COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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November 1, 2024

MEMORANDUM

TO: The Honorable Luke E. Torian,
Chair, House Appropriations Committee

The Honorable Mark D. Sickles
Chair, House Health and Human Services Committee

The Honorable L. Louise Lucas
Chair, Senate Finance Committee

The Honorable Ghazala F. Hashmi
Chair, Senate Education and Health Committee

FROM: Cheryl Roberts
Director, Virginia Department of Medical Assistance Services

SUBJECT: Recommendations to Improve Access to and Successful Utilization of the Medicaid Works Program

This report is submitted in compliance with Chapter 335 of the 2024 Acts of Assembly, which states:

That the Department of Medical Assistance Services shall convene a work group of relevant stakeholders to study and make recommendations to improve access to and successful utilization of the federal Medicaid Works program. The work group shall report its findings and recommendations to the Chairmen of the House Committees on Appropriations and Health and Human Services and the Senate Committees on Education and Health and Finance and Appropriations by November 1, 2024.

Should you have any questions or need additional information, please feel free to contact me at 804-664-2660.

CR/wf
Enclosure

Pc: The Honorable Janet V. Kelly, Secretary of Health and Human Resources

Recommendations to Improve Access to and Successful Utilization of the Medicaid Works Program

November 2024

Report Mandate:

Chapter 335 of the 2024 Acts of Assembly states: Department of Medical Assistance Services shall convene a work group of relevant stakeholders to study and make recommendations to improve access to and successful utilization of the federal Medicaid Works program. The work group shall report its findings and recommendations to the Chairmen of the House Committees on Appropriations and Health and Human Services and the Senate Committees on Education and Health and Finance and Appropriations by November 1, 2024.

History of Medicaid Works: Virginia's Medicaid Ticket to Work Basic Eligibility Group

The Medicaid Ticket to Work Basic eligibility group was established by the Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA). This legislation modified the Medicaid and Medicare programs in several ways to increase access to health coverage for working individuals with disabilities. To this end, the Ticket to Work Basic eligibility group permits working individuals with disabilities to earn income and maintain resources in excess of the income and resource limits applied to other eligibility groups, enabling enrollees to increase their work activity without fear of losing their health coverage.

To be eligible for Ticket to Work Basic, individuals must:

- meet the Social Security Administration's definition of disability, except for earnings;
- have earned income;
- be between ages 16 and 64; and
- have income and resources that do not exceed standards set by the state.

Virginia's Ticket to Work Basic eligibility group, called Medicaid Works, was implemented in 2007. The Medicaid Works benefit package is considered an "alternative benefit package," it includes all benefits provided in the approved Medicaid state plan plus personal care services with no patient pay liability.

Medicaid Works Financial Eligibility Requirements

The Medicaid Works financial eligibility rules applied at application are stricter than those applied when determining ongoing eligibility, such as during the annual renewal process. This is unique compared to all other Virginia Medicaid eligibility groups in which the same eligibility rules are applied at application and when determining ongoing eligibility.

In 2021, the Medicaid Works income limit applied at application was increased from 80% of the federal poverty limit (FPL) to 138% FPL ($1,732 a month for an individual in 2024), both earned

and unearned income are counted. The eligibility resource limit applied at application is $2,000 for an individual. Applicants must also establish a Work Incentive Account (WIN account), a separate account established to contain only earned income and allowable unearned income disregards, to be eligible for Medicaid Works.

Once enrolled, significant disregards are applied to the individual's income and resources for the purposes of determining their ongoing eligibility. Earned income up to $6,250 a month, $75,000 a year, that is deposited into the individual's WIN account is disregarded. Unearned income, such as Social Security Administration (SSA) benefits, must remain at or below 138% FPL. SSA benefit increases due to the additional work activity or the annual cost-of-living adjustment (COLA) that are deposited into the WIN account are disregarded from unearned income. Medicaid Works is one of only two eligibility groups for which COLA adjustments are disregarded. Lastly, resources maintained in the WIN account up to the SSA 1619(b) threshold ($45,976 in 2024) are disregarded. Resources not in the WIN account must remain below $2,000 for an individual.

Work Group

As directed, the Department of Medical Assistance (DMAS) convened and facilitated a work group of relevant stakeholders to review Virginia's Medicaid Works eligibility group. The work group reviewed Virginia's current Medicaid Works policies and procedures, analyzed federal options and Ticket to Work Basic programs in other states, and discussed the personal experiences of work group members and the experiences of individuals they represent.

Work group participants:

- The Arc of Virginia (Lucy Cantrell)
- Endependence Center (Maureen Hollowell)
- Choice Group (Beth Martin)
- Virginia Association of Community Services Boards (Jennifer Faison)
- Virginia Department of Aging and Rehabilitative Services (David Leon, Catherine Harrison)
- Virginia Department of Social Services (Adrienne Jackson)

Work group participants agreed that Medicaid Works is a valuable support for individuals with disabilities who seek to work or to increase their work activity. They identified several barriers to increasing enrollment and developed recommendations to strengthen the program and increase participation.

Identified Barriers

Work group participants identified barriers to participation in Medicaid Works to be:

1. Low financial eligibility requirements applied at application. Of the 42 states with a Ticket to Work Basic eligibility group, Virginia has the second lowest income limit and the lowest resource limit. In 2022, the Ticket to Work Basic national average income limit was $2,902 a month and the average resource limit was $9,542.

2. Lack of residential supports available to Medicaid Works participants. Personal care was noted as an important inclusion that should be maintained.
3. Hesitance of Developmental Disability (DD) Waiver participants to transition into Medicaid Works for fear of losing the more comprehensive DD Waiver benefit package.
4. Low awareness of Medicaid Works, its benefits, and how to enroll among community members and advocates.
5. The complexity of the application process and poor understanding of Medicaid Works eligibility rules by Benefit Program Specialists at local Department of Social Service (LDSS) agencies.

Recommendations

Recommendations were developed by work group members to address the identified barriers. The work group did not rank their recommendations as additional analysis on each is necessary to determine cost effectiveness, level of difficulty and timeline to implement, and projected number of impacted individuals. DMAS does not have the internal resources necessary to conduct this analysis, and external support is necessary to fully explore the impacts of each option and to ensure proper implementation of any program changes.

1. Increase Alignment between Medicaid Works and Developmental Disability Waivers

DMAS administers three Medicaid 1915(c) Home and Community-Based Services Waivers that serve individuals with an intellectual or developmental disability: the Building Independence Waiver, the Community Living Waiver, and the Family and Individual Supports Waiver, collectively referred to as the Developmental Disability (DD) Waivers. DD Waiver eligibility consists of three eligibility criteria: diagnostic criteria, functional criteria, and Medicaid financial criteria. To meet DD Waiver financial eligibility requirements, an individual must be Medicaid eligible in one of the 'eligibility groups served by the waiver', as defined in the 1915(c) waiver. These Medicaid eligibility groups are Supplemental Security Income (SSI) Recipients; Aged, Blind or Disabled with income under 80% FPL (ABD); Low-Income Families with Children (LIFC); Medicaid for Pregnant Women; Medicaid for Children under 19; Medicaid Expansion; and 300% SSI. Individuals eligible for Medicaid in an eligibility group other these, such as Medically Needy or Medicaid Works, do not meet DD Waiver financial eligibility and are not eligible. Individuals must also have a higher level of care need to meet the DD Waiver diagnostic and functional eligibility criteria compared to the Medicaid Works disability criteria.

The DD Waiver benefit package is more robust and provides supports and services not provided by Medicaid Works. Medicaid Works, however, permits enrollees to earn and retain significantly more income than the eligibility groups served by the waiver. Based on the eligibility requirements of the groups served by the waiver, the maximum income that a DD Waiver recipient can have is 300% SSI ($2,829 a month for an individual), this includes both earned and unearned income. This is significantly less than the ongoing income limit for Medicaid Works, $6,250 of earned

income plus unearned income up to 138% FPL ($1,732 for an individual) per month.

This results in individuals who meet the higher DD level of care need, but are still able to work and earn income, having to choose between maintaining access to the benefits only available to through the DD waiver and increasing their work activity, as permitted in Medicaid Works. Adopting one of the following two recommendations would help this population maintain services and supports while also permitting them to increase their work activity.

a. Add Residential Supports to the Medicaid Works Benefit Package.

Virginia Medicaid provides enhanced residential supports to DD Waiver recipients. These supports include independent living supports, shared living, in-home supports, group home residential, and sponsored residential. The change would strengthen the Medicaid's ability to support enrollees who do not meet the higher level of care need to be eligible for a DD Waiver or are on the DD Waiver waitlist in achieving greater independence and make the program more attractive to a broader population.

Making some or all these residential supports available to Medicaid Works participants would also ease the transition of DD Waiver recipients interested in moving into Medicaid Works in order to increase the amount of their earnings that they can keep. Current policy requires the state to maintain a DD Waiver recipients waiver slot for 180 days when they transition to Medicare Works, allowing them to return to the DD Waiver program if they determine that it is the better option for them.

Additional fiscal analysis is necessary to determine the cost of adding these services to the Medicaid Works benefit package and the fiscal impact would be determined by the types of residential supports added. Medicaid Works members are enrolled in managed care, and it would need to be determined if new services should be provided through managed care or fee-for-service, and the operational and fiscal impact of each service delivery model.

A Medicaid state plan amendment (SPA) would be required to add benefits to the Medicaid Works benefit package. Additional CMS approval may be needed depending on the specific supports provided and the settings in which they are to be provided. The changes would also require state authority and funding.

b. Add Medicaid Works as an Eligibility Group Served by the DD Waiver

As an alternative to recommendation 1.a., Medicaid Works could be added as an eligibility group serviced by the DD Waiver. This would permit working individuals with disabilities who also meet the DD Waiver eligibility criteria to work more without losing waiver eligibility. Individuals would still need to meet DD Waiver diagnostic and functional eligibility and go through the standard waiver screening and application process.

The addition of Medicaid Works as an eligibility group served by the waiver would not result in all Medicaid Works participants being eligible for a DD Waiver, only those who also meet DD Waiver diagnostic and functional eligibility criteria. Additionally, the higher Medicaid Works income and

resource limits would not apply to all DD Waiver recipients, only to those who also met the Medicaid Works nonfinancial requirements of being aged 16 to 65, having a disability as defined by SSA, and having earned income. The change would not increase the number of DD Waiver slots, it would expand the population eligible for a DD Waiver. Lastly, because the DD Waiver benefit package includes all services covered by Medicaid Works, individuals would not be enrolled in 2 programs, but receive the full-benefit package available through the DD Wavier.

A policy decision would need to be made regarding the application of patient pay for personal care services received by individuals who are enrolled in a DD Waiver with underlying Medicaid Works eligibility. There is no patient pay obligation for personal care in Medicaid Works. Currently, when a DD Waiver recipient has underlying eligibility in an eligibility group that does not require a patient pay, they do not have a patient pay under the DD Waiver either. Expanding the number of individual DD Waiver recipients receiving personal care with no patient pay would have a fiscal impact.

There is limited data available regarding the number of individuals who meet eligibility criteria for both Medicaid Works and a DD Waiver. As a result, the work group was unable to estimate the number of DD Waiver recipients who would be permitted to increase their earnings or the number of Medicaid Works recipients who would meet the DD Waiver diagnostic and functional eligibility criteria were this change adopted.

A Medicaid SPA and 1915(c) wavier amendment would be required to add Medicaid Works as an eligibility group served by the waiver. Additional state authority and funding would also be required.

2. Increase the Initial and/or Ongoing Medicaid Works Income Limit

The lower income limit applied when determining eligibility for Medicaid Works, when compared to the level of allowable ongoing earnings, prevents working individuals with disabilities who earn more than 138% FPL, but less than $6,250 a month, from being eligible for Medicaid Works. Additionally, the lower ongoing unearned income limit was seen as a barrier to continued enrollment. Work group members proposed increasing the Medicaid Works income limits in one of the following ways.

1. Increase the initial income limit to 300% SSI to align with the Commonwealth Coordinated Care Plus (CCC Plus) and DD Waiver income limits.
2. Increase the initial income limit to approximately 500% FPL to match ongoing eligibility criteria for Medicaid Works ($75,000 per year). Unearned and earned income added together could not exceed 500% FPL.
3. Increase the ongoing eligibility income limit for unearned income to 300% SSI. This would be in addition to the $6,250 monthly earned income disregard.

Either of the first two options could be implemented in conjunction with the third option to increase both the initial and ongoing income eligibility limits.

Increasing the income limit in any manner would require a SPA and state authority and funding. A fiscal impact for each recommendation could not be determined by the work group due to the lack of data available to project the potential number of newly eligible individuals.

3. Increase and Enhance Information Provided for Members, Eligibility Staff and Providers

Robust outreach efforts in other states have successfully increased enrollment in their Ticket to Work basic eligibility groups. Additionally, states that have branded their Ticket to Work eligibility group as a specific program designed to support workers with disabilities have also seen increased enrollment. Work group members stated that the program was not well known within the community and should be more highly publicized.

Specific recommendation included:

- Produce new Medicaid Works outreach materials for use by DMAS and stakeholders at community events.
- Host community education and training events.
- Promote the program through DMAS and other state managed social media accounts.
- Solicit speaking opportunities at organizations that serve disabled and blind populations.
- Use traditional media such as television and radio to promote the program.
- Provide additional training to benefit program staff and Medicaid providers.

No state or federal approval would be needed to implement this option. Additional funding would be necessary for the development and distribution of new outreach materials, additional staff needed to develop materials and conduct trainings, and a paid ad campaign.

4. Application Updates

Virginia's Medicaid application does not gather all the information necessary to determine eligibility for Medicaid Works, for example, it does not ask if the individual has a WIN account. There is also no way for an applicant to indicate interest in Medicaid Works on the application. Collecting the information needed to determine Medicaid Works eligibility or interest in the program at application, when changes are reports and at renewal would decrease the administrative burden for applicants and benefit program staff. It would also increase awareness of the program.

Changes to the Medicaid application must be approved by CMS. Additionally, there would be a fiscal impact associated with modifying the application and renewal forms across all modalities and necessary case management system changes.

Summary

Medicaid Works is a valuable program that enables individuals with disabilities to work and increase their income while maintaining the health care upon which they rely. Despite this, the program is underutilized. The above recommendations are intended to increase enrollment in the program and strengthen the supports provided to Medicaid Works participants.

About DMAS and Medicaid

The mission of the Virginia Medicaid agency is to improve the health and well-being of Virginians through access to high-quality health care coverage. The Department of Medical Assistance Services (DMAS) administers Virginia's Medicaid and CHIP programs for approximately two million Virginians. Members have access to primary and specialty health services, inpatient care, dental, behavioral health as well as addiction and recovery treatment services. In addition, Medicaid long-term services and supports enable thousands of Virginians to remain in their homes or to access residential and nursing home care.

Medicaid members historically have included children, pregnant women, parents and caretakers, older adults, and individuals with disabilities. In 2019, Virginia expanded the Medicaid eligibility rules to make health care coverage available to more than 600,000 newly eligible, low-income adults.

Medicaid and CHIP (known in Virginia as Family Access to Medical Insurance Security, or FAMIS) are jointly funded by Virginia and the federal government under Title XIX and Title XXI of the Social Security Act. Virginia generally receives an approximate dollar-for-dollar federal spending match in the Medicaid program. Medicaid expansion qualifies the Commonwealth for a federal funding match of no less than 90% for newly eligible adults, generating cost savings that benefit the overall state budget.