medicaid Infrastructure Grant Advisory Committee

Medicaid Infrastructure Grant Advisory Committee

Subcommittee Membership

Technical Design Subcommittee

Daniel Mueller, Consumer
Tony Young, Endependence Center of Northern Virginia, Inc
Martha Stevens, Richmond Behavioral Health Authority
Quincy Omphlette, Henrico-Hanover-Charles City-New Kent DSB
Linda G.Broady-Myers, American Council of the Blind
Warren King, Eggleston Services
Nita Grignol/Teja Stokes, ARC of Virginia
Susan O'Mara, Virginia Commonwealth University
Pat Lovell, Virginia Spinal Cord Injury Council
H.K. Lee, Jr., Eli Lilly and Company
Karen W. Brown, Brain Injury Services, Inc.
Joyce Morelli, Consumer
Michael Shank, Department of Mental Health, Mental Retardation, and Substance Abuse Services
Maureen Hollowell, Endependence Center, Inc.
Raymond Bridge, Mental Health Planning Council
Joanne Ellis, Career Support Systems, Inc.
Sevelia Allen/Jim Taylor, Department for the Blind and Vision Impaired
Ronald Lanier/Leslie Hutcheson Prince, Department for the Deaf and Hard of Hearing
Kathryn Kotula, Department of Medical Assistance Services
Joseph Ashley, Department of Rehabilitative Services
Hilary Malawer, Department for the Rights of Virginians with Disabilities

Communication/Education Subcommittee

Christine Bryant Cannaday, Virginia Chapter, National Multiple Sclerosis Society
John Toscano, The Autism Program of Virginia
Duke Storen, Department of Social Services
LaDonna Larsen, Consumer
Lisa Madron, Prince William County Community Services Board
Caryn Weir-Wiggins, Virginia Commonwealth University HIV/AIDS Center
Robbie Watts, Disability Determination Services
Kenneth Lovern, President, Virginia Association for the Blind
Karen Tefelski/Sharon Brent, vaACCSES Employment Services Association
Mary Brown, PRS, Inc.
Gayle Harding, Disability Services Board, Northern Neck Area
Christina Wood, Rappahannock Goodwill Industries, Inc.
Michael Cooper, Endependence Center of Northern Virginia, Inc.

Coordination of Services Subcommittee

Amy Wright, Virginia Board for People with Disabilities
Jenny McKenzie, President, Virginia Association of the Deaf Blind
Genni Sasnett, St. John's Community Services
Rhonda Jeter, Central Virginia Independent Living Center
Val Marsh, Virginia Alliance for the Mentally Ill
David Williams,Virginia Rehabilitation Association
Carol Webster, District 19 Community Services Board
Debe Fults, disAbility Resource Center
Patty Gilbertson, Hampton-Newport News Community Services Board
Karen Michalski-Karney, Blue Ridge Independent Living Center

Technical Design Subcommittee
Medicaid Infrastructure Grant Advisory Committee

Consumer Expectations for the Medicaid Buy-In Program

Presented at the October 30, 2002, Disability Commission meeting by Advisory Committee members Raymond Bridge and Maureen Hollowell.

Introduction

The following are the Medicaid Infrastructure Grant Advisory Committee consumer conclusions on what is required for a viable Medicaid Buy-In Program for Virginia. As we developed these recommendations over the past months, three things have guided us:

- The five principles adopted by the entire Advisory Committee.
- Agreement among consumers that we must have a robust Buy-In program that strongly supports return to work.
- Lessons and examples drawn from the experience of dozens of States that have Medicaid Buy-In programs.

The more the Advisory Committee learned about the Buy-In opportunity, the more Advisory Committee grasped its potential for allowing Virginians with disabilities to go to work and build careers. We need a robust Buy-In program, we expect the Commonwealth to provide it, and we will be patient but persistent until we achieve it.

These are the design principals that consumers endorse:

FIRST, the Medicaid Buy-In is an employment incentive program for persons with disabilities, not a welfare program. The Virginia program must be designed to shift the life-planning of a person with disabilities from the current system that fosters permanent beneficiary status and limited employment, to authentic career planning, becoming a productively employed taxpayer, and saving for independence and retirement.

SECOND, The Medicaid Buy-In program should be kept as simple as possible - simple for consumers to participate in and understand- simple for State administration. It also should be simple for employers who hire Buy-In participants, with minimal paperwork.

THIRD, Virginians with disabilities understand that premiums and cost sharing are integral to the Medicaid Buy-In opportunity, just as they are with workplace health insurance. We embrace the need for affordable co-payments and premium policies that would defray costs, yet allow people who meet eligibility criteria to retain Medicaid.

FOURTH, we expect to take full advantage of employer-sponsored health plans as we return to work. However employer health plans may not cover, or adequately cover, the medical services that some disabled people must have in order to work, so access to Medicaid through the Buy-in is essential.

FIFTH, working Virginians with disabilities want a system that is forward-looking in allowing and encouraging personal savings for such purposes as assistive technology and other work-

related expenses, training, and retirement accounts so we can be more self-sufficient now and in retirement.

SIXTH, a Medicaid Buy-In should have an income ceiling that is high enough to allow individuals with disabilities people to earn enough income for self-sufficiency without losing access to Medicaid. Working people with disabilities, whose income or resources exceed eligibility requirements, should have the options of buying-into Medicaid by paying the full cost, in the event they are unable to purchase adequate health insurance through the private sector.

SEVENTH, a Medicaid Buy-in must include certain transitional safeguards when employment or earning capacity are interrupted or lost. Consumers who are between jobs but actively seeking employment should be allowed to retain Medicaid by buying in for a reasonable period to promote a sustained work effort.

Under a Federal "easy back on" provision, working consumers who lose their earning capacity because of disability may request expedited reinstatement of SSI or SSDI disability benefits. The Virginia Medicaid program should facilitate this transition by disregarding assets that were earned under the Buy-In and deposited in a retirement account or other designated savings account.

EIGHTH, consumers need and should have a system that allows individuals to continue to participate in Medicaid's Home and Community-Based Services waivers (e.g., DD, MR, HIV) but encourages them to start or return to competitive employment.

NINTH, consumers need and should have a system that allows access to Personal Assistance Services (PAS) for those who need those services to start or return to work and retain competitive employment.

TENTH, Calculation of the cost of implementing a Buy-In program must account not only for costs, but also for offsetting revenue or cost reductions that accrue to Virginia as people with disabilities go to work. As the Buy-In and other new employment incentives enable more Virginians with disabilities to work, dependence on publicly funded programs will decrease, sliding-scale fees and premiums will increase, and more taxes will be paid. Costs will be shifted away from many state or locally funded programs. Two examples are the after-care pharmacy and locally funded indigent medical care. Additional benefits will accrue to employers as the workforce expands, and Virginia's economic activity will be stimulated by the rising incomes of workers with disabilities. We urge you to survey potential state and local revenue gains as you estimate the true cost of implementing a Buy-In program.

FINALLY, we recognize the gravity of the budget problems facing the Commonwealth. We understand that given these problems we will design a Medicaid Buy-In in a way that limits the number of participants at first, but incorporates our recommendations for robust provisions. This will allows Virginia to learn about true costs and benefits of the program; and in the future, to grow the program to include individuals with higher income and personal resources levels.

On behalf of all Virginians with disabilities, we ask for a long-term commitment to make this happen, and pledge our commitment to continue the work of the Advisory Committee. With this commitment, we believe that ultimately most Virginians with disabilities will be able to be competitively employed with continuing access to comprehensive health care coverage.

Medicaid Infrastructure Grant Advisory Committee
Benefits and Services Coordination Subcommittee

Recommendations to DMAS on Coordination of Services Related to Development of a Medicaid Buy-In Program for Virginia

Recommendation I:	**Require three levels of Coordination Planning for the Virginia Medicaid Buy-In (MIB) implementation at the State, regional/local and individual planning team levels.**
Recommendation II:	**Develop and refine VA's MIB program through the strategic use of decision support technology, the help of a "System's Integrator"[1] and comprehensive benefits analysis across related state and local benefits programs.**
Recommendation III:	**Endorse and support the customization of WorkWORLD software for VA Benefits Planning through available resources.**
Recommendation IV:	**Develop a simple Procedural Safeguards booklet expressly designed for consumer and family use when considering or using the Medicaid Buy-In program.**
Recommendation V:	**Advance Virginia's Benefits Planning and Assistance Outreach (BPAO) System.**
Recommendation VI:	**Incent innovations in regional or local Coordination of benefit programs through small start-up grant opportunities.**
Recommendation VII:	**Develop a coordinated single application process for benefits programs related to Medicaid and assess the feasibility of the application process to serve as a system change model for other coordination needs. (Consider a state level review and approval process for all policy change and development for consumer benefits programs in VA).**

[1] This is a staff support position proposed in recent DOL grant proposal developed by DRS Grants Development Office for the WorkFORCE Coordinating Grant competitive (A System's Integrator will bring together knowledgeable state agency reps and other stakeholders as key informants to identify policies and program information to be coded into the software and state policy change planning).

Implementing Recommendations: The following provides more detail on the Subcommittee's recommendations, a rationale for the recommendation, and short- and long- term strategies to reach the recommendations.

Recommendation 1: Three levels of Coordination Planning are needed for successful Virginia MIB implementation (State, regional/local and individual planning team level).

Rationale: Due to the complexities of benefits across programs, regions and localities, varying eligibility algorithms (individual vs. family income levels), etc., benefits analysis must be simplified into discrete planning units according to the various perspectives of the stakeholders at all levels. Using the research above identifying all the related state and local agencies/entities and the major state system change initiatives occurring in VA, the Subcommittee recommends that *benefits coordination planning* related to the Medicaid Buy-In occur at three levels. (i.e., Three benefits coordination planning work teams should be developed to meet periodically throughout the life to the four-year MIG Grant):

1) State Level Benefits Coordination (State leadership and policy/procedure staff);
2) Regional/Local Level Benefits Coordination; and
3) Individual Case Level Benefits Coordination (individuals, families, and case workers)

The Subcommittee strongly agrees that without careful coordination of benefits and programs at the state, regional/local and individual case level, a MIB participant could easily gain in the area of employment yet lose other essential services/benefits —producing a major net loss for the individual and his/her family.

The Subcommittee recommends that the goals of benefits coordination planning at each level should be to:

- Holistically examine all benefits accessed by Virginians with disabilities within each level;
- Examine consumer benefits from increased employment levels and Medicaid continuation vs. any penalties that could invoked from other benefit programs due to increased earnings;
- Examine all benefits accessed by Virginians with disabilities holistically and determine if MIB participants will experience a net gain or a net loss;
- Determine if any net losses would amount to further disincentives for employment and consumer efforts to become more self-sufficient through personal earnings and savings;
- Identify conflicting regulations, policies, and procedures related to MIB implementation at each level examine the impact of the allowable increased earnings through employment for MIB participants on eligibility and service continuation criteria for other needed programs benefits at the state, regional/local and individual case level;
- Determine any unintended consequences of the proposed MIB across each benefits and services at each level; and
- Make any recommendations for changes or amendments in the VA code, regulations, program policies and procedures in order to encourage increasing levels of self-sufficiency through personal earnings and savings.

Level 1	Level 2	Level 3
*Governor's Office/Secretary HHR *Disability Commission/General Assembly *Key Business/Economic Organizations *other Secretariat /State Government (HHR, Commerce, and Transportation) *Olmstead Task Force Rep *VA SSA rep *State Agency heads and a designee responsible for eligibility policy and procedures: • DMAS • DRS • DMHMRAS • VHDA and DHCD • HUD (select one VA office) • Transportation (DRPT) • DSS • DOH • DOE • WorkForce Investment council/WIB *National Expert on Benefits Planning and Assistance Outreach (BPAO) Rep (experience in other states) *WorkWORLD at a policy level	*Regional/Local DSS *Regional/Local DOH *Regional/Local DOE *Regional/Local MHMRSAS (CSB/BHA) *Regional/local DRS *Regional/local WIB *Regional/local PHA *Regional HUD *Regional/local BPAO *Regional/local DSBs *Regional/local provider networks *Regional/local public school transition *Regional/local business and employer associations *State funded regional waiver technical assistance managers *VA Case Manager's Association *Advocacy groups *One Stops Centers *Family Support groups *Self-Advocacy groups *WorkWORLD including regional and local benefit variations	Person-Centered Planning Teams including: *Consumer /family *Employer *Providers *Case Managers/Support Coordinators (also examine effects on consumer records) *One-on-one BPAO and/or WorkWORLD individual plan development.

Short Term Strategies:

1) Conduct State Government Level Buy-In introduction meeting chaired by the HHR Secretary, Patrons of Buy-In Resolutions and SunTrust or other Business Leader to ensure the attention and focus of state leadership in the Medicaid Buy-In including how it changes the earnings potential of Virginians with disabilities, the potentials for conflicting eligibility policies, and need for services/policies coordination.
2) Require state agencies to designate policy level agency staff to work on group work to identify on pertinent policies that will be affected by MIB changes.
3) Work group holds meeting(s) to identify policies that will be affected by initial design ideas and MIG staff finalize a phase I design for MIB that will bring about no harm to participants based on this initial review of polices across support programs (by October 25).
4) Subcommittee makes public comments at Disability Commission on process and finalized plans with regard to future coordination.

Long Term Strategies:

1) State Invited-Conference to kick off coordination hosted by Sec. Woods
2) With formal nominal or other process at conference, develop State Benefits Coordination Plan
3) Development of regional teams to implement State Benefits Coordination Plan
4) Evaluate state Benefits Coordination Plan Implementation (MIG)
5) Provide feedback to state and regional teams regarding quality and effectiveness of state Benefits Coordination Plan implementation.
6) Define clear expectations and incentives to ensure on-going coordination across benefits programs and the Buy-In program policies at the state program level, thereby bringing about no harm to consumers.
7) Use state "System's Integrator" type state level professional to serve as state coordinator of process.
8) Have a "go to" person in each agency on the Buy-In
9) Consider umbrella or collaborative agencies management at state level
10) Define clear expectations and incentives to ensure on-going coordination across benefits programs and the Buy-In program policies at the local level including consumers, families/advocacy groups and providers/programs.
11) Develop work plan from the State-Invited Conference and have a regional team implement and meet on an on-going basis with the goal of "Benefits Coordination to facilitate increasing self-sufficiency within region"
12) Use BPAO staff to serve as regional coordinator
13) Have a "go to" person in each agency on the Buy-In
14) **Evaluate use of effectiveness of three tier planning in two years on a comprehensive basis using an outside, neutral evaluator and review required, on-going internal evaluation data.**

Recommendation II: **Develop and refine VA's Medicaid Buy-In design through the strategic use of decision support technology, the help of a "System's Integrator"[2] and comprehensive benefits analysis across related state and local benefits programs.**

Rationale:

An immediate global assessment of benefit policies across agencies is needed in order to begin initial development of a Phase 1 MIB Design from which initial cost forecasting can be conducted. The initial plan and later continuous improvements for the VA Buy-In should be based on analyses of how policies affect consumer profiles and real Virginians with disabilities, not on educated guesses. The Subcommittee believes planning will be consumer-responsive only with appropriate decision support planning, having the help of a "professional" who is knowledgeable and communicates well across agencies, and with comprehensive, holistic analyses across benefit programs and services.

Short-term strategies:

- Apply for Olmstead Workforce grant, use any available resources to begin comprehensive analyses in a spread sheet format, identify a "go to" person on buy-in related questions at each agency, ...

[2] This is a Staff support position proposed in recent DOL grant proposal developed by DRS Grants Development Office for the WorkFORCE Coordinating Grant competitive (A System's Integrator will bring together knowledgeable state agency reps and other stakeholders as key informants to identify policies and program information to be coded into the software and state policy change planning).

Long term strategies:

- Develop a plan for continuous quality improvement of the Medicaid Buy-In design through WorkWORLD software, a System's Integrator, and regular comprehensive, holistic analyses across benefit programs and services.
- Evaluate attainment of goals outlined in the Olmstead WorkFORCE Grant Proposal in two years on a comprehensive basis using an outside, neutral evaluator and review required, on-going internal evaluation data.

Recommendation III: **Endorse and support the customization of WorkWORLD software for VA Benefits planning.**

Rationale:

To assist in the complicated analysis of benefits coordination at the state, local and individual levels across all programs and services, the Subcommittee recommends that the MIG Grant and/or the Commonwealth endorse and support the customization of WorkWORLD software for VA Benefits (either through the Olmstead workforce grant if awarded or through other sources). WorkWORLD is software and services designed to support people with disabilities making critical decisions about gainful activity (employment/entrepreneurship) and the use of work incentives, taking into account Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, Medicare, Section 8 rental assistance, and Food Stamps. WorkWORLD software allows people to learn about policies that may affect them and to try ambitious "What If?" scenarios to see how their choices can affect their cash benefits, net income, access to health care and other risks and opportunities. People use the software to create sample situations, refine their plans, avoid risky situations, reduce fears of gainful activity, evaluate options, and create reports, graphics, and proposals for better communication with agency representatives. There are a growing number of independent users in almost every state. WorkWORLD is available free by request or by downloading the software at http://www.workworld.org/ (made possible by a contract from SSA). Many individuals with disabilities, benefits consultants, vocational rehabilitation counselors, job coaches, volunteers, parents, educators, and others are discovering the usefulness of the software.

Several states are now using or planning to use WorkWORLD software to improve planning and development of Medicaid Buy-In programs in order to assure consumer-responsiveness and that no harm will result to any consumer from participation in each State's newly designed program. Customizing the Software for Virginia will make the basic WorkWORLD software more comprehensive, more functional, and responsive to Virginia state, regional and local initiatives and unique benefits.

To advance consistent policy interpretation across the state, across programs and benefits planners, and across consumers and families, the State should strategically plan the roll out of WorkWORLD throughout the state providing user training and technical support as needed and allowing for regular updates of the system. Although software will be free to user, research shows all levels of users need initial training and some follow-up updates.

Short Term Strategies:

- Olmstead grant or if not awarded, use funding from existing grants programs

Long Term Strategies:

- Strategically plan the roll out and adequate training of WorkWORLD and Benefits planning throughout the state with consumers, families, agencies, staff, and advocates.
- Update software as needed through state and grant funds....
- Evaluate effectiveness of training in two years on a comprehensive basis using an outside, neutral evaluator and review required, on-going internal evaluation data.

Recommendation IV: **Support the development of a simple Procedural Safeguards booklet expressly designed for consumer and family use when considering or using the Medicaid Buy-In participants.**

Rationale: Consumers and families need basic safeguard information. In that many do not have access to the internet a simple written document and posters should be developed for consumers and employer personnel offices. Booklet will identify who to contact with complaints and concerns, Appeals Process, VOPA supports, etc. ...

Short-term strategies:

- Have BPAOs help design booklet and have printed and disseminated through MIG.

Long-term strategies:

- Update regularly through combined funding from related agencies....
- Evaluate use of Procedural Safeguards Manual in two years on a comprehensive basis using an outside, neutral evaluator and review required, on-going internal evaluation data.

Recommendation V: **Advance Virginia's Benefits Planning and Assistance Outreach (BPAO)**

To advance coordination and consistency in the implementation of the MIG at the individual and local systems levels, the Subcommittee recommends that the Commonwealth seek to advance Virginia's Benefits Planning and Assistance Outreach (BPAO) through increased state guidelines for internal training requirements and development of BPAO capacity on an internal basis and later through expansion of BPAO capacity through additional state resources.

Rationale:

SSA has funded minimal start up grants for state's to begin individualized Benefits Planning and Assistance Outreach (BPAO) to help reduce individual fear and develop an individualized plan for increase self-sufficiency through personal earnings and savings. Preliminary findings show that individualized planning will be needed to help many persons with disabilities feel personally comfortable enough to return to work. VA needs to find budget neutral ways to fund more BPAO during difficult budget period and to expand state resources covering BPAO in the future.

Short Term Strategies:

- Require all programs serving adults with disabilities to ensure staff Knowledge, Skills and Abilities (KSAs) include documented understanding of BPAO and VA decision support software.
- Explore private pay and/or use of an IRWE to fund individual benefits and self-sufficiency planning.

Long Term Strategies:

- Expand state resources to include individualized BPAO services for smaller, more realistic caseloads than currently available.
- Explore Medicaid Waiver and/or VR reimbursement for individual benefits and self-sufficiency plan development.
- Evaluate expanded BPAO Coordination in two years on a comprehensive basis using an outside, neutral evaluator and review required, on-going internal evaluation data.

Recommendation VI: **Based on evaluation data, strategically incent innovation in regional or local Coordination Teams through small start-up grants**

Rationale: To ensure attention and on-going improvement efforts, small start- up grants serve as excellent incentives to localities if the process is a simple application with demonstration of proposed enhanced collaboration planning. The goal of this program would be to demonstrate model programs that enhance and ensure on-going coordination across benefits programs and the Buy-In program policies at the local level including consumers, families/advocacy groups and providers/programs.

Short Term Strategies:

- Plan a model start up grant program for year III of MIG
- MIG and/or other initiatives would identify an amount of funding which can be set aside for small start up grants (e.g., $150,000) and would issue simple RFP process to regional and local planning entities.

Long Term Strategies

- Simple application process would be developed to include documentation of strong interagency/program/ consumer communication and collaboration.
- Teams would be asked to design innovative ideas to enhance coordination including set of data, single application systems, use of other technology, consumer operated systems, local conferences, etc.
- MIG would evaluate models and disseminate evidence- based systems.

Recommendation VII: **Develop a coordinated single application process for benefits programs related to Medicaid and assess the feasibility of the application process to serve as a system change model for other coordination needs. (Consider also on-going state and local coordinated policy development and interpretation, review and approval process).**

Rationale: Confusion abounds across agencies and beneficiaries –we must simplify the system.
Short Term Strategies:

- See state of Washington's Plan
- Require all teams state, regional and local to consider this as an outcome goal for their planning activities.

Long Term Strategies:

- Seek to develop a paper and on-line single application system
- Seek to develop a process by which all new human services policies at the state, regional and local level are reviewed and approved in order to coordinate benefits and ensure increased self-sufficiency and personal dignity.

Medicaid Infrastructure Grant Advisory Committee
Communication and Education Subcommittee
Report and Recommendations

In response to its charge to "gain consensus and report on ideas for an effective communication and education plan that will ensure the success and appropriate use of the Virginia Medicaid Buy-In", the Communication and Education (C&E) Subcommittee of the Statewide Medicaid Infrastructure Grant (MIG) Advisory Committee has developed a number of recommendations for the point at which the Medicaid Buy-In (MBI) program is implemented.

First, the C&E Subcommittee recommends that all information dissemination and education efforts focus on a four-prong approach to reach potential audiences, as described below. The Subcommittee found this categorization helpful in conceptualizing and prioritizing the various groups to be targeted for MBI information and for determining the kinds of information that will be needed by the audiences in each prong.

Multi-Prong Approach to Communication and Education

1st prong: Medicaid recipients with disabilities, especially those who are working, and their families. Recipients and family members will receive information from multiple sources using multiple media, to help them understand existing work incentives and the MBI. These strategies are detailed in the following section.

2nd prong: "Hands-on" intake/eligibility workers who are directly involved in the Medicaid application and eligibility determination process, as well as direct service providers such as case managers/support coordinators, rehabilitation counselors, employment service providers, waiver services providers, transition specialists, social workers, and health department staff. These service workers with direct involvement with individuals with disabilities who may benefit from 1619b work incentive and the MBI, will receive small group training and other targeted communications to help them understand the rules and regulations of these programs and provide them with the tools to assist recipients in exploring these opportunities.

3rd prong: Employers of working Medicaid recipients. Targeted employers will be invited to forums sponsored by the Business Leadership Network, to help them understand existing work incentives and the MBI for their employees with disabilities. These employers will learn that the work incentives and the Buy-In can be a strong employment resource for each business to help them maximize staff and personnel training resources, increased diversity, reduce paper work, etc.

4th prong: Individuals and organizations, including disability advocacy organizations, that work with Virginians with disabilities, as well as with service providers who have direct contact with Medicaid recipients. This prong includes such groups as professional associations, university-affiliated training programs (e.g., special education, rehabilitation, nursing), United Way agencies. The focus of information dissemination for these groups will be a variety of mechanisms to provide general MBI program information, and contact information for accessing available MBI resources.

Information Needs and Dissemination Strategies

The Subcommittee determined that all prongs will need the same basic set of information, although the level of detail and emphasis will vary from one prong to the next. The information needs for all prongs include:

- Basic program description and implementation plan;
- Process for application/accessing MBI program;
- Likely impact on other benefits and eligibility for other services, including examples of the impact of accessing the MBI using individual consumer profiles;
  NOTE: This was identified as the key information need for potential program participants. Several Subcommittee members commented that, unless questions related to this issue are resolved to the satisfaction of individuals who are eligible for the MBI program, those individuals will not be willing to pursue the MBI opportunity.
- Documentation requirements for MBI eligibility; and
- Process to resume benefits in case of work interruption, and timeframe for resumption of benefits.

The Subcommittee determined that some strategies were more relevant or effective for some groups than for others. Therefore, the Subcommittee has developed the following specific recommendations for information dissemination and training activities by prongs. These recommendations are ranked by priority within subgroups:

Prong 1: Recipients

1. Articles or notices in existing newsletters (e.g., VAMI, ARC, HandiNet) with targeted information, including website address and other contact information;
2. Direct mailings: possible "check stuffer" for current SSI/SSDI recipients, targeted mailing to current or recent applicants for Medicaid, and to targeted groups of recipients of other benefits (e.g., food stamps, WIC, state PAS program) who are likely to be eligible for or receiving Medicaid;
3. MBI program brochures with basic program information mentioned above; produced in multiple languages and alternative formats, disseminated widely to service and advocacy organizations and consumer groups;
4. Media campaign, with targeted news articles (including real-life stories), talk show interviews (both TV and radio);

5. **Captioned** video(s) that provide program description and real-life information (like the New Hampshire video), with website address and contacts for further detailed information; videos can be used in conjunction with other strategies (presentations, on the website, as part of the media campaign, etc.); and
6. Presentations at statewide conferences that involve consumers: Collaborations, IAPSRS conference, NAMI family conference;
7. Public service announcements on radio & TV;
8. Web-based information/sites (should include basic program description, how to access the program (with links to DSS on MBI site(s), and from DSS to this site), information on likely effects on other benefits (possibly link to WorkWORLD[1] site), basic documentation requirements for application, on-line or downloadable application form, information on resumption of benefits if work disruption occurs; and
9. Web-based learning tools (e.g., WorkWORLD) for assessing likely-effects of program participation on other benefits.

Prong 1: Family members

1. Newsletter articles/notices (see number 1 under Recipients, above);
2. Direct mailings (see number 2 under Recipients, above);
3. MBI program brochures (see number 3 under Recipients, above);
4. Media campaign (see number 4 under Recipients, above);
5. Videos (see number 5 under Recipients, above);
6. Presentations at statewide conferences that involve family members: IAPSRS conference, Transition Forum, NAMI family conference (see number 6 under Recipients, above);
7. Web-based information/sites (see number 8 under Recipients, above);
8. Web-based learning tools (see number 9 under Recipients, above); and
9. Public service announcements on radio & TV.

Prong 2: Eligibility Workers

1. Local/regional training by the Department of Medical Assistance Services (DMAS), which should provide **both** clear and straightforward information on program requirements, documentation, etc., AND explicit discussion of program goals and philosophy.
2. Separate MBI OR broader work incentives conference/forum, regional &/or statewide, collaboratively planned and implemented with other interested organizations;
3. Presentations at statewide or regional professional association conferences (e.g., the Virginia Association of Social Workers, the Virginia Alliance for the Mentally Ill (VAMI) annual conference for family members, the annual Transition Forum, the Collaborations Conference);

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[1] WorkWORLD is decision support software designed to help people with disabilities, advocates, benefit counselors, and others find employment-based solutions to higher net income through best use of Federal and State work incentives and benefits. This software was developed at the Employment Support Institute of Virginia Commonwealth University, under contract to the Social Security Administration.

4. Direct mailings, preferably e-mail, using existing mailing lists/systems/listservs (e.g., through DSS for their eligibility workers, through professional association listservs);
5. Web-based information/sites with information on likely effects on other benefits (possibly link to WorkWORLD site), basic documentation requirements for application, on-line or downloadable application form, information on resumption of benefits if work disruption occurs;
6. Video(s) (see number 5 under Recipients, above);
7. Web-based learning tools (e.g., WorkWORLD) for assessing likely effects of program participation on other benefits and eligibility for other services.

Prong 2: Other service providers

1. Professional association conference presentations (see number 3 under Eligibility Workers, above);
2. Direct mailings (see number 4 under Eligibility Workers, above);
3. DMAS training (see number 1 under Eligibility Workers, above). The Subcommittee recommends that service providers who have direct contact with current and potential Medicaid recipients be encouraged to participate in the regional DMAS training on the MBI program;
4. Separate MBI OR broader Work Incentives conference/forum (see number 2 under Eligibility Workers, above);
5. Web-based information/sites (see number 5 under Eligibility Workers, above); and
6. Web-based learning tools (see number 7 under Eligibility Workers, above).

Prong 3: Employers

1. Provide employers with information on what advantages there are for them to have employees participating in the Medicaid Buy-In program (e.g., employees with disabilities not being limited in work hours, assistance in paying employer portion of health insurance cost, wider employee pool will be available);
2. Give employers another "hook" (e.g., availability of technical assistance on accessibility issues, consultation on job analysis to address disability issues) to address general concerns about employing individuals with disabilities;
3. Keep basic program information brief, and provide contact details (web address, telephone numbers, etc) for getting further information; and
4. Use Employer Leadership Forum approach and existing organizations (e.g., Virginia's Business Leadership Network, Society for Human Resource Management (SHRM), trade associations, Chambers of Commerce, as well as membership groups such as Kiwanis, Jaycees, etc.) to "get the word out" to employers.

Prong 4: Advocacy organizations with direct consumer contact

1. Presentations at statewide or regional professional association conferences (see number 3 under Eligibility Workers, above);
2. Direct mailings (see number 4 under Eligibility Workers, above);
3. Web-based information/sites (see number 5 under Eligibility Workers, above);

4. DMAS training (see number 1 under Eligibility Workers, above). The Subcommittee recommends that representatives from advocacy organizations that have direct contact with current and potential Medicaid recipients be encouraged to participate in the regional DMAS training on the MBI program;
5. Separate MBI OR broader Work Incentives conference/forum (see number 2 under Eligibility Workers, above); and
6. Web-based learning tools (see number 7 under Eligibility Workers, above).

Prong 4: Other advocacy organizations, professional associations, etc.

1. Web-based information/sites (see number 5 under Eligibility Workers, above);
2. Professional association conference presentations (see number 3 under Eligibility Workers, above);
3. Direct mailings (see number 4 under Eligibility Workers, above); and
4. Separate MBI OR broader Work Incentives conference/forum (see number 2 under Eligibility Workers, above).

Finally, in addition to these specific recommendations, the Subcommittee also had several general recommendations to keep in mind as information about the MBI program is being developed and disseminated:

- Examine DMAS' experience with information dissemination and provider training on the Family Access to Medical Insurance Security (FAMIS) program, both for what TO do and what NOT to do;
- Be sure to train Prong 2 audiences first, to ensure they have the necessary, correct, and standard information, before information is disseminated more widely to other groups or a media campaign is initiated;
- Train the Prong 2 eligibility workers together with Prong 2 service providers in local/regional groups, to ensure the same information is disseminated, and to create opportunities for ongoing contact and dialogue among these groups;
- Use these training opportunities to generate enthusiasm and interest of eligibility workers and other service providers for the MBI program, rather than presenting the program as a complex option that will be challenging to access and use (i.e., focus on encouraging rather than discouraging use of the program!);
- Ensure that ongoing training is provided to Prong 2 eligibility workers, so that they are up-to-date and continue providing consistent information; And
- Ensure that all materials developed to provide information on the MBI are accessible; for example, videos must be captioned, written materials must be available in alternative formats such as large print and Braille, contact telephone numbers must include TTY/TDD access (as well as staff who are trained in the use of such equipment!), web-based information must be accessible to screen readers, and all information should be provided in clear and simple language.

Appendix G

Employer Leadership Forum

Commonwealth's Medicaid Buy-In Program Crafted at Employer Leadership Forum Hosted by SunTrust Bank, Mid-Atlantic

Richmond, VA – Representatives of more than 30 employers, VCU -RRTC Business Roundtable members and several public officials met recently at the Employer Leadership Forum hosted by SunTrust Bank to discuss the development of the Commonwealth's Medicaid Buy-In Program which will enable working persons with disabilities to earn higher income while covered by Medicaid. The purpose of the Forum was to unveil the Buy-In as an economic and workforce opportunity for business, and to gain direct input from key employers and businesses for program design.

The Virginia Department of Medical Assistance Services (DMAS) will work with the Department of Rehabilitative Services (DRS) to compile the results of the Forum and other task force meetings, and make an initial legislation and budget recommendation for the Buy-In Program at the next General Assembly session

"The Medicaid Buy-In Program is important to the economy of Virginia. It will enable employers to reach into an undertapped layer of workers, those with disabilities, which in turn will benefit employers by increasing the talent pool needed to grow our business," said A. Dale Cannady, Regional President and CEO, SunTrust Bank, Central Virginia.

Those in attendance included: The Honorable Timothy S. Kaine, Lt. Governor of Virginia; The Honorable John H. Hager, Assistant to the Governor for Commonwealth Preparedness and Chair of the VCU-RRTC Business Roundtable; Senator Yvonne B. Miller, Norfolk, a member of the Disability Services Commission, Mr. James A. Rothrock, Commissioner of the Department of Rehabilitative Services and Cynthia B. Jones, Deputy Director of DMAS and business representatives from the private sector.

SunTrust Bank, Mid-Atlantic is a part of SunTrust Banks, Inc., headquartered in Atlanta, Georgia, which is one of the nation's largest commercial banking organizations. The company operates through an extensive distribution network in Alabama, Florida, Georgia, Maryland, Tennessee, Virginia and the District of Columbia and also serves customers in selected markets nationally. Its primary businesses include deposit, credit, trust and investment services. Through various subsidiaries the company provides credit cards, mortgage banking, insurance, brokerage and capital markets services. SunTrust's Internet address is www.suntrust.com

Participants of Employer Leadership Forum and Contact Information

Participating Employers	Company / Address / Phone number
Allison, Dana	UKROP'S STORES 600 Southlake Blvd. Richmond, VA 23236
Barnett, Debbie	TRIGON 2015 Staple Mills Road Richmond, VA 23279
Cannaday, Dale	SUNTRUST 919 East Main St., Suite 102 Richmond, VA 23219
Carlyle, Tom	KRAFT 6002 South Laburnum Ave. Richmond, VA 23231
Compton, David	PHILLIP MORRIS PO Box 23261 Richmond, VA 23261
Crowder, Maryann	VA CHAMBER of COMMERCE 9 South 5th Street Richmond, VA 23219
Cureton, Karl	DATA CENTER LABS
DeGain, Cindy	VA FARM BUREAU PO Box 27552 Richmond, VA 23261
Dorneman, Ross	SUNTRUST 919 East Main St., Suite 102 Richmond, VA 23219
Filippi, David	COLONIAL METAL PRODUCTS 2000 Midway Avenue Petersburg, VA 23803
Fowler, Cynthia	INFINEON TECHNOLOGIES 6000 Technology Blvd. Sandston, VA 23120-5000
Hewett, Millie	MANPOWER 1051 East Main St., Suite 102 Richmond, VA 23219
Jones, Addison	SUPPLY ROOM COMPANIES 14140 North Wash. Highway Ashland, VA 23005
Kruegar, Gary	CIRCUIT CITY 9954 Mayland Drive Richmond, VA 23233
Layman, Charles	GOODWILL COALITION 6301 Midlothian Turnpike Richmond, VA 23225

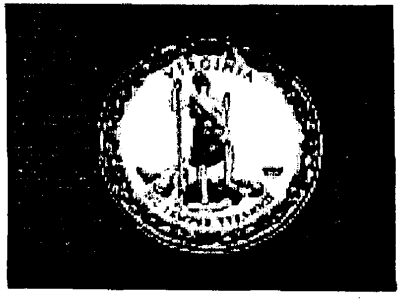
McCabe, Chuck	PEOPLE's INCOME TAX 4915 Radford Ave., Suite 100-A Richmond, VA 23230
McCary, Katherine	SUNTRUST 919 E. Main St. Richmond, VA 23219
Morris, E.S. "Crickett"	VA SEVEN-ELEVEN FRANCHISE OWNERS ASSOC. 2 Idlewood Boulevard, Route 3 Staunton, VA 22401
Schaaf, Barbara	BODDIE-NOELL 4801 Jefferson Davis Highway Richmond, VA 23234
Sharkey, Chip	LILLIAN VERNON 2600 International Parkway Virginia Beach, VA 24352
Spencer, Sid	PHILLIP MORRIS USA PO Box 23261 Richmond, VA 23261
Taylor, Irving	VERIZON 600 East Main St., 11th Flr. Richmond, VA 23219
Walton, Patricia	GREATER RICHMOND CHAMBER WORKFORCE 201 East Franklin St., Richmond, VA 23219
Wiggins, Don	VA TRUSSES PO BOX 46 Yorktown, VA 23690

Appendix H

Virginia Commonwealth University
Survey and Evaluation Research Laboratory

Listening Tour Report

DRAFT
12/06/02



The Virginia Department of Medical Assistance Services

Summary of Listening Tour Sessions for Input on the Development of a Virginia Medicaid Buy-In Opportunity

October, 2002

INTRODUCTION

BACKGROUND AND OVERVIEW

The Virginia Department of Medical Assistance Services (DMAS) is currently examining the feasibility of creating a Medicaid Buy-In program for the State of Virginia. The purpose of the program is to remove barriers to employment in order to allow Virginians with disabilities to maximize their potential for personal growth and independence. Such a program would permit working people with disabilities to pay a premium to participate in Virginia's Medicaid program as though they were purchasing private health care coverage.

The development of Medicaid Buy-In programs in individual States was authorized under the Balanced Budget Act (BBA) of 1997 and the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999. Since that time, approximately 20 states have developed and implemented various forms of Buy-In programs.

A major disincentive for Virginians with disabilities who are willing and able to work is the potential loss of health care coverage (Medicaid) if they earn too much income. For some individuals, this means making a choice between going to work and having health insurance coverage. Taking a job might actually put the working individual in greater financial risk than not working. A Medicaid Buy-In program can permit higher income and resource levels while insuring continuation of needed health care coverage.

PROJECT SCOPE AND APPROACH

The Department of Medical Assistance Services contracted with the Center for Public Policy (CPP) at Virginia Commonwealth University to conduct and document a series of facilitated listening tours designed to gather first-hand input on several critical aspects of the program. The desired outcome was the identification of critical issues that should be addressed as well as suggestions for program design and operation.

Ten listening tour sessions were held in five geographic locations: Abingdon, Manassas, Richmond, Roanoke and Virginia Beach between the dates of July 22 and August 1, 2002. Each session was scheduled for three hours to allow adequate time for full discussion.

Listening tour sessions were designed to facilitate discussion and generate ideas among participants, rather than to conduct a public hearing on pre-determined proposals. In order to accomplish this, invitations were sent out to a broad cross section of people across the state. Invitees included consumers with disabilities and advocacy organizations representing their interests, various types of providers who serve individuals with disabilities, representatives from health and human service organizations, and current Medicaid recipients in the blind and disabled covered group.

The Virginia Department of Rehabilitative Services (DRS) and the Department of Rights for Virginians With Disabilities (DRVD)[1] compiled a list of invitees for each session. DMAS then supplemented these lists with Medicaid participants to gain additional consumer input. Approximately 50 individuals were identified and invited to each of the ten sessions.

The morning sessions solicited a mixture of participants representing social service agencies and various advocacy groups. Afternoon sessions primarily reflected a mixture of consumers and providers of services to people with disabilities. A total of 145 people attended the listening tour sessions.

Three primary topic areas were identified by DMAS for discussion and input by participants:

1. What income limits should be established and what are the critical issues that need to be considered in establishing these limits?

2. What should the resource or asset limits be and what are the critical issues that need to be considered in establishing these limits?

3. What should premium and cost-sharing components be and what are the critical issues that need to be considered in establishing these fees?

[1] Effective July 16, 2002, the Department for Rights of Virginians with Disabilities ceased to exist as an executive branch state agency and was replaced by the newly created, independent state agency, the Virginia Office for Protection and Advocacy (VOPA).

A similar discussion format was used for all sessions. Each session opened with participant introductions and an overview of the session. A brief presentation was provided to help answer basic questions about Virginia's Medicaid program and the intent and key components of a Medicaid Buy-In program.

Written materials were provided to supplement and reinforce key information highlighted during the presentation. Braille and large print format documents were also made available. In addition, interpreters were on hand for each session.

DMAS staff attended each session and served as a technical resource for questions of fact but did not participate in group discussions.

To help maximize the ability to provide input, DMAS staff provided e-mail and other contact information that participants could use to provide any additional comments they might have after attending the sessions.

PREPARING THE REPORT

Participant comments were solicited and recorded on easels at the front of the room by the session facilitator. Ideas and suggestions were clarified as needed but were not debated or evaluated in terms or merit or accuracy by the facilitator.

The recorded comments from each session were summarized and themes identified under each of the three primary topic areas. Frequency of occurrence between morning and afternoon groupings as well as

between meeting locations was the primary consideration used to identify themes.

No order of priority is implied among the themes under each of the topic areas. Rather, this report attempts to capture the essence of the session conversations to help further inform policy makers regarding the key issues to consider and some of the options that are available.

Issues and Suggestions Regarding Medicaid Buy-In Program Income Limits

AN INCOME LIMIT SET AT 250 PERCENT OF THE FEDERAL POVERTY LIMIT (FPL) IS REASONABLE

Increasing the earnable income limit from the current $7,088 per year (80 percent of the FPL) to $22,150 per year (250 percent FPL) was considered a reasonable limit by most participants. This income limit was considered to be the minimum that should be established. Also, this limit was strongly supported if there were exceptions to what counted toward "earned" income (see discussion below).

It was noted that the 250 percent of the FPL would be of minimal help to current SSI 1619(b) program participants but would help all those not currently eligible for this program.

"We need a program that will allow people to succeed and not lose their benefits. People with disabilities are afraid to work and that's not right."

Northern Virginia Session Participant

INCOME LIMITS SHOULD REFLECT REGIONAL DIFFERENCES IN COSTS OF LIVING – ONE SIZE WILL NOT FIT ALL

Participants in the urban regions were strongly in favor of setting higher income limits in areas with documented higher costs of living. This was one of the few differences in comments made between the urban and rural listening sessions. This comment was not offered in the Abingdon and Roanoke sessions but was suggested in the Richmond, Manassas and Virginia Beach areas.

It was noted by several participants that the current FPL definitions had changed little during the past decade and have not kept pace with inflation rates. Setting a single income limit across the Commonwealth would in effect, penalize those people in high cost of living areas and would not further the program objective of increasing financial independence.

WHILE INCOME LIMITS ARE NEEDED, THEY SHOULD REFLECT TRUE DISCRETIONARY INCOME AND NOT GROSS INCOME LEVELS IF THE PROGRAM INTENT IS TO ENCOURAGE AND FOSTER GREATER FINANCIAL INDEPENDENCE AND STABILITY AMONG THE WORKERS WITH DISBILITIES

Many individuals have considerable out-of-pocket expenses for medical treatment, ongoing care,

prescription drugs and special equipment. The costs of these expenses should not count toward the income cap.

It was noted that some people would need to incur additional expenses if they were to be expected to work to their fullest and highest potential (re: costs for special equipment; personal assistance; etc.). In addition, out-of-pocket costs that are directly related to the person's work activities (such as transportation, uniforms, job training, etc.) should be deducted from countable income. Financial assistance provided for job training or career development activities should not be counted as income.

A HOLISTIC VIEW OF THE INDIVIDUAL'S LIVING SITUATION IS REQUIRED WHEN SETTING INCOME LIMITS

There is a complex mix of support programs that people with disabilities depend upon. The Medicaid Buy-In program needs to take into account the potential loss of benefits provided by other critical programs as the individual's income increases. Concern was expressed that individuals could find themselves in a situation where their increased earned income actually resulted in a reduced quality of life due to the loss of other benefits and assistance.

DISCOUNTS AND EXCEPTIONS SHOULD BE PROVIDED FOR THE CARE OF DEPENDENTS

Monies received through child support payments should not be counted as income as these funds are used for the care and support of other individuals. Those paying child support should have the ability to deduct these payments from their countable income for the same reasons. Child expenses not covered by child support payments should also be deducted from income calculations.

Issues and Suggestions Regarding Limits on Personal Resources and Assets

THE CURRENT LIMITS ON PERSONAL RESOURCES AND ASSETS ARE UNREALISTIC AND DO NOT SUPPORT THE GOAL OF INCREASED SELF-SUFFICIENCY AND INDEPENDENCE

There was general agreement that the current Medicaid eligibility guidelines require individuals to spend down their resources to near subsistence levels of living. These limits would need to be increased if individuals with disabilities are expected to increase their standard of living and decrease their dependence on public assistance.

A cap on personal assets ranging from $4,000 to $10,000 for individuals was viewed as more realistic and reasonable. Increasing the cap would permit people to create "rainy day" funds that would provide a financial cushion during times of unemployment or unanticipated expenses. This cap would work in conjunction with the exemption of certain monies set aside for specific purposes in special savings accounts (see further discussion below).

One frequently mentioned scenario was the need to have funds readily available for vehicle repairs. The inability to pay for unexpected repairs could result in the loss of a job, negating the positive gains made by that individual.

There is a current disincentive built into the guidelines for marriage. This disincentive should be removed and an incentive for married couples included under the Buy-In guidelines.

EXEMPT THE VALUE OF HOMES AND VEHICLES FROM ASSET CALCULATIONS

Having a place to live is a basic human need. The value of a home, and contiguous property, occupied by an individual with disabilities should not be considered an asset when calculating personal resource limits.

This was a topic where comments varied somewhat between the urban and rural sessions. Participants in rural areas expressed a desire to not limit the amount of property that was excepted as long as it was contiguous to the home. Participants in urban areas indicated that the amount of property exempted should not be set at an arbitrary acreage, but rather, reflect the minimum and maximum lot sizes permitted under local zoning ordinances.

Transportation is also a basic, critical need. Ownership of one vehicle should be allowed and should not be included in the determination of personal asset limits. This exemption should be allowed even if the individual with disabilities is not able to drive the vehicle themselves

since ownership of the vehicle would increase their chances of arranging transportation.

It was recognized that some guidelines would need to be established regarding the amount of home and vehicle value that would be exempted under the Buy-In program but session participants cautioned that setting hard dollar caps could pose problems.

Limits that may be set on the exempted values of homes should consider the average value of homes within each region since housing costs vary widely across the state. In addition, some individuals with disabilities may require costly adaptations and modifications which could add to their homes value.

Transportation costs will also vary depending on individual needs. Some individuals with disabilities can safely use standard automobiles while others need more costly, specially equipped cars or vans.

"We want to be able to save money and take care of ourselves and our families like everyone else."

Roanoke Session Participant

ALLOW WORKING INDIVIDUALS TO ESTABLISH SPECIAL SAVINGS ACCOUNTS TO HELP MEET THEIR UNIQUE NEEDS

The working individual with disabilities should be allowed to create special savings funds that would help meet their unique medical needs and improve their ability to find and retain quality employment. Such a fund could also be used to help pay for Buy-In premiums and co-payments. Assets in these funds should not be counted toward established asset limits.

For example, some individuals could benefit from a savings fund that would help pay for future maintenance and upkeep for specialized equipment they need for daily functioning or to work. Other individuals might wish to set aside funds for future job training or education to help expand their employment and wage-earning opportunities.

Greater flexibility should be provided to permit family or non-family members to create special trusts for individuals with disabilities. The assets of these trusts should not count toward asset limits. Money withdrawn from these trusts should not be counted as income if it is used to address needs directly related to the individual's disability or to purchase a home or vehicle.

To encourage self-sufficiency and improved quality of life, individuals should be able to set aside funds for a down payment on a home. Individuals who already own a home should be able to establish a savings account for home modifications, maintenance and repair so that they can remain in their home.

One suggested model was the Plan for Achieving Self-Support (PASS) administered by the Social Security Administration for SSI recipients who are blind or

disabled. A PASS helps working individuals with disabilities acquire those items, services or skills that are needed to compete for entry level jobs in a professional, business or trade environment. Income set aside under a PASS does not reduce SSI benefits and money saved or things owned are not counted against resource limits.

The plan can help pay for expenses related to business start ups, tuition and related educational and training expenses, employment services, transportation, equipment and tools, and other expenses. Each plan is designed to meet each individuals' employment goals and work abilities, permitting a great deal of flexibility.

Using a similar approach under the Buy-In program, a determination could be made as to what the individual with disabilities would need to function and work at their highest capacity and a savings plan created to help meet those needs.

PERMIT INDIVIDUALS TO SAVE FOR FUTURE NEEDS FOR THEMSELVES AND THEIR FAMILIES WITHOUT PENALTY

In addition to meeting special needs, the individual with disabilities should be allowed to contribute to retirement funds to meet their long-term needs. Contributions to retirement funds could be discounted from countable income and the value of these funds should not be calculated toward asset limits.

Concern was also expressed that current asset limitations placed undue financial hardship on family members when they passed away. It was suggested that Buy-In participants be allowed to have prepaid burial plans and burial plots and the value of these resources not be counted as personal assets. It was also suggested that the value of life insurance policies be exempted.

Participants suggested that special savings accounts should also be allowed to help pay for education expenses. Eligible expenses would include those of the individual with disabilities as well as their children. These savings should not be considered a countable asset.

DO NOT COUNT INHERITED RESOURCES TOWARD INCOME OR ASSET LIMITS IF THESE RESOURCES ARE USED TO MEET BASIC OR SPECIAL NEEDS

Permit individuals to use inherited resources to meet recognized special needs or create approved, exempt special savings accounts. If these resources are invested in approved uses, they should not count toward personal asset limits. These resources should also not be counted as income if used in this manner.

Create a set period of time to allow an individual to research and decide how they wish to handle inherited non-cash resources before they are counted as personal assets. For example, an individual may inherit a house and decide they do not want to live in it nor keep it as an asset. But, because of poor market conditions, they may not be able to sell the house immediately and invest their profits into approved savings accounts or to pay for

special needs. What may appear on paper to be an asset is not a true asset until it has cash value.

ESTABLISH CLEAR DISTINCTIONS REGARDING PERSONAL ASSETS AND BUSINESS-RELATED ASSETS

Self-employed individuals may have resources and equipment that are necessary to do business. These assets should not be considered personal assets. Anything necessary to produce income should be exempt when calculating asset limits. This would include such resources as computers, office equipment, telephones, etc. as well as land if it is being farmed or otherwise used to generate income for the individual with disabilities.

DO NOT REQUIRE ASSET SPEND DOWNS WHEN A CHANGE IN EMPLOYMENT STATUS OCCURS

Participants indicated that many individuals with disabilities have unstable employment patterns due to medical complications or other factors outside of their control. If an individual's income drops to a level where they are no longer participating in the Buy-In program, they should be able to retain assets or resources they were able to accumulate while in the program. This "hold-harmless" approach would permit easy re-entry into the Medicaid program without an interruption of medical coverage.

Issues and Suggestions Regarding Amounts of Premiums and Co-Payments

EMPHASIS SHOULD BE PLACED ON MONTHLY PREMIUMS RATHER THAN CO-PAYMENTS

Monthly premiums should shoulder the majority of the cost-sharing burden rather than reliance on out-of-pocket co-payments. A monthly premium with minimum co-payments would provide a greater degree of financial predictability for the individual.

This system would reflect typical private insurance programs. Allow the option of paying premiums through employer payroll deduction or deductions from SSDI payments.

CHARGE PREMIUMS ON A SLIDING FEE SCALE BASED ON COUNTABLE INCOME

Premiums should be charged on a sliding fee scale based on the level of countable income. Countable income could include only what the individual actually earns or could include all sources of income, both earned and unearned, with various exemptions for out-of-pocket expenses for medical care and medications, work-related expenses, and basic living expenses.

Premiums should be charged as a percentage of countable income but should not be set at levels that would be counterproductive to the goals of encouraging people to work to their maximum potential and creating an improved standard of living. A percentage of five percent of countable income was considered to be reasonable though there was not complete consensus among session participants.

REASONABLE CO-PAYMENTS SHOULD BE CHARGED TO HELP SUPPORT THE PROGRAM

Co-payments are both reasonable and expected to help pay for the Buy-In program. Several participants indicated that a system of co-payments would help encourage the responsible use of services. Other participants expressed concern that co-payments could discourage or prohibit people from accessing necessary care.

There is a need to balance the collection of co-payments with the need to have ready accessibility to services, without which, the individual may jeopardize their health and subsequent employability. No consensus was established on the amounts that should be charged for co-payments with suggestions ranging from current Medicaid requirements up to what private insurance programs charge.

Co-payments can place a financial burden on individuals who need a high level of services or for those who have a

medical condition that unexpectedly occurs or worsens. A cap on the amount of co-payments an individual would be expected to pay per year could be provided to help ensure no financial hardship occurs.

Co-payments should be established for doctor's visits, medications and other primary services but at levels below the average of what private insurance programs charge to make them affordable to individuals with disabilities.

Higher co-payments could be charged for emergency room visits to discourage non-urgent usage. It should be up to the individual's health care provider to determine whether a visit was an urgent situation or whether or not the individual had other options available for needed services.

"We want to replicate the real world of employment with a system of both premiums and co-payments. Let's not be condescending to the disabled."

Richmond Session Participant

PROVIDE THE OPTION OF USING MEDICAID AS A SECOND, WRAP-AROUND INSURER

Some individuals with disabilities will desire to retain their Medicaid coverage even if their employer provides medical coverage as an employment benefit. The employers insurance may not provide the same amount of services or levels of benefits as Medicaid. Important relationships may be compromised if the individual with disabilities' regular physicians and health care providers do not participate in the health care program offered by the employer.

CREATE A FLEXIBLE PROGRAM THAT ENCOURAGES EMPLOYER SUPPORT AND PARTICIPATION

Provide employers the option to pay premiums for their employees. This may create an affordable alternative to employers, especially small businesses, for providing health care benefits to their employees.

Tax credits or other special benefits could be provided to employers as an incentive to participate in the Buy-In program.

DO NOT CALCULATE INCOME LEVELS, AND RESULTING MONTHLY PREMIUM CHARGES, ON A MONTHLY BASIS

Many working individuals with disabilities have sporadic employment patterns due to a variety of factors. Calculating income on a monthly basis and paying premiums that varied on a frequent basis could be cumbersome and confusing to the consumer. A system is needed for calculating countable income levels over a longer time period, such as every six to twelve months, so that premium payments are more predictable.

CONTINUE THE OPTION TO PARTICIPATE IN MEDICAID IF INCOME LEVELS EXCEED PROGRAM LIMITS

An option should be provided to continue Medicaid coverage for individuals whose income level exceeds the program limits. Provide these individuals the option to pay up to 100 percent of the cost of Medicaid insurance

on a sliding fee scale. This would help insure that critical coverage provided through the Medicaid program would not be lost.

PROVIDE FLEXIBILITY IN THE COLLECTION OF PREMIUMS TO REFLECT CHANGING EMPLOYMENT SITUATIONS

When income begins to exceed the standard Medicaid program income level, offer a grace period of three to six months before charging premiums. This would permit more accurate income level assessments as well as help the individual gain a greater degree of financial stability before having to pay premiums.

A grace period for the nonpayment of premiums should also be established during temporary periods of unemployment or the transition to another job.

Additional Issues and Suggestions Regarding The Design and Operation of the Medicaid Buy-In Program

DO NOT DESIGN A SYSTEM THAT IS OVERLY COMPLEX AND DIFFICULT TO UNDERSTAND AND ADMINISTER

The collection of premiums needs to be simple and cost effective. Care should be taken to ensure that the State does not spend $10 to collect a $5 premium.

There was some discussion concerning the need to keep the overall program as simple to understand and administer as possible. This might be accomplished by setting higher limits on allowable income levels as well as personal assets and resources rather than setting lower limits and establishing a range of exemptions that would modify those limits.

A program that is easy to understand and is not administratively burdensome to providers will help increase the number of providers available to consumers. This will result in increased choice and higher levels of service. Efforts should be made to simplify paperwork and expand the number of providers.

DO NOT LIMIT PROGRAM PARTICIPATION TO AGE 65 OR LESS

The benefits and levels of services provided by Medicaid can be very critical to people with various disabilities. Some of these services are not covered under the Medicare Program. Provide an option to continue participation in the Medicaid Buy-In program beyond the age of 65. It may be cost effective to have Medicaid pay for Medicare supplemental coverage.

ENSURE THAT MEDICAID COVERAGE IS UNINTERRUPTED FOR INDIVIDUALS WHO EXPERIENCE CHANGES IN THEIR WORK SITUATIONS

The Buy-In program needs to provide a "soft landing" for those individuals who lose their jobs or are no longer able to work or experience extended periods of unemployment. There should be no interruption of benefits for these individuals due to the fluctuation in their income levels.

Individuals who were able to accumulate assets or resources under the Buy-In program limits should be able to retain those resources when their income levels drop and they become eligible to be covered under the standard Medicaid program.

COORDINATION AMONG AGENCIES AND PROGRAMS IS ESSENTIAL FOR MAXIMUM PROGRAM SUCCESS

A consistent definition of "disabled" needs to be formulated among state and federal agencies to help coordinate the provision of services.
A comprehensive view of available programs and assistance needs to be instituted to help ensure that

changes in income do not result in the loss of critical services to the individual with disabilities. The incentives to work provided through the Buy-In program could be easily negated if the individual then loses assistance for housing, food, transportation or other services provided by programs with different income guidelines and asset limitations.

The Ticket to Work, Section 8, AFDC and FAMIS programs are just a few examples of programs that will need to complement and coordinate with one another. Changes in the Medicaid program at the Federal level, the Olmstead Act and other major events will also have to be factored into how the Buy-In program operates.

"We need a program that everyone can understand and use. Organizations at the state and local level will really have to work together to make this happen."

Abingdon Session Participant

THE PROGRAM NEEDS TO BE CONSUMER FRIENDLY TO ENCOURAGE MAXIMUM PARTICIPATION BY THOSE THAT ARE ELIGIBLE

A coordinated marketing and education effort is needed to help educate both consumers and providers alike. People must know about and understand the program and know where to go to gain additional information or to apply.

Clearly defined points of entry in the community would be very beneficial. It should be clear to social service intake workers, Social Security Administration personnel, employees of the Department of Rehabilitative Services and others who is eligible and where an individual needs to go and who to see to get information and sign up to participate.

Regular, periodic meetings should be held with program partners to share information and insights about how the program is working and identify what changes may be needed to make it work more effectively and efficiently. These meetings can also be useful in helping various organizations create consistent interpretations of program rules and guidelines.

THE COMMUNITY OF PROVIDERS SHOULD WORK TOGETHER TO HELP MAKE THE PROGRAM EFFECTIVE

Disagreement at the state and national levels exists among organizations who provide services or serve in advocacy positions concerning the needs and priorities of various disability groups. The community of providers needs to come together to help support the program if it is to be effective and sustainable.

THE PROGRAM NEEDS TO BE PROMOTED AS A WORK INCENTIVE PROGRAM TO HELP GAIN SUPPORT AND ADEQUATE FUNDING

Accurate data is needed to document the number of individuals with disabilities who are willing and able to work but who currently limit their employment to retain Medicaid coverage. The economic costs of lost opportunity could then be calculated.

Figures could be derived estimating the economic stimulus that would be achieved if individuals with disabilities were able to work to their maximum abilities. This would include benefits to employers as well as the economic benefits and improved standards of living for the individual with disabilities. Savings to the taxpayer can also be achieved as employers begin to add individuals with disabilities to their private health care programs as a benefit of employment.

Data is also needed to help document the benefits of providing health care, especially preventative care, to the individual with disabilities and how this care reduces costs to taxpayers in the long-term.

Severe budget restrictions are evident but a "bare bones" approach to creating a program will not meet the long-term needs of the individual with disabilities. Care must also be taken that the creation of a Buy-In program does not reduce the level of care provided to existing Medicaid recipients.

CONTINUE TO INVOLVE CONSUMERS IN PROGRAM DESIGN AND MODIFICATION

Policy makers and program designers need to continue to solicit and incorporate input from consumers. This perspective is critical to help ensure the program is meeting critical, targeted needs and is operating efficiently.

Increased consumer choice and direction will help normalize the program. Further discussions are needed to help determine how a program of consumer directed services would work.

To the greatest extent practical, consumer discussions should take place where transportation is readily available to facilitate participation. Providing web-based information in a screen reader format would also promote consumer understanding and involvement.

A WAIVER-BASED APPROACH IS NOT DESIRABLE

There are currently many problems with the existing waiver programs including the lack of funding to fully implement them. Consumers need a greater level of predictability regarding what will be covered and to what extent to help them make informed choices.

Individuals need to be able to retain personal assistance and other services without interruption when entering the Buy-In program or transitioning from waiver programs.

CONTINUE HOLDING DISCUSSIONS WITH CONSUMERS, ADVOCATES AND OTHER INTERESTED PARTIES

Many participants expressed their appreciation in being invited to the listening tour sessions. They enjoyed the opportunity to share their experiences and suggestions and to have the chance to listen and learn from others. Participants indicated that the facilitated format helped keep the discussion productive without inhibiting what was discussed or the types of comments that could be offered. It was suggested that these types of sessions be repeated on a periodic basis to help gain new insights

and perspectives as the program is launched and implemented.

Appendix One
Organizations and Interest Groups Represented at Each Listening Tour Location

Abingdon

Appalachian Independence Center
Center for Independent Living
Consumers
Cumberland Mountain Community Service Board
Department for the Blind and Vision Impaired, Bristol Regional Office
Department of Medical Assistance Services
Frontier Health, Bristol
Highlands Community Service Board
Junction Center for Independent Living
Mt. Rogers Community Service Board
National Alliance for the Mentally Ill, Tri-County Family Support
Planning District 1 Community Service Board
Turning Point Consumer Services

Manassas

Clarendon House
Consumers
Department of Rehabilitative Services
Department of Rehabilitative Services, Fairfax
ENDependence Center of Northern Virginia, Inc.
Fairfax Community Service Board - PACT program
Fairfax/Falls Church Community Service Board
Family member of Medicaid recipient
Fauquier Disability Services Board
Laurie Mitchell Employment Center
Medicaid Buy-In Technical Design Committee
Multiple Sclerosis Society - Washington D.C.
Northern Virginia Mental Health Consumers Association
Parent of Medicaid Recipient
PETC
Service Source
SRC Council
Virginia Board for People with Disabilities
Virginia Brain Injury Council
Virginia Department for the Blind and Vision Impaired
Virginia Office for Protection and Advocacy
Westminster Retirement Community at Lake Ridge

Richmond

American Council for the Blind
Central Virginia Center for Independent Living
Choice Group
Consumers
Department for the Rights of Virginians with Disabilities
Department of Mental Health, Mental Retardation and Substance Abuse Services
Department of Rehabilitative Services
Department of Rehabilitative Services, Central Region
Department of Rehabilitative Services, Chesterfield/Petersburg Regional Office
Department of Rehabilitative Services Field Counselor
Department of Rehabilitative Services, Henrico Field Office
Department of Rehabilitative Services, Petersburg Field Office
Disability Determination Services

Disability Resource Center
Hanover Mental Health
Human Service Specialist for a person with a disability
Mental Health Association of Virginia
Mill House
Richmond Behavioral Health Authority
Richmond Goodwill Industries
St. John's Community Services
Virginia Assistive Technology System
Virginia Association for Persons with Supported Employment
Virginia Board for People with Disabilities
Virginia Department for the Blind and Vision Impaired
Virginia Employment Commission, WIA
Woodrow Wilson Rehabilitation Center

Roanoke

Alliance for the Mentally Ill - Roanoke Valley
Blue Ridge Behavioral Healthcare
Blue Ridge Independent Living Center
Consumers
Council of Community Services
Department of Rehabilitative Services, Christiansburg Office
Goodwill Industries of the Valleys
New River Valley Community Service Board
On Our Own of Roanoke Valley
Region 10 Community Service Board
Roanoke City Department of Social Services
Roanoke County Department of Social Services
Statewide Rehabilitation Council for the Blind
Thompson's Brain Injury, Inc.
Valley Associates for Independent Living
Virginia Association for the Blind
Virginia Department for the Blind and Vision Impaired, Roanoke Regional Office
Virginia Employment Commission
Virginia Human Services Training Center
Woodrow Wilson Rehabilitation Center

Virginia Beach

Alliance for the Mentally Ill, Virginia Beach
Autism Network for Hearing and Visually Impaired Persons
Chesapeake Community Service Board
Consumers
Department of Mental Health, Mental Retardation and Substance Abuse Services, Virginia Beach
Department of Rehabilitative Services
Department of Rehabilitative Services, Norfolk Field Office
Department of Rehabilitative Services, Portsmouth Field Office
Department of Rehabilitative Services, Virginia Beach Field Office
Eastern Shore Center for Independent Living
Eastern Shore Disability Services Board
Eastern State Hospital
Eli Lilly Corporation, Public Health Systems Division
Hampton Roads Chapter – MS Society
Hampton/Newport News Community Service Board
Medicaid Buy-In Committee
Mobility on Wheels
Norfolk Community Service Board
Peninsula Center for Independent Living
Sugar Plum Bakery
Virginia Association for the Blind

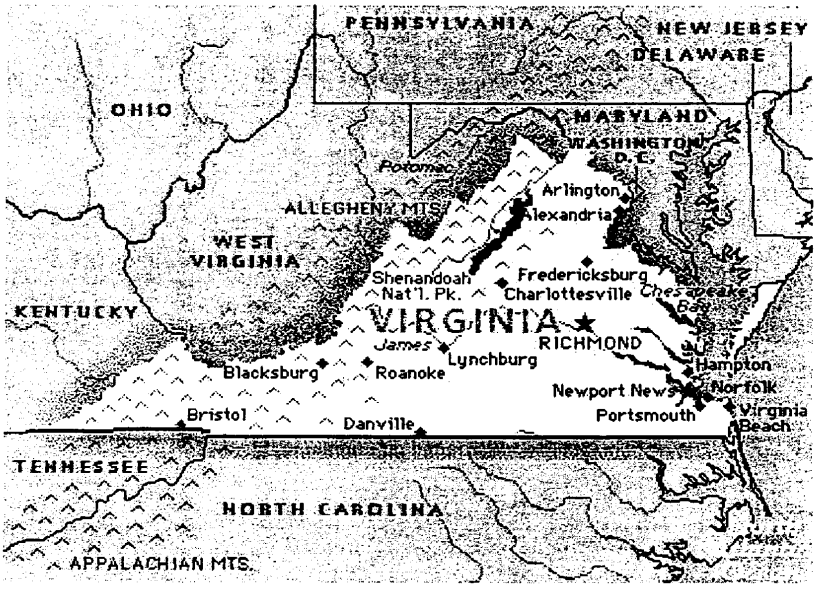
Appendix I

Virginia Commonwealth University
Survey and Evaluation Research Laboratory

Medicaid Recipients in Blind and Disabled Eligibility Categories Report

DRAFT
12/06/02

Medicaid Buy-In Survey of Medicaid Recipients in Blind and Disabled Eligibility Categories: Report of Findings



Prepared for:

Virginia Department of Medical Assistance Services

December 2002

Prepared by:
Kirsten Barrett, Ph.D.
Virginia Commonwealth University
Survey and Evaluation Research Laboratory

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EXECUTIVE SUMMARY

The Americans with Disabilities Act and numerous technological and medical innovations have significantly increased employment opportunities for persons with disabilities in the United States. Despite the many improvements that enable individuals with disabilities to engage in or expand employment, less than one-half of one percent of Social Security Disability Insurance and Supplemental Security Income beneficiaries leave the disability rolls and return to work. Fear of losing health care coverage and other services have been found to be significant barriers keeping individuals with disabilities from maximizing their employment, earnings potential, and independence. The loss of eligibility for important health coverage due to increased income as a direct result of earnings has taught many employable people with disabilities to not become employed or to limit the number of hours worked. These employment disincentives have led to underemployment of people with disabilities and loss of a valuable workforce pool in Virginia.

The Virginia Department of Medical Assistance Services (DMAS) contracted with the Survey and Evaluation Research Laboratory (SERL) at Virginia Commonwealth University to gain information from Medicaid recipients in the blind and disabled eligibility categories about how the development of a Medicaid Buy-In program could further enhance their participation in competitive employment. The findings of this research are intended to provide guidance to DMAS in their effort to develop a Medicaid Buy-In program that addresses the health care coverage needs of individuals with serious disabilities who are seeking or are engaged in competitive employment.

The *Medicaid Buy-In Survey* was developed to gather information from individuals about employment status, health insurance coverage, and knowledge of work incentives such as Medicaid Buy-In programs. A total of 1,754 out of 2,920 surveys were completed and returned to yield a response rate of 60%.

Survey respondents were evenly distributed across the Commonwealth of Virginia. The average age of respondents was 49 years with a range from 18 years to 70 years. Approximately 60% were female and 40% were male. The majority, 80%, were not married at the time of survey

completion. Approximately 40% reported having less than a high school education or equivalent. Forty-seven percent of the respondents reported having one disability, 29% reported two disabilities and 15% reported three disabilities. Physical disability and mental health impairments were the two most frequently cited disabilities. The least frequently cited disabilities were HIV/AIDS and drug / alcohol dependency.

The following are key findings from the survey with regard to employment, health insurance, and awareness of Medicaid buy-in programs.

Employment:

- Only 6% of respondents (n=102) reported having a job for which they received pay. Of the 1,596 respondents who reported not working, 36% (n=579) reported a desire to work.
- The majority of non-working respondents reported that their disability makes it impossible for them to work. Nineteen percent of non-working respondents with Medicaid indicated that they were fearful of losing their Medicaid coverage if they became employed.
- Non-working respondents indicated that availability of vocational training, transportation, and prescription medications would help them transition into employment.
- One of the more interesting, and potentially encouraging findings, was that those who expressed a desire to work tended to cite disability less often as a reason for not working than their counterparts. Seventy percent of those wanting to work reported disability as one reason for not working. Ninety-one percent of those not wanting to work reported their disability as a reason for not working. Those wanting to work reported transportation, lack of skills, fear of losing personal assistance services, and fear of losing Medicaid benefits as reasons for not working more often than their counterparts.
- Seventy-two percent of the 102 working respondents reported working 30 hours or less a week. Only 28% of working respondents reported a desire to work additional hours per week.
- Forty-eight employed respondents, approximately 50%, reported that they limit their work hours in order to continue receiving certain benefits such as SSI, SSDI, and Medicaid. However, of these, only 15 reported a desire to work additional hours. This suggests that some individuals who intentionally limit their hours are content in doing so.

Health Insurance

- Of the 1,754 respondents, 92% reported having some form of health insurance. Many respondents, 71%, reported having at least two kinds of health insurance.
- The majority of respondents, 92%, reported having Medicaid. Approximately 70% reported having both Medicaid and Medicare.
- Of the 1,621 respondents who reported having health insurance, 60% reported paying a premium. Reported premiums ranged from $1 to $591 with a median cost of $50.
- Twenty-five percent of employed, insured respondents reported that they are afraid of working more hours or accepting a salary increase because of the potential impact on their health insurance coverage. This is lower than the percent of employed respondents that indicated a voluntary restriction in work hours to continue receiving certain benefits such as SSI, SSDI, and Medicaid. This discrepancy may suggest that the fear of losing non-health insurance related benefits or a combination of health and non-health related benefits are a more significant consideration for respondents than losing health insurance alone.
- Of the respondents who were concerned about the impact of increased wages and/or hours on health insurance coverage, 71% (n=17) reported a willingness to pay an income-based premium to keep their health insurance.

Awareness of Medicaid Buy-In Programs

- Ninety percent of respondents never heard of Medicaid buy-in programs. This is consistent with previous research done by SERL on behalf of DMAS.[1] It is further evidence of the need for intensive public education efforts.

The *Medicaid Buy-In Survey* yielded interesting findings across a range of topics. The vast majority of respondents were not working at the time of survey completion. Those who did report working appeared to do so with less than full-time status and low earnings. Further, many indicated that they limit hours or pay to maintain benefits, but when asked about wanting to work more hours, a lesser number said this was desirable.

[1] Barrett, K. (2002). *Medicaid Work Incentive Survey: Report of Findings.* Prepared for the Department of Medical Assistance Services by the Survey and Evaluation Research Laboratory.

I. BACKGROUND & PURPOSE:

The Americans with Disabilities Act and numerous technological and medical innovations have significantly increased employment opportunities for persons with disabilities in the United States. Despite the many improvements that enable individuals with disabilities to engage in or expand employment, less than one-half of one percent of Social Security Disability Insurance and Supplemental Security Income beneficiaries leave the disability rolls and return to work. Fear of losing health care coverage and other services have been found to be significant barriers keeping individuals with disabilities from maximizing their employment, earnings potential, and independence. The loss of eligibility for important health coverage due to increased income as a direct result of earnings has taught many employable people with disabilities to not become employed or to limit the number of hours worked. These employment disincentives have led to underemployment of people with disabilities and loss of a valuable workforce pool in Virginia.

Through its Medicaid Infrastructure Grant and as directed by the 2002 Virginia General Assembly, the Department of Medical Assistance Services (DMAS) is pursuing development of a Medicaid Buy-In (MBI) program to allow working persons with disabilities to purchase health care coverage under the Medicaid program, thus removing a barrier to full employment for these individuals. DMAS considers the Aged, Blind and Disabled coverage group to be the most likely current Medicaid eligibility group to participate in a MBI.[2] In order to learn more about these individuals, DMAS contracted with the Virginia Commonwealth University's Survey Evaluation and Research Laboratory (SERL) to conduct survey research on this population. The purpose of this research was to investigate the health care knowledge and experience of the Blind and Disabled Medicaid recipients in this group; their health insurance status and needs; their ability to work, work hours and earning capacity. The findings of this research are intended to provide guidance to DMAS in their effort to develop a Medicaid Buy-In program that addresses the health care coverage needs of individuals with serious disabilities who are seeking or are engaged in competitive employment.

[2] This category of Medicaid eligibility was added effective July 1, 2001, as a result of an action by the 2000 General Assembly and enables coverage for elderly and disabled individuals with income levels up to 80% of the Federal Poverty Limit.

II. RESEARCH METHODOLOGY:[3]

Survey Development and Design

The *Medicaid Buy-In Survey* was developed to gather information from Medicaid recipients who are blind and/or otherwise disabled about their employment status, their health insurance coverage, their Medicaid status, and their knowledge of work incentives such as Medicaid Buy-In programs. DMAS worked with SERL to develop a number of closed-ended survey questions that fit into one of the following broad categories: demographics, employment, and health insurance coverage. Key stakeholders at DMAS, Department of Rehabilitative Services (DRS), and other state agencies and organizations reviewed the survey prior to its distribution.

Survey Distribution

The *Medicaid Buy-In Survey* was sent via first class mail to 3,052 individuals that met the Social Security Administration's definition of disabled. The names and addresses for the mailing were provided to SERL from DMAS.

SERL sent a pre-notification postcard to the entire sample ten days prior to the mailing of the survey. The postcard alerted individuals to the fact that they would be receiving a survey from SERL, on behalf of DMAS, within 10 to 14 days. Seven days thereafter, the mail survey was sent. A $3 incentive was included in the first mailing along with a postage paid, return envelope. Two weeks after the first-wave mailing of the survey, a reminder postcard was mailed. Seven days thereafter, all non-responders were sent a second survey packet. This was identical to the first except for a revised cover letter and the exclusion of the $3 incentive.

A copy of the prenotification postcard, cover letter, survey, reminder postcard, and second-wave mailing cover letter can be found in Appendix 1.

[3] The VCU Institutional Review Board (IRB) reviewed and approved the study protocol prior to the initiation of data collection.

II. Research Methodology (con't):

Response Rate

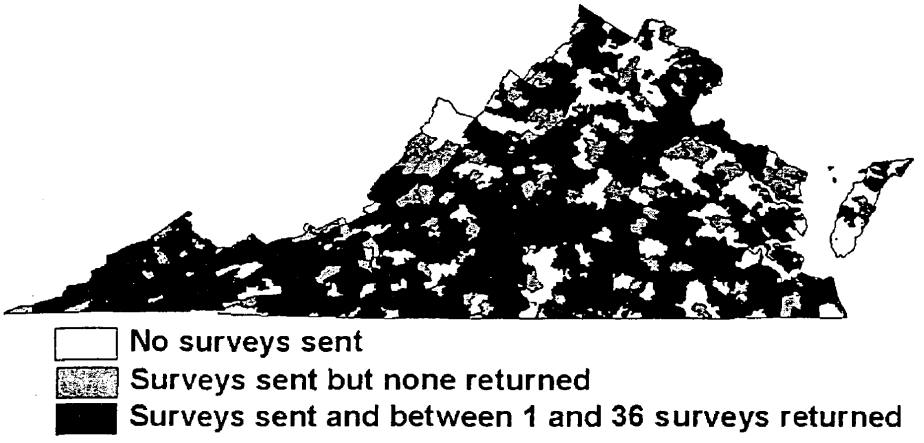
After accounting for bad addresses, deceased individuals, duplicate addresses, and refusals, the total sample size of 3,052 was reduced to 2,920. A total of 1,754 surveys were completed, 96 by telephone.[4] The response rate was 60%.

III. DESCRIPTION OF THE SURVEY RESPONDENTS

Geographic Distribution

Medicaid recipients in the blind and disabled eligibility categories from across the Commonwealth responded to the survey. Figure one illustrates the distribution of survey respondents and non-respondents.

Figure 1 - Distribution of Respondents by Zip Code Tabulation Area



[4] A toll-free phone line and a TTY line were made available for survey respondents who were unable to complete the survey by mail.

III. DESCRIPTION OF THE SURVEY RESPONDENTS (con't)

Age, Gender, Marital Status

The average age of respondents was 49 years with a range from 18 to 70 years. Nearly 60% of respondents were female (n=1,015) and 40% were male (n=722). The majority of the respondents, 80%, reported not being married (n=1,374).

Dependent Children

The majority of the respondents, 81% (n=1,414) reported having no dependent children living in their homes. Sixteen percent of respondents (n=288) did have dependent children in their homes. An additional 3% did not respond to the question.

Educational Attainment

Approximately 40% of the respondents reported having less than a high school education (n=818), 31% reported a high school education or equivalent (n=527), and 20% had some college education or a college degree (n=340).

Disability Type

Each respondent was asked to identify which disability category pertained to him/her from a list that was provided. Respondents were instructed to check all of the disability categories that applied. Options included, but were not limited to, physical disability, hearing impairment, mental health impairment, and developmental disabilities. Forty-seven percent of the respondents checked one disability category only (n=796), 29% of respondents checked two disability categories (n=486), and 15% checked three disability categories (n=249). The remaining 8% checked between four to twelve disability categories (n=141).[5]

[5] Eighty-two respondents failed to check any of the 12 disability categories on the survey. These respondents, along with those under the age of 18, are excluded from the analyses related to disability type.

III. DESCRIPTION OF THE SURVEY RESPONDENTS (con't)

Physical disability was cited by 64% of the respondents (n=1,076). Mental health impairments were reported by 33% of the respondents (n=554). The least frequently cited disabilities were HIV/AIDS (n=21) and drug/alcohol dependency (n=43).[6] Table one indicates the total number of respondents reporting each type of disability.

Table 1 - Disability Type of Respondents

Disability Type	# of Respondents	Percent of Total (N=1,672)
Physical disability	1,076	64%
Mental health impairment	554	33%
Other	392	23%
Respiratory impairment	257	15%
Developmental disability	201	12%
Blind or visually impaired	145	9%
Brain injury	139	8%
Spinal cord injury	125	8%
Deaf or hard-of-hearing	121	7%
Speech impairment	113	7%
Drug / alcohol dependency	43	3%
HIV/AIDS	21	1%

NOTE: Respondents were instructed to check all disability categories that applied. Counts within disability type are unduplicated. Counts across category types are, to a degree, duplicated.

IV. EMPLOYMENT

Respondents were asked a series of questions related to their current employment status. This included questions about current employment status, type of occupation, tenure at current job, hours worked per week, earnings, number of different jobs within the past two years, desire to work more hours, and support services that make work possible.

[6] Of those checking only one disability category, nearly 50% indicated that they had a physical disability and nearly 25% indicated that they had mental health impairments.

IV. EMPLOYMENT (con't)

Work Status and Desire to Work

Only 6% of respondents (n=102) reported having a job for which they receive pay. Of the 1,596 respondents who reported not working, 36% (n=579) reported a desire to work. Twenty-three percent reported a desire to work one to 10 hours per week and 34% reported a desired to work between 11 and 20 hours per week. Thirty-six percent reported a desire to work between 21 and 40 hours per week. The remaining 7% reported a desire to work more than 40 hours per week.

Respondents who reported not currently working were asked to indicate the reason(s) why. A list of six choices was provided. Instructions were given to check all reasons that applied. Of the 1,596 respondents who reported not currently working, 65% reported one reason, 15% reported two reasons and 9% reported three reasons. The remainder reported either no reason (4%) or four or more reasons (8%).

Many respondents reported that their disability made impossible for them to work.[7] Table two highlights the reasons for not currently working by the 1,596 respondents reporting not currently working.

[7] Of the 1,032 respondents that indicated only one reason for not currently working, 90% cited their disability as the reason.

IV. EMPLOYMENT (con't)

Table 2 - Reasons for Not Currently Working

REASON	# OF RESPONDENTS	PERCENT OF TOTAL (N=1,596)
Disability makes it impossible	1308	82%
Afraid of losing Medicaid benefits[8]	282	18%
Other	260	16%
Lack of skills / need job training	212	13%
No transportation	186	12%
Afraid of losing personal assistance services	164	10%
No job close to residence	109	7%

NOTE: Respondents were instructed to check all disability categories that applied. Counts within disability type are unduplicated. Counts across category types are, to a degree, duplicated.

Respondents not currently working were asked if there were any services that could be provided that would enable them to work. Nine options were provided and respondents were asked to check all that applied. Vocational training, transportation, and prescription medications were the three most frequently cited services identified by respondents. Table three highlights the services desired by the 1,596 respondents that reported not currently working.

[8] Table 2 is based on a frequency count for all non-working respondents. Since "afraid of losing my Medicaid benefits" is specific to a subset of non-working individuals, a second analysis was done in an effort to generate the most accurate findings possible. When limited to respondents that reported not working AND receiving Medicaid, the

IV. EMPLOYMENT (con't)

Table 3 - Services that Would Enable Non-Working Respondents to Work

SERVICE	# OF RESPONDENTS	PERCENT OF TOTAL (N=1,596)
Vocational training / job training	278	17%
Assistance with transportation	244	15%
Prescription medications	225	14%
Other	189	12%
Training in the use of assistive technology	145	9%
Personal assistance services in the workplace	104	7%
Personal assistance services in the home	76	5%
Changes / modifications in the home or the workplace	84	5%
Interpreter services	18	1%

NOTE: Respondents were instructed to check all disability categories that applied. Counts within disability type are unduplicated. Counts across category types are, to a degree, duplicated.

Comparisons between Unemployed Respondents Based on Desire to Work

The Medicaid Buy-In program will be particularly meaningful to unemployed individuals with disabilities that want to work. To that end, efforts have been made to compare unemployed respondents expressing a desire to work to those not wanting to work with regard to disability type(s), reasons for not working, education, health insurance coverage, , other sources of support, and services that would assist the respondent in gaining employment.

In general, those individuals wanting to work and those not wanting to work were similar with regard to the total number of disabilities reported, disability type, health insurance coverage, and other sources of support.

number of respondents checking "afraid of losing my Medicaid" as a factor totaled 256 and the percent indicating

IV. EMPLOYMENT (con't)

One of the more interesting, and potentially encouraging findings, was that those persons who expressed a desire to work tended to cite disability less often as a reason for not working than their counterparts. Seventy percent of those wanting to work reported disability as one reason for not working. Ninety-one percent of those persons not wanting to work reported their disability as a reason for not working. Individuals wanting to work reported transportation, lack of skills, fear of losing personal assistance services, and fear of losing Medicaid benefits as reasons for not working more often than their counterparts.

It is interesting to note that those that reported wanting to work tended to have a high school education but also tended to report that a lack of skills was an inhibiting factor with regard to employment. This is encouraging in that vocational training services may be more effective for these individuals since they may not have to face the additional barrier of not having a high school diploma.

In terms of services that would make employment feasible, those that wanted to work identified the following more often than their counterparts who reported not wanting to work: assistance with transportation, personal assistance at the workplace, prescription medications, training in the use of assistive technology, and vocational training.

Detailed tables comparing those who reported a desire to work versus those that stated they did not want to work can be found in Appendix 2.

Findings from Employed Individuals

A series of questions were asked of the subset of respondents who reported currently working (n=102). The questions related to employment tenure, hours work, limitations to work, and wages. Tables four, five, and six highlight the findings.

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changed from 18% to 19%.

IV. EMPLOYMENT (con't)

Table 4 - Employment Tenure

How long have you been working at your current job?		
	# of Respondents	**# of Total**
Less than 6 months	29	30%
6 to 11 months	15	16%
12 months to 2 years	14	14%
More than 2 years	39	40%
TOTAL	97*	100%

*Total less than 102 due to question non-response.

Table 5 - Hours Worked per Week

In general, how many hours do you work each week?		
	# of Respondents	**# of Total**
1 to 10 hours / week	22	24%
11 to 20 hours / week	30	33%
21 t0 30 hours / week	21	23%
31 to 40 hours / week	17	19%
More than 40 hours / week	1	1%
TOTAL	91*	100%

*Total less than 102 due to question non-response.

Table 6 - Desire to Work More Hours per Week

Do you want to work more hours per week?		
	# of Respondents	**# of Total**
Yes	27	28%
No	68	72%
TOTAL	95*	100%

*Total less than 102 due to question non-response.

Respondents indicating a desire to work more hours per week were asked to indicate the total number of hours they wanted to work each week. Respondents indicated a desire to work an average of 31 hours per week with a range from a low of seven hours to a high of 50.

IV. EMPLOYMENT (con't)

Interestingly, as depicted in table seven, 48 of the 102 employed respondents (48%) indicated that they limit the number of hours they work per week in order to keep certain benefits. However, only 15 of these 48 employed respondents indicated a desire to work more hours (31%). This seems to suggest that some individuals are content to limit their work hours.

Table 7 - Number of Respondents Limiting Work Hours to Receive Benefits

Do you limit the number of hours you work per week so that you can keep certain benefits (i.e., SSI, SSDI, Medicaid)?		
	# of Respondents	**# of Total**
Yes	48	51%
No	47	49%
TOTAL	95*	100%

*Total less than 102 due to question non-response.

Respondents were asked to indicate how much they earn per month. Table eight highlights the findings. Approximately 75% reported earning less than $500 per month. Low earnings are not unexpected given the fact that approximately 50% of respondents reported working 20 hours or less per week.

Table 8 - Earnings per Month

In general, how much do you earn in a month?		
	# of Respondents	**# of Total**
Less than $100 / month	24	25%
$100 to $199 / month	18	19%
$200 to $299 / month	32	34%
$500 to $799 / month	12	13%
$800 to $1,099 / month	6	6%
$1,100 to $1,299 / month	0	0%
More than $1,300 / month	3	32%
TOTAL	*95	100%

*Total less than 102 due to question non-response.

IV. EMPLOYMENT (con't)

Respondents were also asked what services would make it possible for them to work additional hours at their job. They were given a list of eight options and asked to check all that applied. It was anticipated that this question would be answered by those respondents wanting to work more hours. However, respondents other than those indicating a desire to work more hours also answered this question. This may indicate that those that are satisfied with their current work hours may need services to allow them to work more effectively. Table nine highlights the findings.

Table 9 - Services that Would Enable Working Respondents to Work More Hours

SERVICE	# OF RESPONDENTS	PERCENT OF TOTAL (N=101)
Other*	35	34%
Prescription medication	18	18%
Assistance with transportation	17	17%
Changes / modifications in the home or workplace	8	8%
Personal assistance services in the workplace	7	7%
Training in the use of assistive technology	7	7%
Personal assistance services in the home	3	3%
Interpreter services	2	2%

*Verbatim responses included "job training", "have employer assign more hours", "health improvement", "not losing my Medicaid or SSDI", "not losing any benefits", and "a chance to receive SSI and have a job."
NOTE: Respondents were instructed to check all disability categories that applied. Counts within disability type are unduplicated. Counts across category types are, to a degree, duplicated.

V. HEALTH INSURANCE

Type of Health Insurance

Respondents were asked a series of questions about health insurance coverage. Of the 1,754 respondents, 92% (n=1,621) reported having some form of health insurance. Respondents who reported having health insurance were asked to indicate which kind from a list of six provided (with an "other" option). The majority of respondents reported having, at a minimum, Medicaid (92%). Approximately 71% of the respondents reported having two different kinds of health insurance (n=1,149). Nearly 70% reported having Medicare and Medicare (n=1,115). Table 10 highlights the findings.

Table 10 - Sources of Health Insurance

HEALTH INSURANCE TYPE	# OF RESPONDENTS	PERCENT OF TOTAL (n=1,621)
Medicaid	1,486	92%
Medicare	1,285	79%
Medigap policy	9	<1%
TRICARE/CHAMPUS/ Veteran's health coverage	14	1%
Employer / Retiree plan	10	<1%
Individual health insurance policy	27	2%
Other	37	2%

NOTE: Respondents were instructed to check all disability categories that applied. Counts within disability type are unduplicated. Counts across category types are, to a degree, duplicated.

V. HEALTH INSURANCE (con't)

Health Insurance Premiums

Those who reported having health insurance were asked if they paid a monthly premium and, if so, how much they paid. Approximately 60% (n=985) of the respondents reported not paying a premium while 12% (n=201) did. Interestingly, 20% (n=331) of the respondents with health insurance did not know if they paid a monthly premium or not.[9] As mentioned previously, the majority of insured respondents reported having, at a minimum, Medicaid. Many reported having both Medicaid and Medicare. The lack of knowledge about one's monthly premium may be due to the fact that Medicaid covers the Medicare premium when an individual is covered by both.

The average monthly premium for respondents that reported paying a monthly premium was $77 with a rather large standard deviation of $92.[10] Monthly premiums ranged from $1 to $591 with a median of $50.

Spend-Downs, Insurance Supplements, and Employment Behavior

Respondents reporting to have Medicaid were asked a set of specific questions related to spend-downs, insurance supplements and employment behavior. Tables 11, 12, and 13 highlight the findings.

[9] Six percent of respondents with health insurance did not answer the question regarding monthly premiums.

V. HEALTH INSURANCE (con't)

Table 11 - Payment of Spend-Downs

Do you pay a spend-down?		
	# OF RESPONDENTS	**PERCENT OF TOTAL (n=1,486)**
Yes	128	9%
No	670	45%
Don't Know	578	39%
No response	110	7%
Total	1,486	100%

Table 12 - Medicaid as a Supplement

Do you have Medicaid to supplement other health insurance that does not cover certain health care costs?		
	# OF RESPONDENTS	**PERCENT OF TOTAL (n=1,486)**
Yes	671	45%
No	615	41%
No response	200	14%
Total	1,486	100%

Table 13 - Turn Down Opportunities to Preserve Medicaid Coverage

Have you ever turned down increased hours or turned down salary raises because you were afraid you might lose your Medicaid?		
	# OF RESPONDENTS	**PERCENT OF TOTAL (n=1,486)**
Yes	99	7%
No	1189	80%
No response	198	13%
Total	1,486	100%

[10] Based on 147 of 201 respondents who reported paying a monthly premium.

V. HEALTH INSURANCE (con't)

The 1,471 respondents that were not working but reported having health insurance were asked if they are not working because of a fear of losing their health insurance coverage. Of the 1,314 respondents that answered this question, only 12% (n=176) reported not working because of a concern about losing their health insurance. This concern was not a factor for 77% of the unemployed respondents.[11]

Similarly, those that were working were asked if they were afraid to work more hours or get a salary increase because of potential impact on health insurance coverage. Of the 93 employed, insured respondents, 25% indicated that fear of losing their insurance coverage was a motivating factor in avoiding increased hours or wages. Thirty-four percent indicated that it was not a factor and 37% provided no response.

Of the 24 respondents who indicated that they were concerned about the impact of increased wages and/or hours on their health insurance, 71% (n=17) reported a willingness to pay a reasonable, income-based premium to keep their health insurance.

Source of Benefits and Monthly Income

Survey respondents were asked to identify their different sources of benefits and monthly income. Seven items were provided and respondents were asked to check all that applied. The majority of respondents, 84%, reported one or two sources of support. Table 14 provides a summary of the types of support identified.

V. HEALTH INSURANCE (con't)

Table 14 - Sources of Benefits and Monthly Income

SOURCE OF SUPPORT	# OF RESPONDENTS	PERCENT OF TOTAL (n=1,754)
Social Security Disability Insurance (SSDI)	1,204	69%
Food stamps	709	40%
Supplemental Security Income (SSI)	401	23%
Subsidized housing or Section 8 housing	205	12%
Other	200	11%
Employment	76	4%
Temporary Assistance for Needy Families (TANF)	12	<1%

NOTE: Respondents were instructed to check all disability categories that applied. Counts within disability type are unduplicated. Counts across category types are, to a degree, duplicated.

VI. MEDICAID BUY-IN KNOWLEDGE

Survey respondents were asked if they had ever heard of a Medicaid Buy-In program. If they had heard of such a program, they were asked to indicate how they learned about it. The vast majority of respondents, 90% (n=1,572), had never heard of a Medicaid Buy-In program. Of the 106 respondents who had heard of the Medicaid Buy-In program, the majority heard about it through their case manager / social worker (38%) or via the newspaper or public service announcement (28%).

This finding with regard to awareness of Medicaid Buy-In programs is consistent with those found in a recent DMAS study involving 1619(b) eligible individuals.[12] This need for a strong public awareness campaign to increase consumer knowledge about the Medicaid Buy-In program will be critical to its long-term success.

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[11] Nineteen percent of unemployed respondents with Medicaid reported that a fear of losing Medicaid was a factor in their decision to not seek employment.

[12] Barrett, K. (2002). *Medicaid Work Incentive Survey: Report of Findings.* Prepared for the Department of Medical Assistance Services by the Survey and Evaluation Research Laboratory.

VII. CONCLUSION

The *Medicaid Buy-In Survey* yielded interesting findings across a range of topics. The vast majority of respondents were not working at the time of survey completion. Those who did report working appeared to do so with less than full-time status and low earnings. Further, many indicated that they limit hours or pay to maintain benefits, but when asked about wanting to work more hours, a lesser number said this was desirable. These findings suggest that the Medicaid Buy-In be designed in a way that designed to allow for different levels of work rather than categorizing individuals as employed or unemployed.

Comparisons between unemployed individuals based on their desire to work yielded important findings. Those that reported a desire to work tended to identify "modifiable" reasons for not working. This included reasons such as transportation, skills training, personal assistance services, and Medicaid coverage. Those not wanting to work tended to report that their disability was the reason for not working. Also, those wanting to work had higher levels of educational attainment that their counterparts who did not want to work. Since their were important differences between respondents based on their desire to work, it is important that the Medicaid Buy-In program contain features that are consistent with the needs of the subset of unemployed individuals who express a desire to work.

VIII. LIMITATIONS

The *Medicaid Buy-In Survey* was administered through the mail. Incentives and a second-wave mailing to non-responders were used to minimize non-response bias that is inherent in mail survey methodology. It is not known if those who responded are characteristically different than those who did not. However, a 60% response rate is encouraging along with the fact that there was representation across all regions of the Commonwealth.

VIII. LIMITATIONS (con't)

A self-developed survey was utilized because an instrument did not exist that adequately captured information relative to the research questions posed. Further refinement of the instrument is recommended based on the results of this study. Recommendations include refining skip patterns and question order. For example, some respondents reported that they were not working because they were afraid of losing their Medicaid benefits. However, some of these respondents, later in the survey, failed to check Medicaid as a source of their health insurance coverage.

Appendix J

Comparison
Balanced Budget Act of 1997
Ticket to Work and Work Incentive Improvement Act of 1999

Comparison of the BBA and the TWWIIA

	BBA 1997	BASIC COVERAGE GROUP (TWWIIA XV)	MEDICAL IMPROVEMENT GROUP (TWWIIA XVI) **[Basic Coverage Group must be covered]**
Who can be covered	Disabled individuals. (States must do a disability determination to ensure that the individual would meet the definition of disability under the SSI program)	Disabled individuals age 16 through 64. (States must do a disability determination to ensure that the individual would meet the definition of disability under the SSI program)	Employed individuals with a medically determinable severe impairment who lose eligibility under the XV group because they are no longer meet the definition of disability under the SSI or SSDI programs To cover this group you must cover the Basic Coverage Group under TWWIIA
Income Standard	1) 250% of the Federal poverty level for a family 2) If (1) is met, the applicant's Unearned income must be less than SSI FBR (currently $512 a month for an individual, $769 for a couple). *All earned income is disregarded in determining the individual's eligibility.*	State establishes its own standard. *Earned income is not automatically disregarded.* State can choose not to have an income standard.	State establishes its own standard. *Earned income is not automatically disregarded.* State can choose not to have an income standard.
Resource Standard	SSI resource standard ($2000 for individual, $3000 for couple).	State establishes its own standard. State can choose not to have a resource standard.	State establishes its own standard. State can choose not to have a resource standard.

	BBA	Basic Coverage Group	Medical Improvement Group
Rules for Determining Eligibility	SSI rules and methodologies	If State establishes income and/or resource standards, SSI rules and methodologies apply. (*This includes the SSI earned income disregard of $65 plus one-half of the remainder.*) If State chooses not to establish income and resource standards, no rules or methodologies apply.	If State establishes income and/or resource standards, SSI rules and methodologies apply. (*This includes the SSI earned income disregard of $65 plus one-half of the remainder.*) If state chooses not to establish income and resource standards, no rules or methodologies apply.
Use of More Restrictive Eligibility Rules Than SSI (209(b) States)	Yes.	Yes.	Yes.
Use of More Liberal Income & Resource Methodologies Than SSI (Section 1902(r)(2))	Yes. States can disregard additional income (earned or unearned) and/or resources in either both the 250% family income test and the individual eligibility determination. States can disregard all income and resources if they choose to do so. States will not loose Federal funding if they increase income disregards.	Yes. States that establish an income and/or resource standard can disregard additional income and/or resources if they choose to do so. States will not loose Federal funding if they increase income disregards.	Yes. States that establish an income and/or resource standard can disregard additional income and/or resources if they choose to do so. States will not loose Federal funding if they increase income disregards.

	BBA	Basic Coverage Group	Medical Improvement Group
Premiums & Cost-sharing Charges	States may require payment of premiums and other cost-sharing charges on a sliding scale based on income. States are not required to collect premiums or cost-sharing charges.	1) States may (but are not required to) require payment of premiums and other cost-sharing charges on a sliding scale based on income. For individuals with an income below 250% of the FPL, premiums can not exceed 7.5% of their income. 2) For individuals with income over 250% of the poverty level, States may (but are not required to) charge 100% of premiums. If the State chooses to charge 100% of premiums for individuals whose income falls between 250% and 450% of the FPL, then the total amount of premiums can not exceed 7.5% if their income. 3) States must charge 100% of premiums for any individual whose adjusted gross annual income (as defined under IRS rules) exceeds $75,000.	1) States may (but are not Required to) require payment of premiums and other cost-sharing charges on a sliding scale based on income. For individuals with an income below 250% of the FPL, premiums can not exceed 7.5% of their income. 2) For individuals with income Over 250% of the poverty level, States may (but are not required to) charge 100% of premiums. If the State chooses to charge 100% of premiums for individuals whose income falls between 250% and 450% of the FPL, then the total amount of premiums can not exceed 7.5% of their income. 3) States must charge 100% of premiums for any individual whose adjusted gross annual income (as defined under IRS) rules exceeds $75,000.

	BBA	Basic Coverage Group	Medical Improvement Group
		This requirement applies regardless of whether a State charges premiums and cost-sharing under (1) or (2) above.	This requirement applies regardless of whether a State charges premiums and cost-sharing under (1) or (2) above.
Maintenance of Effort – States must demonstrate that they are maintaining funding for programs (other than Medicaid) to assist disabled individuals who want to work	No requirement	Required	Required

Appendix K

Features of other States' Medicaid Buy In Programs

STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Alaska	7/1/99	Disabled individual 16-64 who is not eligible for adult public assistance and employed.	28 participants for the first full year. For FY'01 estimated costs $243.30 and for FY'02 estimated costs $194,200, these excluded premium revenue and savings from their Adult Public Assistance program.	274 participants as of 9/30/02. Actual costs for FY'02 was $961,414.07 the . actual costs for FY'01 was $691.792, this number does not take into account the recipients who would have stayed on SSI/APA Medicaid had this category not allowed them to work.	Income can not exceed 250% of FPL. Unearned income can not exceed $1,011 for an individual and $1,216 for a couple. Asset limit is $2,000 for an individual and $3,000 for a couple.	Dividends from the Alaska Permanent Fund Dividend Program are excluded.	Premiums based on a sliding fee scale. <100% = 0 >100% = 10% of their income.

STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Arkansas	2-1-01	A person that is at least 16 but under 65 years old, employed, and considered disabled according to the Supplemental Security disability definition.	Projected 72 eligibles by 12-01 with an estimated cost of $204,110.	66 eligible individuals as of August 2002.	Income must be under 250% of FPL. The spouse's income is disregarded. Resource limit is $4,000 for an individual and $6,400 for a family of four.	Approved Accounts are excluded up to $10,000.	Co-pays are paid on a sliding fee scale. <100% FPL =they will pay the regular Medicaid costs for pharmacy and inpatient services. 100% FPL= $10 for physician's visits and generic pharmacy drugs;$15 for brand name pharmacy drugs;25% of their first day's Medicaid per diem rate for an inpatient hospital stay;10% of the Medicaid maximum allowable reimbursement rate for orthopedic appliances and prosthetic devices; and $10/day for Occupation, Physical, Speech therapy, and private duty nursing services.
California	4/00	A person defined as disabled under the SSA.	Between 6,835 and 13,811 participants for the first few years. Costing $198,00 for '99-'00 and $5,666,000 for '00-'01 with a 50/50 federal match.	655 participants as of 10/02.	Income can not exceed 250% of FPL. Resource limits are $2,000 for individuals and $3,000 for couples.	Disability income will be disregarded. Retirement accounts will be disregarded as a resource. No other disregards for the resource limit.	Premiums are based on a sliding fee scale. The premiums will be between $20 and $250/month.

STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Connecticut	10/1/00	The working disabled between 18 and 64.	Estimates at end of year 1: 1208 (907 previously ineligible for Medicaid). Total estimated expenditures were $4.1 million in additional funding.	Actual enrollment after first year: 1712. No data available on new Medicaid expenditures. (2400 participants as of 9/02)	Income can not exceed $75,000/yr., exclude countable income up to 200% of FPL. Income eligibility limit is $6,250 per month in adjusted gross income. Net countable income can not exceed $3,082.50/month when using SSI rules. Liquid assets can not exceed $10,000 for an individual and $15,000 for a couple.	Retirement, medical savings, and disability related expense accounts are excluded.	Premiums based on a sliding fee scale. >200% FPL=10% of their income. Spouse's income will be included when determining premiums.
Florida	4/1/02-program terminated 6/30/02	Indiv. between 16 and 64, disabled, and working.	1500 participants costing $8million	15 participants as of 6/30/02.	Income can not exceed 250% of FPL., exclude cash assets in the amount of $8,000 for an individual and $9,000 for a couple.	Exclude any retirement account recognized by the Internal Revenue Service	No cost-sharing
Illinois	12/01	Working Illinois residents with disabilities between the age 16-64.	500 participants for the first year costing 312/person	210 participants as of 9/30/02.	Income can not exceed 200% of FPL. Asset limit of $10,000. disregarded.	N/A	Premiums are based on a sliding fee scale up to 7.5% of the total income. There is also a $2 for each prescription filled, $3 for each doctor visit, and a $3/day charge may apply to each hospital stay.

STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Indiana	7/1/02	Individual 16-64 that meet the Indiana disability requirements and employed.	Less than 2000 participants for the first year. Costing 1.2 million in state(38%)and federal dollars(62%)	1,675 participants as of 9/30/02	Income can not exceed 350% of FPL, exclude spouse's income and IRWE. Resource limit is$2000 for a single person and $3000 for a married couple.	Exclude retirement accounts, and savings for independence and employability up to $20,000 for goods and services not covered under any other public funded program.	Premiums based on a sliding fee scale. <150% FPL=0 150% - 350% FPL= $ $48-$254 Income of spouse included in premium determination. Deductions made for premiums paid towards private health insurance.
Iowa	3/1/00	An indiv. under the age of 65 that is eligible for medical assistance or additional medical assistance if their earnings are disregarded.	100 participants in 2000, 400 in 2001 and 700 in 2002. $458,748 from 3/00-6/00, $326,941from 7/00-6/01 and 902, 000 from 7/01-6/02	4,555 participants as of 9/30/02. $948,882 for SFY 2000, $14,254,872 for SFY 2001, $29,535,662 for SFY2002 and $10,490,125. Total = $55,229,541.	Income can not exceed 250% of FPL. Asset limit of $12,000 for an individual and $13,000 for a couple.	Retirement, medical savings, and assistive technology savings are disregarded. Unearned income is also disregarded.	Premiums are based on a progressive fee scale. <150%FPL=0 >150%FPL= the maximum premium charged commensurate with the average cost of insurance paid by state employees.
Kansas	7/1/02	A disabled person who is between the ages of 16 and 64.	50-70 participants.	412 participants as of 10/01/02. No data is available on the expenditures.	Income can not exceed 300% of FPL of countable income. The Asset limit is $15,000. SSA exclusions also apply.	Retirement, savings and training accounts, and individual development accounts are disregarded.	Premiums are based on a sliding fee scale. A premium begins when a person has a countable income above 100%FPL. Premiums are based on where countable income falls within eight levels of premiums ranging from $55-$152.

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STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Maine	8/99	Indiv. that meets the SSA/SSI standards for eligibility and working.	200 participants costing $489,600 for the first year.	633 participants by 12/01 (year 3 of the program) with only 16.6% being new to the Medicaid program.	Unearned income can not exceed 100% FPL; Combined income can not exceed 250% of FPL. Asset limit is $8,000 for an individual and $12,000 for a couple.	$75 from unearned income (must be under 100% FPL to proceed to other disregards.) $20 plus an additional $65 from earned income and ½ of the remainder monthly income; then an additional $55 state disregard.	Premiums are based on a sliding fee scale. <150%FPL=0 150% -200% FPL=$10/month 200%-250%FPL =$20/month. If the indiv. pays Medicare Part B premiums or has retroactive coverage there is no premium.
Massachusetts 1115 waiver	1998	Disabled		3,624 working adults; 2,281 disabled children; 2,754 disabled non-working adults as of 2/00.	There is no maximum income eligibility requirement.		Premiums based on income, family size, and availability of other insurance. Clients pay a one-time deductible similar to a Medicaid spend-down to enroll. Premiums are not paid if the income does not exceed 200% of FPL.

STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Minnesota	7/1/99	Individuals who are at least 16 but under 65 years old, employed, and certified disabled by SSA or State Medical Review Team (SMRT)	Preliminary enrollment projections for FY 2000 = 480, FY 2001 = 960, FY 2002 = 1080, and for FY 2003 = 1200. The FY 2003 projected enrollment was exceeded in FY 2001. Original fiscal predictions FY 2001 $19,176,246 FY 2002 $22,824,693 FY 2003 $27,229,618.	5,840 participants as of 6/02. Costing 40,000,000 for FY 2001 in state dollars.	There is no maximum income limit for eligibility. There is a $20,000 limit on assets. In addition to the excluded assets under standard MA, spouse's assets, retirement accounts, and medical expense accounts set up by an employer are not counted in the asset limit.	Retirement accounts, including 401(k) plans, 403(b) plans, Keogh plans, and pension plans are disregarded when determining countable assets. Medical expense accounts set up by an employer are disregarded when determining countable assets. Spouses' income and assets are not counted.	People with incomes (earned and unearned) equal to or above 100% of FPL must pay a premium. Premiums are based on a sliding fee scale, which starts at one percent of income for incomes equal to 100% of FPL and gradually increases to 7.5% of income for incomes at or above 300% of FPL.
Missouri	7/01/02	Indiv. that is considered disabled under the SSI definition or has a medically improved disability under TWWIIA.		248 participants as of 7/15/02. 28 of the participants pay premiums.	Income can not exceed 250% of FPL, excluding spouse or child's income up to $100,000. One half of marital assets and all assets are excluded.	Independent living development accounts are limited to deposits of earned income and earning on deposits while in the program. Exclude retirement, medical savings, and family development accounts; and PASS plans.	Premiums are based on a sliding fee scale. 150% -175% FPL= 4% of 163% of FPL. 176% -200% FPL=5% of 188% of FPL. 201% - 225% FPL=6% of 213% of FPL. 226% - 250% FPL=7% of 238% of FPL.

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STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Mississippi	7/1/00	Working disabled.		In 2001 98 participants costing $343,545. 356 as of 9/30/02	Income can not exceed 250% of FPL. Resource limits are $24,000 for individuals and $26,000 for couples. Countable earnings (after all SSI earned income disregards applied) cannot exceed 250% of poverty. Unearned income cannot exceed 135% of poverty.	Retirement plans are disregarded if they are through an employer.	The premiums are 5% of all countable income.
Nebraska	6/1/99	Working disabled	250-450 participants with a cost of $350,000.	In FY 2001 there were 148 participants costing $762,456(fed. 60.505%) $497,698(state 39.495%) $1,260,154(total).	Income can not exceed 250% of FPL. Resource limit is $4,000 for an individual and $6,000 for a couple.	N/A	Premiums are based on a progressive rate. If the income is 200% of FPL or higher they will pay between 2% and 10% of their "countable" income.
New Hampshire	2/1/02	Indiv. 18 and over that meet the NH eligibility for state supplemental assistance.	500 participants for 2002, with 56 being new. $9,133/new person.	Approx. 640 enrollees as of 6/30/02. 21 of the participants were completely new to the program and 113 participants were paying premiums. Actual costs not available.	Income can not exceed 450% of FPL; spousal income included. IRWE disregard. Asset limit $30,000 for a couple and $20,000 for an individual.	Individual Development Accounts, retirement accounts, medical savings accounts, and employability accounts are excluded.	Premiums based on a sliding fee scale. >150% FPL= $80-$210 Medicare premiums and employer health insurance premiums paid by family members of participant are deducted from the buy-in premium amount.

STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
New Jersey	10/1/00	Employed individuals consider disabled under the SSI definition.	300 participants for 2001. $75,000 in State and Federal funds for 2001. $150,000 for 2002.	497 participants as of 10/02. SFY 2001 750,000 SFY 2002 1.5 million	Unearned income can not exceed 100% FPL. Earned income can not exceed 250% FPL, asset limit of $20,000 for an individual and $30,000 for a couple.	Disregards are homes in which the participant lives; vehicle used for medical and/or work transportation, and IRA/401 K accounts.	Monthly premium of $25 for an individual and $50 for a couple.
New Mexico	1/1/01	A person who is 18 or older, working, and has met SSA criteria for disability for 12 month.	336 participants at $430/person/month.	455 participants as of 1/02 at $210,17/person/month.	Income can not exceed 250% of FPL. Resource limit is $10,000 for an individual and $15,000 for a couple. Unearned income limit is $1,060.	Twenty dollars plus an additional $65 form earned income and ½ of the remainder income; work-related expenses; retirement and medical savings accounts; and spouse's assets; and unearned income higher than $512 are disregarded.	Co-pays for individuals that earn 250% of FPL. Native Americans are exempt from co-pays. $2 for prescriptions; $5 for an outpatient visit, dental visit, and a missed visit; $15 for an emergency visit; and $25 for an inpatient hospital admission. There is a $600 maximum amount for those who income is below 100%FPL. A $1,500 maximum for those who earn 100%-250%FPL.
Oregon	2/1/99	Individuals who have lost SSI due to initial receipt of SSDI and are waiting to receive Medicare and individuals who are working and earning at least minimum wage as per SSA definition of qualifying quarter.	300-600 participants over the first 3 years. Cost projections are not available.	166 as of 12/99 335 as of 12/00 464 as of 12/01 521 as of 9/02 Costs are not available.	Countable earnings can not exceed 250% of FPL. Resource limit is $12,000.	Disregard employment, independence retirement and medical savings accounts, and uncarned income.	Premium = Gross – taxes – EIEs -200% FPL * 2% to 10% of remaining income. Cost Share = Any unearned income over the Oregon Supplemental Income Program Standard.

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STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Pennsylvania	1/1/02	Individual between 16 and 64 that meets the SSA definition of disabled (except SGA), working and receiving compensation	3,000 participants in the first year. 10,000 participants in the first 3 years. Costs for FY 01-02 are $25,766,000 for the state and $30,728,000 in federal money.	681 participants as of 6/30/02. No data is available on expenditures.	Income can not exceed 250% of FPL. Resource limit of $10,000.	N/A	5% of an individual's countable income.
South Carolina	10/1/98	Disabled under age 65 who are working.	1100-1200 participants.	As of 10/02 there were 73 participants costing $174,777.50.	Income can not exceed 250% of FPL. The resource limit is $2,000.	Resource limits disregard the value of one car, the value of life estate interest in real property, the value of household goods and personal effects, and the value of individual interests in heirs' property.	There are no premiums or other cost-sharing requirements.

STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Utah	7/1/01	A disabled individual.	323 participants costing $1,000,000.	325 participants as of 6/30/02, costing 3,089,721.61. In June of 2002 181 participants joined the program.	Income can not exceed 250% of the FPL. The Resource limit is $15,000.	Twenty dollars of unearned income along with IRWE's and $65 and ½ the remainder of earned income. Retirement and 401k accounts of the individual are exempt from the resource limit	Premiums are based on the eligible individual's income only. If household income is >100% FPL the individual is obligated to pay a percentage (between 30% and 55%) of their income after health insurance premiums are deducted. The percentage is determined by where their and their spouse's income falls between 100% and 2505% FPL for the total household size.

STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Vermont	1/1/00	An individual who is over the age of 18.	260 participants costing $100,000.	210 participants with only 10% being new to the program as of 10/1/01 384 as of 10/1/02 Costs are unavailable at this time.	Two-step income test: Test (1) household income <250%FPL allowing only SSI income disregards, i.e. $20 from unearned income and $65 plus one-half the balance from earned income. Test (2) income under Protected Income Level (or SSI payment level, whichever is higher) allowing same SSI disregards as in Step 1 plus disregard of $500 from SSDI benefit and all of the earned income of the disabled member. Resource Test: $2,000 for individual or $3,000 for couple; once on the program, all earnings of the disabled person accumulated after 1/1/00 may be excluded if they are kept in a separate account from other assets.	$500 of a person's SSDI checks. All earned income of disabled person	Monthly Premiums are based on a progressive system. <185%FPL=0 185%- 225% FPL =$20 225-250%FPL with other insurance = $24 225 –250%FPL without other insurance = $50

STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Washington	1/02	Individual 16-64; meet federal disability requirements; and employed. Employment is defined as getting paid for working, having earnings that are subject to federal income tax, and having payroll taxes taken out of wages. Self-employment is "proven" with IRS SE form, business license, or legitimate business records.	422 new enrollees to Medicaid for 2002 and 1,125 for 2003. $4 million for 2002-2003.	114 new enrollees in Medicaid Buy-In as of 10/02/02.	Net income can not exceed 220% of FPL. The asset test is waived.	Exclude $20 from unearned income, e.g., SSDI or Veterans benefits; exclude$65 and ½ the remainder from earned income; exclude amounts defined in federal statute, e.g., IRWE.	1) Monthly premium equal to a total of 50% of unearned income in excess of the medically needy level (currently $571); 5% of all unearned income; and 2.5% of earned income after deducting $65. 2) Compare amount in #1 to 7.5% of the total income and take the lesser amount.

STATE MEDICAID BUY-IN PROGRAMS

State	Date	Target Population	Original Projections	Actual Number of Participants and Expenditure	Income and Resource Limits	Increase financial Security	Cost-Sharing
Wisconsin	3/15/00	Individual that are over 18 years of age, determined disabled by the Department of Health and Family Services, and employed or attempting to become employed through the Health and Employment Counseling (HEC) program.	1700 participants for the first year. Costs for 2000 $3,295,200 and $11,244,200 for 2001.	2,092 as of 3/26/02. Costs were $211,671 for 2000, $5,276,853 for 2001 and $12,889,302 for 2002.	Income can not exceed 250% of FPL. Resource limit is $15,000.	, independence accounts, retirement accounts, standard living allowance ($634/month), IRWE, medical and remedial expenses, and the primary car and house are excluded. Deposits into the independence account can not exceed 50% of a person's earned income each year Note: Spouse's income is not utilized in determining premium, but is when determining financial eligibility.	Premiums are based on a sliding fee scale. If the income is less than 150% they are not obligated to pay a premium. If the sum of 3-3.5% of their earned income and 100% of their unearned income after deductions is higher than 150% of FPL pay between $ 25 and there is no maximum premium. Deductions include maintenance allowance of at least $20 plus SSI federal benefit rate plus the state supplemental payment rate, medical and remedial expenses, and IRWE.
Wyoming	The State plan was approved by CMS in 6/02.	Working individuals with disabilities that are between the ages of 16 and 64.	300 participants	N/A	Income not to exceed 100% of FPL. There are no resource or unearned income limits.	N/A	Premiums will be 7.5% of an individual's annual income. If an individual has unearned income at or above $600 this is taken into consideration for the purposed of premium calculation.

Appendix L

MBI Enrollment and Annualized Cost Projections

VIRGINIA MEDICAID BUY-IN ENROLLMENT AND ANNUALIZED COST PROJECTIONS (State Fiscal year 2004)

Row	Unearned Income Standard for Determining Eligibility					
1 Unearned Income Standard	$599	$699	$799	$899	$999	No Unearned Income Standard
2 Proportion of Federal Poverty Limit [1]	81.2%	94.7%	108.3%	121.8%	135.4%	
3 Monthly SSDI Payment Range	$500-599	$600-699	$700-799	$800-899	$900-999	>$999
4 Disabled SSDI Recipients in Virginia [2]	17,610	17,865	14,803	12,251	10,081	31,902
5 Proportion of Employed SSDI Recipients [3]	7.9%	8.0%	8.0%	4.2%	4.2%	1.0%
6 Projected New Medicaid Eligibles (cumulative) [4]	1,391	2,820	4,004	4,519	4,942	5,261
7 Annualized Cost per Medicaid Eligible (GF) [5]	$4,315	$4,315	$4,315	$4,315	$4,315	$4,315
8 Year 1 New Medicaid Expense (GF) [6]	**$3,988,052**	**$8,085,052**	**$11,479,627**	**$12,956,152**	**$14,168,909**	**$15,083,494**
9 YEAR 1 ENROLLEE PREMIUMS State Share $25 (GF Cumulative) [7]	$134,458	$272,589	$387,038	$436,819	$477,708	$508,543
10 State Share $50 (GF Cumulative)	$268,917	$545,179	$774,076	$873,639	$955,415	$1,017,086
11 Year 1 Program Operations GF [8] Staff only	$79,488	$158,976	$218,592	$238,464	$258,336	$278,208
12 **Total State Cost GF ($25)** [9] (services + operations – enrollee premiums)	**$3,933,082**	**$7,971,439**	**$11,311,181**	**$12,757,797**	**$13,949,537**	**$14,853,159**
13 **Total State cost GF ($50)** [10] (services + operations – enrollee premiums)	**$3,798,623**	**$7,698,849**	**$10,924,143**	**$12,320,977**	**$13,471,830**	**$14,344,616**

DMAS, Policy and Research, Medicaid Buy-In, November 2002

NOTES

1. 2002 Federal Poverty Level for one person = $738. Rates are a percent of $738.
2. Source: Social Security Bulletin, Annual Statistical Supplement 2001 (2000 S.J. OASDI Current Pay-Benefits: Geographic Data) page 238
3. Percent of Medicaid Buy-In participants in SSDI benefit bracket. (Iowa 08/00)
   Source: Allen Jensen. "Developing Fiscal Estimates for a Medicaid Buy-In Program: Using Data From Early Implementor States." GWU. July 26, 2002.
4. Calculated by multiplying the VA SSDI recipients by the corresponding Iowa proportion of employed SSDI recipients. Row 4*5.
5. Source: DMAS, Budget Division projections. Fiscal Year 2004 estimate does not include waiver or long term care cost.
6. Information calculated by using the New Mexico " Ramp Up" experience which calculates first year cost according New Mexico's first year monthly participation, or Ramp Up to total population.
7. Amount of participant premium that Virginia receives from participants to pay into the MBI. Calculated using the Ramp Up.
8. General Fund Operation cost projections for personnel. Amounts do not include set-up, PC, training, or DMAS information systems modifications and maintenance.
   Income level participation : corresponding staff $599:4 $699:8 $799:11 $899:12 $999:13 $none:14
9. State Medicaid cost using Ramp Up. Buy-In members premium ($25) cost share minus premium pay out. Rows 8+11 –9.
10. State Medicaid cost using Ramp Up. State percentage of Buy-In members premium ($50) cost share premium payout. Rows 8+11 –10.

Explanation of Cost Projection Components for a Medicaid Buy-In
Department of Medical Assistance Services
SSDI Program Enrollment and Cost Projections Methodology
November 2002

(rows one, two, and four)
The format for this model comes from the Nevada cost projection. Therefore, the DMAS' staff tried to maintain a similar format for ease of comparison. Staff chose to use the same SSDI unearned income ranges (row three) of $100 multiples starting at $500 and going above $1,000 per month. The poverty limits (row two) represent the top dollar amount of each column as a percent of the Federal Poverty Level[1]. The number of SSDI recipients in each unearned income range is from the 2001 Social Security Bulletin and represents Virginia SSDI recipients (row four) from December 2000. DMAS used 2000 information because it was the most current information available. New projections will need to be calculated in December 2002 with 2001 information once SSA publishes these figures.

(rows four, five, six)
A key to cost projections is forecasting a realistic participation rate. Nevada used the Iowa SSDI unearned income participation rates[2] and DMAS chose to use this same information to project the number of new Medicaid eligible participants. DMAS multiplied the number of SSA Virginia SSDI recipients (row four) by the Iowa percent of population working in each income range (row five) to forecast the Virginia MBI participants (row six). This sixth row lists the cumulative number of participants from the lowest level of unearned income ($599) to the highest income level, which is above $1,000 a month. Cumulative sums are used for the subsequent cost projections.

(row five)
Per Allen Jensen and as noted in row five, the proportion of employed SSDI recipients decreases as earned income increases. The highest MBI participation occurs between the unearned income range of $500 to $799. This distribution can be possibly attributed to SSDI recipients who became disabled earlier in their working years and had limited earnings potential due to limited work experience. Now these recipients may have reentered the job market to increase their income. Conversely, SSDI recipients with monthly payment amounts in excess of $800 are likely to be older when they became disabled and have had higher levels of earnings. These individuals may be less likely to seek employment because they may be older and may have a more severe disability.

(row seven)
DMAS determined the cost per participant by looking at available 2002 Medicaid costs for individuals with disabilities. The DMAS Budget division used 2002 utilization data and factored in future medical inflation. These calculations resulted in an approximate annual cost per Medicaid eligible General Fund share of $4,315[3]. These costs have

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[1] 2002, 100% Federal Poverty Level for one person = $738. Rates are a percent of $738.
[2] Proportion of SSDI recipients employed by income range in Iowa (08/00).
Source: Allen Jensen. "Developing Fiscal Estimates For a Medicaid Buy-In Program: Using Data From Early Implementor States." GWU. July 26, 2002. Draft Report.
[3] Source: DMAS, Budget Division projections. Fiscal Year 2004 estimate does not include waiver or long term care cost.

been adjusted for recipients that will also have Medicare coverage. In this manner DMAS deviated slightly from the Nevada model in determining cost per participant.

(row eight)
The State of Nevada also used the New Mexico "Ramp Up" [4] to determine monthly enrollment rates and DMAS chose to use this forecast model. The New Mexico[5] Ramp Up consists of rates of gradual enrollment over a twelve-month period. DMAS does not expect all MBI participants to enroll in the program in the first month and continue for an indefinite period. Instead, full participation will be gradual and will build each month to the forecasted total at the end of the year. DMAS used Ramp Up rates to determine the monthly participation rates and associated annual premium cost to the State of Virginia. The New Mexico Ramp Up technique allows DMAS to more realistically forecast premium costs according to actual monthly utilization. Row eight represents Year One Medicaid expense which was calculated using the New Mexico Ramp Up, Virginia SSDI population, Iowa MBI participant rates, and the estimated 2004 fiscal year annualized cost per Medicaid eligible of $4,315.

The amount of monthly premium for the MBI has not been determined yet. For forecast purposes, two different premiums are shown. DMAS decided to forecast premium income using per member per month (PMPM) premiums of $25 and $50. Virginia can use these premium figures and continue to be compliant with federal regulations if Virginia incorporates sliding scale co-payments into its Buy-In program.

(row nine and ten)
The New Mexico Ramp Up was used to determine income from monthly MBI premiums. The Ramp Up was applied to each unearned income level for a $25 and $50 monthly premium. DMAS has also calculated the amount of monthly premium/income that would be directly applied to State General Funds. Because the federal government shares 51.45%[6] of the 2002 Medicaid cost, the federal government would receive 51.45% of the monthly premium. DMAS calculated this amount into the overall costs to more accurately forecast possible premium income and each is listed in rows nine and ten.

(row eleven)
In regard to operational costs, DMAS calculated support staff salaries to support this new program. These costs represent the General Fund contribution to staff salaries. DMAS operations supplied a participant to staff ratio, salary, and benefit amounts to determine these costs. This ratio is approximately one staff person for 350 participants and the number of staff that make up the operational cost per income limit is listed in spreadsheet footnote eight. Please note that these costs account for only staff and do not include personal computers, training, DMAS information systems configuration, or any other associated costs.

Rows 12 and 13 represent MBI General Fund costs for the first year according to a monthly $25 or $50 premium.

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[4] New Mexico "Ramp-Up" experience was acquired from the Nevada MIG and represents year one MBI monthly participation rates for SSDI participants.
[5] New Mexico implemented its Medicaid Buy-In program in January 2001.
[6] 2002 Federal match is 0.5145