

**Status Report on the Employed Persons with Disabilities Program
Maryland Medical Assistance
January 2005**

I. Introduction

House Bill 630 of the 2003 Session directs the Department of Health and Mental Hygiene (DHMH) to establish a program for employed persons with disabilities that provides them an opportunity to enroll in the Medicaid program when they would not otherwise be eligible because of increased income. Many individuals with disabilities would like to join the workforce, but fear of losing medical services they receive through Medicaid remains a significant barrier. Private insurance is often not available to individuals newly entering the workforce, and Medicaid provides broader coverage than many private health plans. The medical services provided under Medicaid are often the very supports that allow an individual to return to work. The loss of the benefit impacts directly on their ability to work.

The federal Ticket to Work and Work Incentives Improvement Act allows states to establish new Medicaid eligibility categories for working people with disabilities whose income or resources would otherwise make them ineligible for Medicaid. This option, called a Medicaid Buy-In, will help encourage people with disabilities to return to the workforce or increase their current levels of work, helping alleviate their dependence on cash assistance programs.

Individuals who are served in the Medicaid Buy-In program will be able to earn competitive wages, be more involved in their communities and contribute to the State via payroll and income taxes. Currently 29 states have implemented a Medicaid Buy-In program.

II. Background

The Maryland Coalition for Work Incentives Improvement (Coalition) worked over the last several years to develop a proposal for a Medicaid Buy-In. During the 2003 legislative session, the Department supported House Bill 630, which requires the State of Maryland to implement The Employed Persons with Disabilities Program by July 2005, contingent on available funding. Given the desire to immediately remove barriers to employment for people with disabilities, DHMH met with Coalition leaders to discuss the most favorable way to establish this program amidst ongoing fiscal constraints. Both sides agreed, given the funding limitations, the first activity should be to direct attention to those who currently receive Medicaid benefits.

In March 2003, Maryland was awarded the Medicaid Infrastructure Grant from The Centers for Medicare and Medicaid Services (CMS) to provide support in developing a Medicaid Buy-In program and encouraging the competitive employment of individuals with disabilities. Maryland has received a total of \$1 million dollars over the past two

years to help fund infrastructure development, research and staffing costs for the development of a Medicaid Buy-In program.

III. Progress

A. § 1115 Waiver Amendment Request to Implement Small-Scale Medicaid Buy-In

In June 2003, DHMH proposed to CMS a first step in implementing a Medicaid Buy-In Program by continuing coverage for existing Medicaid beneficiaries with disabilities, i.e., Supplemental Security Income (SSI) recipients that as a result of their employment (as well as those that may be employed in the future), face the loss of benefits.

Starting with the SSI population presented fewer operational challenges to the Department while it also assured the State that sufficient funds would be available for the program. This proposal was designed to allow people to maintain their Medicaid eligibility while returning to work and increasing their income, but does not expand Medicaid coverage to a new group of working individuals. DHMH considered this first step to be budget-neutral. This proposal would be structured as an amendment to the existing §1115 HealthChoice waiver.

SSI beneficiaries are categorically eligible for Medicaid and have two work incentive options to help prevent loss of Medicaid benefits—Sections 1619 (a) and 1619 (b) of the Social Security Act. The first of these work incentive provisions, Section 1619 (a), allows workers with disabilities receiving SSI to increase their income above the Substantial Gainful Activity standard (\$810/month for non-blind individuals) and retain SSI cash payments. As earned income increases, SSI cash benefits decrease. Ultimately, as income increases the SSI benefit reaches zero and Medicaid coverage is lost unless the individual is found eligible for the Section 1619 (b) provision. Under Section 1619 (b), even after the cash benefit payment has been eliminated by earned income, Medicaid coverage can continue for individuals with disabilities up to a certain earnings threshold. For Maryland residents, 1619 (b) eligibility currently terminates when an individual's annual income reaches \$29,436. There are currently approximately 500 individuals in the HealthChoice Medicaid managed care program receiving SSI benefits under the 1619 (b) category.

While this proposal would not be a true Buy-in program (given its limited scope in eligibility, no premiums paid by participants, and a different system infrastructure), it would serve as a benefit to the 1619 (b) population until the larger-scale Social Security Disability Insurance (SSDI) program could be developed. DHMH requested that individuals who qualify for 1619 (b) be allowed to increase their income to 300% of the federal poverty FPL (after the standard deductions) while maintaining Medicaid eligibility.

In December 2003, the Department proposed to amend the §1115 HealthChoice Waiver to implement this smaller-scale Medicaid Buy-In program (SSI recipients only) as soon as possible. Since Maryland formally submitted its proposed amendment to the §1115 waiver, Maryland has had extensive discussions with CMS about the goals of the proposal and how it will be operationalized. In May 2004, DHMH submitted budget neutrality documentation to CMS. The proposal is still under review by CMS, and DHMH continues to work with CMS to clarify any potential issues or concerns in the hopes of getting the proposal approved.

B. Increasing 1619 (b) income threshold to 300% of Federal Poverty Level

Recognizing the lack of progress that DHMH has experienced with CMS in trying to move forward the proposed SSI-only program, in May 2004 DHMH began pursuing an alternate route to accomplish similar goals of the proposal in a more expedient manner (while remaining budget neutral). DHMH submitted a proposal to the Social Security Administration (SSA) that would allow SSI 1619 (b) recipients the opportunity to increase their income limits to 300% of the FPL without risking the loss of Medicaid coverage. This earning limit varies by state, and is calculated using a standard formula devised by SSA.

This proposal would be implemented at the SSA level, therefore it would not be limited to the HealthChoice population. This proposal would offer the flexibility to increase income for 1619 (b) individuals in both Medicaid Fee-for-Service and HealthChoice. There are approximately 1,500 individuals in Medicaid (HealthChoice + Medicaid Fee-for-Service) with SSI 1619 (b) coverage.

Similar to the waiver proposal, this proposal would be budget-neutral and would not be a *true* Buy-in program since premiums will not be charged for participation and the potential impact on the number enrolled is limited. However, this proposal would be straightforward and technically easier to implement than the CMS proposal since the eligibility process is already in place for this population and would not have to be changed. In addition, this proposal will eliminate gaps in coverage for this population since they will already be identified in the eligibility system under 1619 (b) coverage. Initial response from SSA has been positive, and discussions are taking place to test this as a pilot program in Maryland (please see attached correspondence).

C. Estimating Enrollment and Costs of the Program

The next step in the Buy-In development is to expand the program to cover other individuals with disabilities, i.e., SSDI recipients. SSDI, Title II of the Social Security Act, provides monthly cash benefits to severely disabled individuals and is based on work history. In total, there are currently 80,733 individuals receiving SSDI benefits in Maryland. The SSDI population is the target population for the expanded Buy-In program; this will be pursued in addition to the SSI portion of the program described above. This expansion to the SSDI population will now be possible with the aid of the \$4

million (total funds) allocated in the Governor’s FY 2006 budget to support this population.

Individuals with SSDI that have earned income greater than \$552/month are currently ineligible for Medicaid. In the proposed program, this expansion group would be required to pay nominal monthly premiums of approximately \$30. The costs and enrollment projections outlined in the following paragraphs are for the SSDI population.

In January 2004, the Regional Economic Studies Institute (RESI) provided enrollment estimates for the SSDI portion of the Maryland Medicaid Buy-In program. These estimates were reviewed by DHMH and the Coalition. RESI’s estimates were based on two proposed eligibility criteria:

1. Individuals with disabilities who receive less than \$850 per month in unearned income (SSDI benefits); and
2. Individuals with disabilities who receive more than \$400 per month in earned income.

It was determined by RESI that **1,469 individuals** meet the requirements of the program as proposed and would be potential participants in the Maryland Medicaid Buy-In. DHMH and the Coalition agreed to use this number as the best estimate for future calculations of cost and enrollment.

Taking the enrollment estimate of 1,469, DHMH worked with the Center for Health Program Development and Management (CHPDM) at the University of Maryland Baltimore County, the Department of Disabilities and the Coalition to develop medical cost projections for this population for the first three years of the program. The table below outlines the potential costs, broken down by total funds (total medical costs for the program) and general funds (Maryland’s portion of the medical costs) required by the State to support the program:

Medical Costs of SSDI population – Medicaid Buy-In Program

Fiscal Year	Estimated Enrollees	Adjusted Costs - Dual -Eligible Mix 70%	
		(Total Funds) Total Costs	(Gen. Funds) Total Costs
2006	1,469	\$ 9,432,696	\$ 4,716,348
2007	1,542	\$ 13,848,312	\$ 6,924,156
2008	1,616	\$ 15,625,620	\$ 7,812,810

Note: Cost estimates are for medical costs only, and do not include administrative costs of the program. In addition, cost estimates do not reflect the potential increase in tax base (and subsequent revenue generated) as a result of more individuals working or increasing their number of work hours.

The “70% Dual-Eligible Mix” referenced above is the number of participants that are eligible for both Medicaid and Medicare services. Dual-eligibles have different total

costs than standard Medicaid recipients since Medicare is the primary payer for some of the services provided. National data have shown that for states with Medicaid Buy-In programs, typically 70% of the participants are “dual eligibles”.

The next component of the cost estimate includes the administrative portion of the program. These estimates assume eligibility and program administration will be incorporated within existing systems and completed manually, with revenue raised through a premium collection component for program participation. Separately, DHMH is pursuing funding for a new eligibility system for the Aged, Blind and Disabled populations. If the Medicaid Buy-In is incorporated into a new eligibility system, future systems and administration costs would be lower than with a manual eligibility system.

The table below provides estimates for the administrative portion of the program:

Administrative Costs – Manual Eligibility System

Fiscal Year	Staffing	Information Systems Changes	Claims Processing (MHA)	Premium Collection	Enrollment Broker	Premium Revenues	(Total Funds) Total Costs	(Gen. Funds) Total Costs
2006	\$902,061	\$2,200,000	\$66,291	\$150,000	\$3,393	(\$366,600)	\$2,955,745	\$ 1,477,873
2007	\$1,085,514	\$250,000	\$103,893	\$10,000	\$2,847	(\$555,120)	\$897,134	\$ 448,567
2008	\$1,149,296	\$250,000	\$112,690	\$5,000	\$2,982	(\$581,760)	\$938,208	\$ 469,104

- Staffing: New staff will be needed to perform the systems change work, make eligibility determinations, collect premiums, and administer the program.
- Information Systems Changes: adding new coverage groups to existing systems requires extensive programming changes, staff time, quality control and additional reporting requirements. The bulk of the costs are start-up costs during the first year, the remaining years have ongoing “machine time” costs.
- Claims Processing (MHA): costs to MAPS, the Mental Hygiene Administration’s Administrative Services Organization, for administering the mental health benefit to approximately 50% of the Buy-In population (includes service coordination and claims payment)
- Premium Collection: costs for a new accounts/receivable system to collect premiums for the Buy-In population and system maintenance during each successive year.
- Enrollment Broker: costs associated with the enrollment broker helping new participants enroll in a health plan.
- Premium Revenues: currently estimated at a \$30/month average, the fees that individuals pay to “Buy-In” to the Medicaid program. Premiums will be set on a sliding scale that varies based on an individual’s income.

Combining these estimates with the medical costs of the program, the estimated total costs are as follows:

Total Costs – Medicaid Buy-In Program

Manual Eligibility System				
Fiscal Year	Medical Costs	Administrative Costs	Total Costs	(General Funds)
2006	\$9,432,696	\$2,955,745	\$12,388,441	\$ 6,194,220
2007	\$13,848,312	\$897,134	\$14,745,446	\$ 7,372,723
2008	\$15,625,620	\$938,208	\$16,563,828	\$ 8,281,914

* Note: Medicaid Infrastructure Grant funding may be able to provide \$300,000 to \$600,000 in support of these activities in FY 2006.

IV. Governor Ehrlich’s Fiscal Year 2006 Budget Allocation

In January 2005, Governor Ehrlich appropriated \$4 million in total funds (\$2 million general funds, \$2 million federal funds) to support the implementation of the Buy-In program. This allocation will allow the Department to begin phasing-in a limited number of enrollees in FY 2006. The bulk of this appropriation will be used to develop information systems and fund the administrative costs described in III.C above. Future allocations would be used to sustain the program and, as funding permits, expand to more individuals.

V. Use of Medicaid Infrastructure Grant Funds

DHMH has finished the second year of Medicaid Infrastructure Grant funding. To date, DHMH has received \$1,000,000 in funds to support the development of the Medicaid Buy-In program and improve the employment opportunities for individuals with disabilities. Grant funds to this point have been spent on developing cost estimates, planning activities and technical assistance for program development. DHMH has roughly \$685,000 remaining grant funding to spend during Calendar Year 2005.

A large portion of grant funding during CY 2005 will be used to assist with the operational and systems changes necessary to implement the Buy-In program in FY 2006. Grant funding will assist with a number of implementation activities, including making information systems changes; and aligning claims processing, premium collection and accounts receivable systems.

Remaining grant funds will be used to support projects already in progress or under development to improve employment outcomes for individuals with disabilities and assist them in sustaining competitive employment. Currently, there are a number of planning activities for which DHMH is using grant funds and coordinating efforts with the Department of Disabilities, Mental Hygiene Administration, and other state agencies. Proposed projects include:

- Personal Care Evaluation - Conduct research and analysis to examine the role of personal care in other states' Buy-In programs, the feasibility/fiscal impact of paying family members as caregivers, access standards for personal care services, network adequacy/backup systems, and training of personal care workers. Also conducting focus groups to examine personal care services in the workplace for 1619 (b) and SSDI working disabled.
- Coordinate with the Mental Hygiene Administration to evaluate the current delivery of supported employment (SE) services in Maryland and identify options for enhancing SE.
- Update the personal care provider directory to include "active" providers only. This will help improve individuals' ability to find personal care providers and increase access to personal care.
- Hiring staff to manage the coordination among Business Leadership Networks and various state agencies and to encourage private sector hiring of people with disabilities.
- Develop Website/Disability resources for benefits information and to encourage individuals with disabilities to work
- Implementation of the SSI-only program as well as using grant funding to support targeted outreach to the SSI 1619 (b) population.

VI. Next Steps

In the upcoming months, DHMH will work with the Department of Disabilities and the Maryland Coalition for Work Incentives Improvement to implement the SSDI portion of the program. With funding now made available to support the program, DHMH can move forward with implementation and a phase-in of enrollees in FY 2006.

DHMH will continue work with CMS and SSA to move forward the SSI-only program or the proposal to increase the SSI 1619 (b) income thresholds. During this stage of planning, the focus will be on deciding how to implement the program and creating program parameters with the goal of ensuring that beneficiaries do not lose access to needed services while participating in the workforce.