Bipartisan Policy Center

Improving Opportunities for Working People With Disabilities

JANUARY 2021

STAFF

Katherine Hayes
Director,
Health Policy

G. William Hoagland
Senior Vice President

Eleni Salyers
Research Analyst,
Health Project

Brian O'Gara
Project Associate,
Health Project

HEALTH PROJECT

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

ADVISORS

The Bipartisan Policy Center staff produced this report in collaboration with a distinguished group of senior advisors and experts, including Sheila Burke, Jim Capretta, and Chris Jennings. BPC would also like to thank experts Henry Claypool and Annette Shea for their contributions to this report.

ACKNOWLEDGMENTS

BPC would like to thank the Robert Wood Johnson Foundation for its generous support.

DISCLAIMER

Table of Contents

Glossary of Terms

ACA – Affordable Care Act

ACL – Administration for Community Living

BBA – Balanced Budget Act of 1997

CMS – Centers for Medicare & Medicaid Services

FPL – Federal poverty level

HCBS – Home and Community-based Services

HHS – Department of Health and Human Services

MBI – Medicaid Buy-in for Workers with Disabilities

MIG – Medicaid Infrastructure Grants

NPRM – Notice of Proposed Rule Making

OASDI – Old Age, Survivors, and Disability Insurance

SSA – Social Security Administration

SSDI – Social Security Disability Insurance

SSI – Supplemental Security Income

TWIAA – Ticket to Work and Work Incentives Improvement Act of 1999

Executive Summary

In the late 1990's Congress recognized that federal policy not only established low expectations for people with disabilities to live and work independently, but also that the Medicaid program created disincentives for those with disabilities who wished to work. Congress, along with the Clinton administration, enacted laws creating two optional Medicaid eligibility groups through section 4733 of the Balanced Budget Act (BBA) of 1997 and Section 201 of the Ticket to Work and Work Incentives Improvement Act (TWWIA) of 1999.

While Medicaid is the primary source of health insurance for people with disabilities, the program provides much more than health care services. Medicaid allows individuals with disabilities to live independently in the community. In addition to health services, Medicaid covers case management services, transportation, specialized medical equipment and supplies, and home and community-based services—including personal care assistant services—among other services not covered by Medicare or private health insurance.

BBA and TWWIIA provided additional flexibility for states to offer Medicaid coverage to higher income working individuals with disabilities who—excluding income—meet the Social Security definition of disability. Together, these programs are referred to as Medicaid Buy-in (MBI) for Workers with Disabilities. Separate and distinct from recently implemented Medicaid Community Engagement Demonstrations with work-requirements, the Medicaid Buy-in eligibility option allows workers with disabilities access to Medicaid community-based services not available through other insurers.

Nationally, 46 states have MBI for working individuals with disabilities—allowing more than 400,000 individuals to work and retain Medicaid coverage over the last decade.[i] MBI states have allowed individuals with disabilities to live and work independently in their communities, resulting in increased earnings, savings, and career opportunities. The positive results of MBI for workers with disabilities include increased enrollee income; increased number of hours worked; and a greater opportunity to accrue savings for home purchases, retirement, and other needs. An analysis of Social Security Administration (SSA) earnings data by Mathematica Policy Research, Inc. determined an average of 40% of participants increased their wages after enrollment in the MBI for workers with disabilities.[ii]

Research has shown that promoting employment for workers with disabilities is also cost-effective policy for state Medicaid agencies. MBI participants have better health outcomes and lower Medicaid utilization rates than their non-working peers with disabilities. Employers also benefit from hiring workers with disabilities—demonstrated by increased profits and cost-effectiveness, higher employee retention, increased reliability and punctuality, employee loyalty, and improved company image.

Despite these successes, less than half of working-age people with disabilities (30.9%) were employed in 2019. This compares to an employment rate of 74.6% for people without disabilities.[iii] States and workers with disabilities face challenges understanding MBI, its opportunities and complexities, and the information to appropriately mobilize its value making strategic data-driven decisions. For example, a state may set income and asset limits very low, not realizing they can use waivers to raise those limits. Since enactment of these MBI programs, no regulations have been issued; the Centers for Medicare & Medicaid Services (CMS) issued only four guidance documents from 1997-2000 and no additional guidance for the past 20 years. With better information and leadership, states could make informed decisions about the buy-in and ways to promote employment for workers with disabilities.

Over the last year, the Bipartisan Policy Center has identified recommendations to improve availability of the MBI for workers with disabilities. As part of that effort, BPC reached out to stakeholders and hosted public and private discussions with experts on the topic. Participants included current and former state and federal officials, consumers, and other experts. Based on those discussions, BPC developed recommendations to improve Medicaid Buy-in programs for working people with disabilities.

The recommendations that follow include ways to make the Medicaid Buy-in for workers with disabilities more understandable, more accessible, and more relevant as states seek to ensure pathways to successful employment outcomes for these workers. The role of strong leadership at the federal and state level is key to the success of these recommendations.

RECOMMENDATIONS

Improving Medicaid Buy-in for workers with disabilities will require both administrative and legislative action. In the near-term, providing additional agency guidance on the combined authorities—Section 4733 of BBA '97 and Section 201 of TWWIIA—and issuing regulations on the two programs will help clarify the range of flexibility available to states. Over the long-term, Congress should enact legislation to combine authorities to streamline and simplify the programs. Specific recommended actions include:

I. Issue an Executive Order That Clarifies and Simplifies the Current Medicaid Buy-in for Workers With Disabilities

A. Direct the Department of Health and Human Services Centers for Medicare & Medicaid Services to issue agency guidance identifying the full range of authority available to states to design, improve, and expand MBI programs for workers with disabilities. Note: The incoming Biden administration has also identified enhanced Social Security work incentives, MBI, and improving competitive integrated employment for people with disabilities. While BPC has yet to take a formal position on those issues, addressing them through a combined Executive Order would underscore the president's commitment to expanding opportunities for workers with disabilities.

B. Instruct the Centers for Medicare & Medicaid Services to change the name "Medicaid Buy-in" to "Medicaid for Workers with Disabilities." Note: The term "Medicaid Buy-in" has been applied more broadly across the Medicaid program in recent years. This has caused confusion and the need for more precise language when referring to Medicaid benefits provided to workers with disabilities.

II. Issue Regulations on Medicaid Buy-in Programs

While CMS released informal agency guidance between 1997 and 2000, no regulations have been issued, nor has there been additional guidance in the last 20 years.

A. HHS/CMS should issue a Notice of Proposed Rule Making (NPRM) to give the agency the opportunity to address topics not addressed through informal agency guidance. Examples include retaining Medicaid when a beneficiary experiences a

medical leave from work, increasing eligibility age beyond age 65 to conform with the Social Security retirement age of 67, treatment of assets after enrollment, or more controversial issues such as how work is defined. This process would solicit input from consumer organizations, states, and other experts, and require HHS to address relevant comments or questions arising from the NPRM, providing further clarification to help guide states.

III. Develop and Pass Legislation

While it is possible to formulate MBI programs for the working disabled by combining multiple statutory authorities with waivers, it should be easier for states to implement these programs.

A. **Congress should enact legislation to update, consolidate, and streamline existing authorities into a single state option.** This option should permit states to offer the full range of Medicaid benefits, a subset of Medicaid benefits designed to supplement employer-sponsored insurance, or other private health insurance coverage.

B. **Congress should reauthorize and appropriate funding to states to assist in the development of programs and draw from other states to learn and convey best practices in promoting successful MBI options.** This would include reauthorization of TWWIIA-funded Medicaid Infrastructure Grants to promote outreach and education about the MBI and successful employment outcomes for people with disabilities. The program should convene stakeholders to address barriers to earnings and employment experienced by people with disabilities, who often rely on home and community-based services to allow them to work. Services include addressing transportation barriers, skills training, and employer outreach.

Background

BRIEF OVERVIEW OF MEDICAID

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government and includes both mandatory and optional populations, as well as mandatory and optional benefits (see Figure 1).

Medicaid eligibility is based on both financial and categorical requirements. States are required to cover certain mandatory populations as a condition of receipt of federal matching funds.[iv] States may also cover certain optional populations. To be eligible for Medicaid, one must meet both income and resource standards and belong to a specific category of eligibility (i.e., low-income pregnant women, children, individuals who are aged, blind, or a person with a disability).[v]

Like Medicaid eligibility requirements, there are both mandatory and optional benefits made available through the program. Mandatory benefits include inpatient and outpatient hospital services, nursing facility services, home health services, physician, nurse midwife, nurse practitioners, laboratory and X-ray services, and other services.[vi] Optional benefits include prescription drugs, physical therapy, case management, personal care services, home and community based-services, and other services.

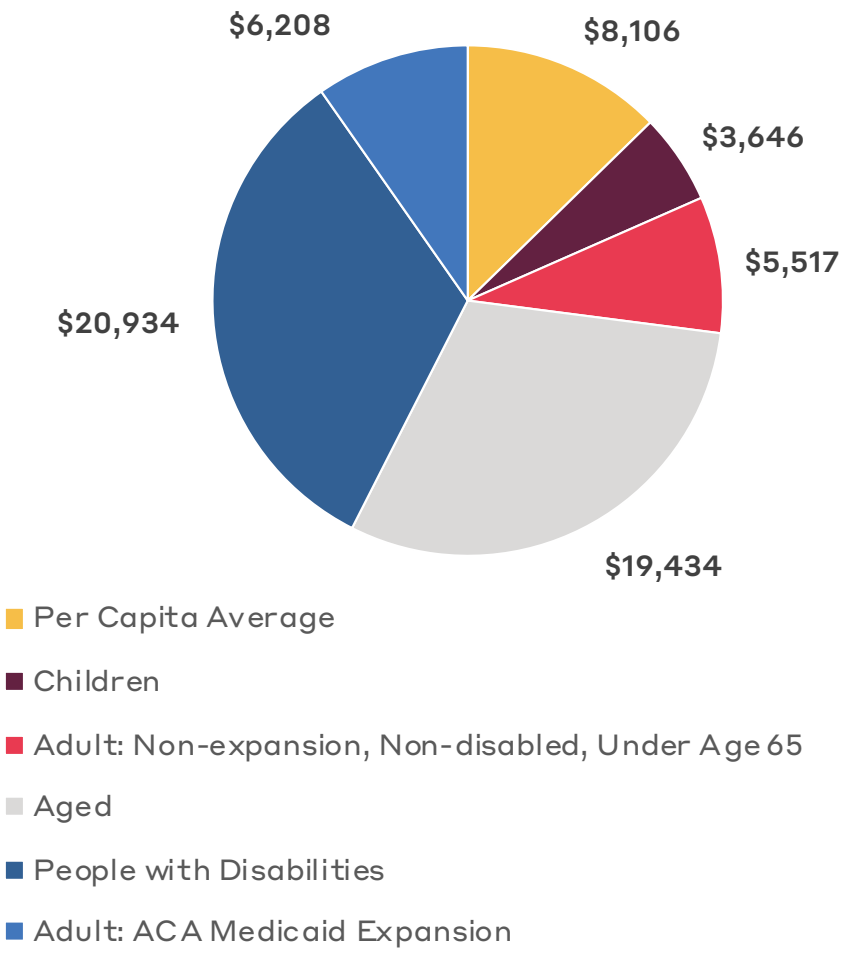
Figure 1: Mandatory and Optional Medicaid Benefits[vii]

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

In federal fiscal year 2019, Medicaid provided health insurance coverage to about 1 in 5, or 74 million low-income Americans[viii]—expending $408 billion on the federal share of program costs.[ix] Spending will likely increase significantly in 2020 as Medicaid enrollment and spending increase as a result of the COVID-19 pandemic and the resulting economic downturn.[x] [1] Despite the complex health needs of the Medicaid population, Medicaid accounts for a smaller percentage of total national health expenditures than Medicare or private insurance.[xi]

1 The Kaiser Family Foundation estimates an increase in Medicaid enrollment by 0.8% and spending by 6.2% over 2019 figures.

Figure 2: Nationwide Average State Medicaid Per Capita Expenditures Based on Enrollment Group (2018)[xii]



For state level per capita spending by enrollment group, see Appendix I.

THE ROLE OF MEDICAID FOR PEOPLE WITH DISABILITIES

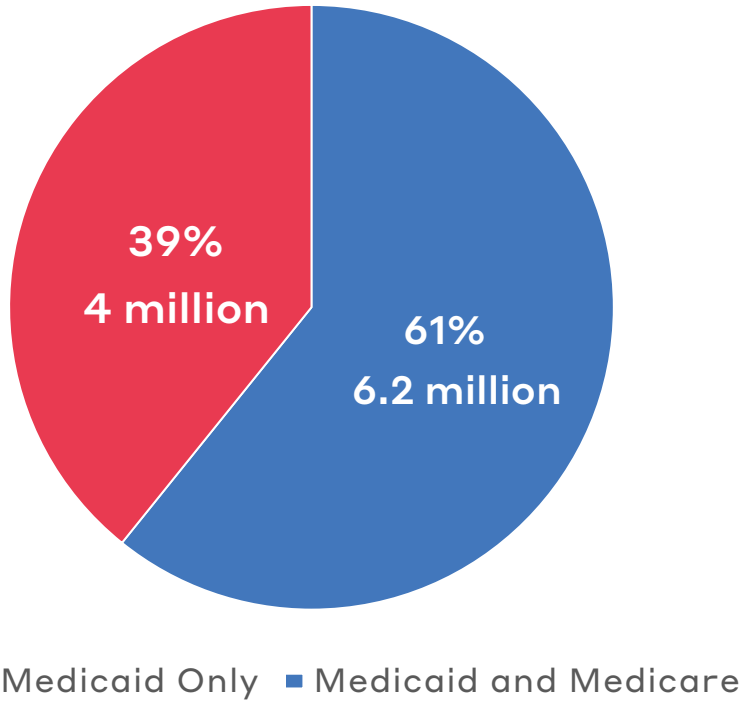
While Medicaid is the primary source of health insurance for people with disabilities, the program provides much more than health care services. Medicaid allows individuals to live independently in the community. In addition to health services, Medicaid covers case management services, transportation, specialized medical equipment and supplies, and home and community-based services, including personal care assistant services—among other services that are not covered by Medicare or private health insurance.

While nursing home care is a mandatory benefit, home and community-based services, or HCBS, are optional. The majority of HCBS are offered by states through 1915(c) waivers. Under these waivers, states may cover services not otherwise covered by Medicaid, including case management services, homemaker, home health aide, personal care, adult day health services, habilitation, respite care, and other services. States may seek coverage of other types of services as part of their waiver applications, provided that the services assist in diverting or transitioning individuals from institutional settings to their homes and communities. These additional services must be approved by the secretary of HHS.[xiii] Medicaid also covers HCBS under two state plan options: 1915(i), which covers the same benefits approved under 1915(c) waivers, and 1915(k), which covers attendant services and supports.[xiv,xv]

In 2015, 10.2 million non-elderly persons were eligible for Medicaid on the basis of disability.[xvi] This does not represent all Medicaid-eligible enrollees with disabilities because some qualify on the basis of poverty level or other enrollment categories. Nearly 40% of those enrollees are eligible for both Medicare and Medicaid (i.e., dual eligible individuals), while more than 60% are eligible for Medicaid only (see Figure 3).[xvii]

Individuals with disabilities qualify for Medicaid through a number of eligibility categories, such as Supplemental Security Income-related pathways—including a number of mandatory and optional populations, such as current and former SSI recipients and other SSI-related groups. For a complete list of mandatory and optional Medicaid eligibility pathways for individuals with disabilities, see Appendix 2.

Figure 3: Enrollment Status of Disabled Medicaid Beneficiaries (2017)[xviii]



More than a third of Medicaid-eligible individuals with disabilities qualify on the basis of eligibility for SSI.[xix] To be eligible for SSI, an individual must be between the ages of 16 and 64, must have a severe, medically determinable physical or mental impairment, and must meet income and resource standards (see Figure 4). In 2020, eligible individuals could earn no more than $783 per month for an individual and $1,175 per month for a couple.[xx] Resource limits, or limits on certain assets, are $2,000 for an individual and $3,000 for a couple.[xxi] Eligibility for SSI is based on whether a person can engage in "substantial gainful activity" that cannot exceed $830 per month, after deducting work expenses. If their income exceeds that amount, they will lose eligibility for SSI, because the two programs are linked in most states.[xxii]

Figure 4: Social Security Income (SSI) Categorical and Financial Eligibility Criteria[xxiii]

Criteria	Description
Categorical	
Aged	Individuals aged 65 and older
Blind	Individuals of any age who have 20/200 or less vision in the better eye with the use of correcting lenses or tunnel vision of 20 degrees or less
Disabled	- Adults aged 18 and older who are unable to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment that is expected to last for at least one year or to result in death - Children under the age of 18 who have a medically determinable physical or mental impairment that results in marked and severe functional limitations and is expected to last for at least one year or to result in death; earnings must not exceed the SGA earnings standard (In 2020, the SGA earnings standard was $1,260 per month. The SGA earnings standard is a proxy measure for total disability; it is not used to determine financial eligibility.)
Financial	
Income Standard	In 2020, $783 per month for an individual (74% of the federal poverty level) and $1,157 per month for a couple (82% of the federal poverty level)
Income-Counting Methodology	Certain income is disregarded, such as the first $20 per month of any income (earned or unearned) and the first $65 per month of earned income plus one-half of any earnings above $65.
Resource Standard	$2,000 for an individual and $3,000 for a couple
Resource-Counting Methodology	Certain resources are disregarded, such as an individual's primary residence, car, household goods and personal effects, and property essential to self-support.

Two-thirds of enrollees become Medicaid-eligible via pathways other than SSI, including those who qualify based on income.[xxiv] Non-elderly individuals who qualify for Medicaid on the basis of disability include adults and children with disabilities they have had since birth and others whose disabling conditions were acquired through illness, injury, or trauma. They enroll in the program through disability pathways including physical conditions, intellectual or developmental

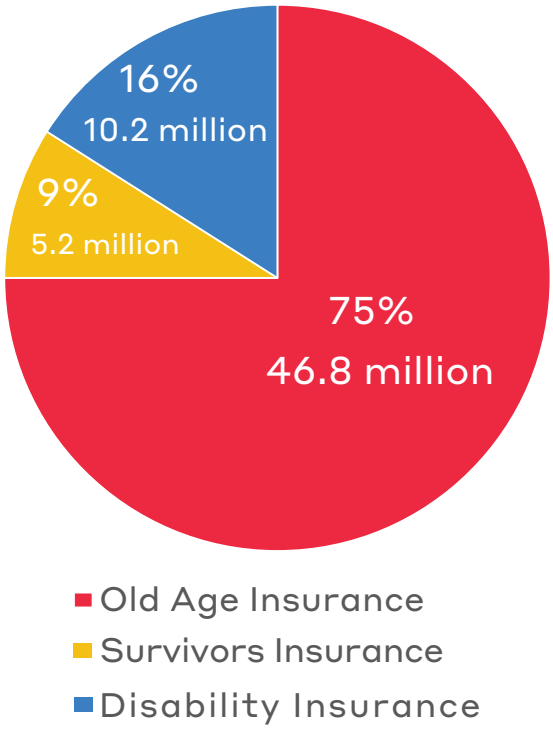
disabilities, or serious behavioral disorders or mental illness.[xxv] Individual needs differ significantly even within categories of eligibility and Medicaid costs vary significantly based on a person's need. For people with disabilities who receive services under the Medicaid program, fear of losing their coverage is one of the most significant barriers to employment, earnings, and independence.[xxvi]

THE INTERACTION OF SSI AND SOCIAL SECURITY DISABILITY INSURANCE

Social Security Disability Insurance, or SSDI, is a work-related insurance program that makes monthly payments to non-elderly disabled workers and their dependents who are considered insured based on their contributions to the Social Security Trust Fund, and eligibility is not income-related.[xxvii] SSI is available to low-income disabled individuals, regardless of work history. While these two programs are different in many ways, both are administered by the Social Security Administration and are available only to individuals who have a disability and meet medical criteria, which are the same for both programs.

Many disabled individuals who qualify for SSI also qualify for SSDI. While SSI triggers Medicaid eligibility in most states, SSDI-eligible individuals qualify for insurance coverage under Medicare after a 2-year waiting period.[xxviii] For individuals who qualify for both Medicare and Medicaid, Medicare is primary payer and Medicaid, as secondary payer, covers services not covered by Medicare.

Figure 5: Old Age, Survivors, and Disability Insurance (OASDI) Beneficiaries by Eligibility Group (2018)[xxix]



STATE OPTIONS FOR MEDICAID BUY-IN PROGRAMS FOR WORKERS WITH DISABILITIES

In the late 1990's Congress recognized the need for additional flexibility for states to offer Medicaid coverage to higher-income workers with disabilities who, excluding income, meet the Social Security definition of disability. The Medicaid Buy-in for workers with disabilities operates through statutory authority provided in Section 4733 of the Balanced Budget Act of 1997 and Section 201 of the Ticket to Work and Work Incentives Improvement Act of 1999. States may also use Section 1115 Medicaid Demonstration authority, as well as a provision of Medicaid law that provides states with full flexibility in setting income and resource standards for Medicaid Buy-in participants.[2]

2 Section 1902(r)(2) of the Social Security Act allows States to use less restrictive income and resource methodologies in determining Medicaid eligibility.

Some states require participants to pay a Medicaid premium, but premiums are not required under federal law. Medicaid offers access to community-based services and supports not offered by Medicare and private insurance. Therefore, for individuals with disabilities who want to work, this option means they don't need to choose between health care and employment. Not only is this coverage important to those at risk of losing community-based services and supports, but unless they are offered employer-sponsored coverage or qualify for Medicare, working means risking becoming completely uninsured.

Prior to passage of the Affordable Care Act in 2010, individuals with disabilities were unlikely to be able to purchase private health insurance because their disability was considered a pre-existing condition. While the ACA allowed individuals with disabilities to purchase coverage without pre-existing condition exclusions or significantly higher premiums, most private health insurance does not provide services that individuals with disabilities frequently require to enter, remain in, or rejoin the workforce. In addition, individuals with disabilities eligible for Medicare are ineligible for marketplace plans. Private health plans and Medicare do not cover many of the critical services, such as specialized durable medical equipment, transportation, home and community-based services including personal assistance services, and other work-related assistance. Because traditional Medicaid is designed to assist low-income individuals, even minor increases in income can result in a loss of eligibility and the loss of the very services that permit them to work and live in their communities.

With enactment of Section 4733 of the BBA, Congress sought to eliminate this disincentive by creating a state option to permit workers with disabilities with incomes up to 250% of the federal poverty level to purchase Medicaid coverage by paying a sliding-scale premium based on income.[xxx] While income and resource standards must comply with SSI standards, states have the ability to disregard certain income and resources when determining eligibility under section 1902(r)(2) of the Social Security Act.

Furthermore, Section 201 of TWWIIA created two new optional Medicaid eligibility categories. First, the law permits individuals with household income over 250% FPL to purchase Medicaid coverage; second, it allows the purchase of coverage for those whose medical condition improves, making them ineligible for SSI or Social Security Disability Insurance since they no longer meet the disability definition.[xxxi]

Another important component of TWWIIA is Section 203, which created an 11-year, $500 million grant program that provided infrastructure funding to states to develop and enhance MBI programs and successful employment outcomes for people with disabilities.[xxxii] That authorization expired in 2011 and was not reauthorized.

Nationally, workers with disabilities also sought to separate MBI from Medicaid and its perception as a "poverty" or "entitlement" program by creating state-specific program names such as Working Health in Kansas, Work Ability in New Jersey, Apple Health for Workers with Disabilities in Washington, Ticket to Work Health Assurance in Missouri, Health Benefits for Workers with Disabilities in Illinois, Health First Colorado, CommonHealth in Massachusetts, and Freedom to Work in Michigan. Nationally, the descriptor "Medicaid Buy-in" has been an identifier for Medicaid workers with disabilities for more than 20 years.

Medicaid Buy-in Programs Today

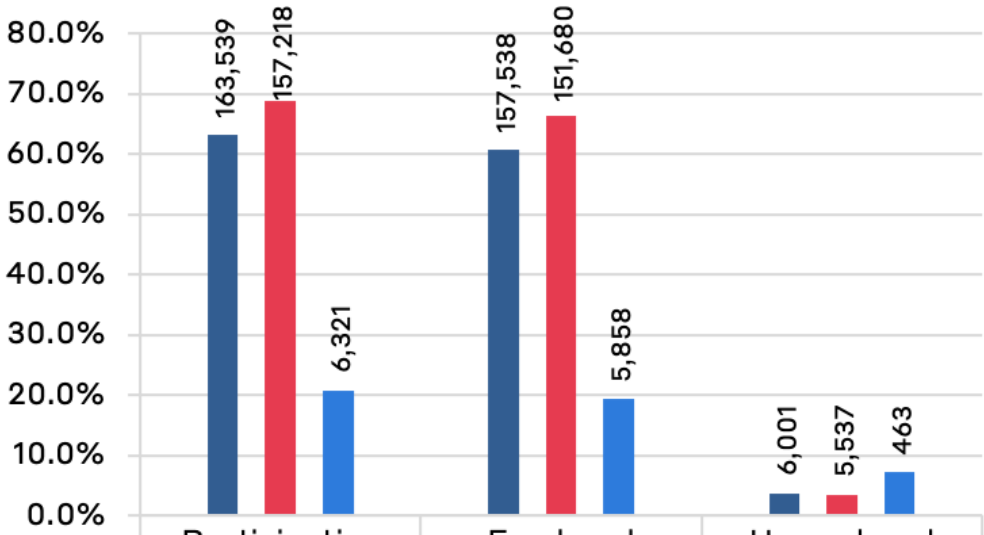
Nationally, 46 states have Medicaid Buy-in programs for working individuals with disabilities.[xxxiii] These states have allowed individuals with disabilities to live and work independently in their communities, resulting in increased earnings, savings, and career opportunities. At the same time, studies demonstrate that Medicaid Buy-in participants have better health outcomes and have lower Medicaid utilization rates than their non-working peers with disabilities.

Together, BBA and TWWIIA have permitted more than 400,000 individuals with disabilities to work and retain Medicaid coverage over the last decade.[xxxiv]As noted, states may use section 1902(r)(2) to include policies that encourage earnings and employment, as well as savings that promote economic well-being and successful community living. States also have the ability to set premiums or not charge premiums at all.[xxxv]

PROGRAM IMPACT

According to the Administration for Community Living (ACL) the program provides workers with disabilities the opportunity to improve their economic status and well-being, and gives purpose and structure to those who would like to work.[xxxvi] Yet less than half of working-age people with disabilities(30.9%) were employed in 2013. This compares to an employment rate of 74.6% for people without disabilities (see Figures 6.1 and 6.2).[xxxvii] For those who do not have severe disabilities, 68.4% work.[xxxviii] Studies have shown that employers also benefit from hiring workers with disabilities, as demonstrated by increased profits and cost-effectiveness, higher employee retention, increased reliability and punctuality, employee loyalty, and improved company image.[xxxix]

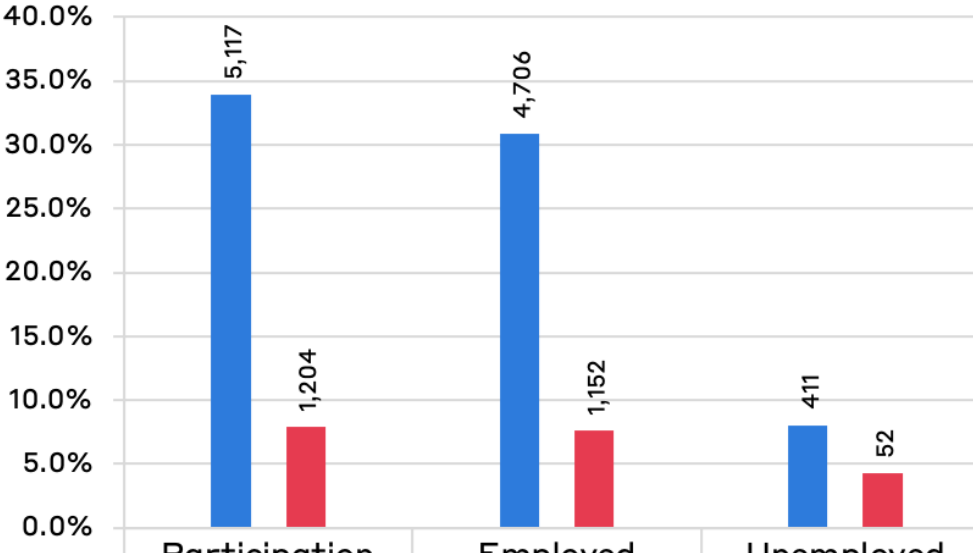
Figure 6.1: Employment Status of Non-disabled and Disabled Workers (2019)[xl] [Numbers in thousands]



	Participation	Employed	Unemployed
Total Population	63.1%	60.8%	3.7%
Persons with no Disability	68.7%	66.3%	3.5%
Persons With a Disability	20.8%	19.3%	7.3%

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

Figure 6.2: Employment Status of Adults With Disabilities Ages 16-64 and 65+ (2019)[xli] [Numbers in thousands]



	Participation	Employed	Unemployed
Persons with a Disability 16-64	33.9%	30.9%	8.0%
Persons with a Disability 65+	7.9%	7.6%	4.3%

Medicaid Buy-in programs have increased opportunities for people with disabilities. As of 2018, 46 states have implemented MBI programs.[xlii] The positive results of MBI programs include increased enrollee income; increased number of hours worked; and a greater opportunity to accrue savings for home purchases, retirement, and other needs. [xliii] An analysis of SSA earnings data by Mathematica Policy Research, Inc. in 2013 determined that an average of 40% of participants increased their wages after enrollment in the MBI.[xliv]

MBI for workers with disabilities have been beneficial to governments, as well. Increased income and hours worked has resulted in increased tax contributions to states and the federal government. Workers with disabilities also have reduced reliance on state and federal programs designed to assist low-income individuals and families, including the Supplemental Nutrition Assistance Program.[xlv] Finally, studies have shown that MBI participants incurred lower annual Medicaid costs than other adult Medicaid enrollees with disabilities.[xlvi]

These programs vary significantly state to state. In developing MBI programs, states make multiple decisions, resulting in significant program differences in key areas, including: the maximum amount

a person can earn and still retain Medicaid coverage, the amount of savings that a person can accrue; and the cost of, or option to, charge a MBI premium.[xlvii]

CHALLENGES

Medicaid Buy-in for workers with disabilities is not well known or understood by states, individuals with disabilities, or front-line staff who assist them. The complex nature of the Medicaid Buy-in programs presents significant challenges to states and to workers. The biggest challenge is the shortage of information available to assist states in making decisions about how to design programs.

Historically, state-determined income and asset limits set low expectations for workers with disabilities, leaving them to choose between health care and work. With better information and leadership, states could make decisions that promote employment for workers with disabilities. Medicaid beneficiaries with disabilities are too often unaware of their state's option for them to work and maintain access to critical community-based services.

According to state officials and advocates, states are not aware of the full range of options available because CMS has not issued comprehensive guidance on those options, nor has the agency codified the group in regulation, either under Section 4733 of BBA or the Section 201 of TWWIA. CMS has not issued regulations for BBA or TWIAA Medicaid Buy-in. Since enactment of these programs, CMS has issued only four guidance documents in the form of State Medicaid Directors' letters from 1997-2000, with no additional guidance for the last 20 years.[xlviii]

During the Obama administration, CMS, ACL, SSA, and the Department of Labor Office of Disability Employment Policy issued information on the options available to states.[xlix,l] However, that information did not include the level of detail necessary to assist states in understanding the full range of options available to states through state plan options and waivers. In an attempt to fill some basic information gaps, ACL, Department of Labor's Office of Disability Employment Policy and CMS released a set of Questions and Answers on Medicaid Buy-in for Workers with disabilities in 2019.[3]

3 HHS Administration for Community Living and DOL Office of Disability and Employment Policy, Medicaid "Buy-in" Q&A, July 2019. Available at: https://www.medicaid.gov/sites/default/files/2019-12/medicaid-buy-in-qa.pdf.

Without comprehensive guidance, states are reluctant to take advantage of the full range of options available, given the risk that the federal government will withhold payment for services deemed not consistent with Medicaid law—known as a Medicaid disallowance. In addition, states often do not have sufficient personnel to conduct appropriate analyses, explore sufficient options, and develop a program that meets the needs of states and citizens. The MBI program for workers with disabilities is also challenging for enrollees to navigate. According to studies, program complexity is a significant barrier faced by current and prospective enrollees. Both anecdotal and statistical survey accounts from state evaluations strongly support a combination of program complexity and poor communication between states, enrollees, and prospective enrollees.[li]

Recommendations

Improving Medicaid Buy-in for workers with disabilities will require both administrative and legislative action. In the near-term, providing additional agency guidance on the combined authorities—Section 4733 of BBA '97 and Section 201 of TWWIIA—and issuing regulations on the two programs will help clarify the range of flexibility available to states. Over the long-term, Congress should enact legislation to combine authorities to streamline and simplify the programs. Specific recommended actions include:

I. Issue an Executive Order That Clarifies and Simplifies the Current Medicaid Buy-in for Workers With Disabilities

A. Direct the Department of Health and Human Services Centers for Medicare & Medicaid Services to issue agency guidance identifying the full range of authority available to states to design, improve, and expand MBI programs for workers with disabilities. Note: The incoming Biden administration has also identified enhanced Social Security work incentives, MBI, and improving competitive integrated employment for people with disabilities. While BPC has yet to take a formal position on those issues, addressing them through a combined Executive Order would underscore the president's commitment to expanding opportunities for workers with disabilities.

B. Instruct the Centers for Medicare & Medicaid to change the name "Medicaid Buy-in" to "Medicaid for Workers with Disabilities." Note: The term "Medicaid Buy-in" has been applied more broadly across the Medicaid program in recent years. This has caused confusion and the need for more precise language when referring to Medicaid benefits provided to workers with disabilities.

II. Issue Regulations on Medicaid Buy-in Programs

While CMS released informal agency guidance between 1997 and 2000, no regulations have been issued, nor has there been additional guidance in the last 20 years.

A. **HHS/CMS should issue a Notice of Proposed Rule Making (NPRM) to give the agency the opportunity to address topics not addressed through informal agency guidance.** Examples include retaining Medicaid when a beneficiary experiences a medical leave from work, increasing eligibility age beyond age 65 to conform with the Social Security retirement age of 67, treatment of assets after enrollment, or more controversial issues, such as how work is defined. This process would solicit input from consumer organizations, states and other experts, and require HHS to address relevant comments or questions arising from the NPRM, providing further clarification to help guide states.

III. Develop and Pass Legislation

While it is possible to formulate MBI programs for the working disabled by combining multiple statutory authorities with waivers, it should be easier for states to implement these programs.

A. **Congress should enact legislation to update, consolidate, and streamline existing authorities into a single state option.** This option should permit states to offer the full range of Medicaid benefits, a subset of Medicaid benefits designed to supplement employer-sponsored insurance, or other private health insurance coverage.

B. **Congress should reauthorize and appropriate funding to states to assist in the development of programs and to draw from other states to learn and convey best practices in promoting successful MBI options.** This would include reauthorization of TWWIIA-funded Medicaid Infrastructure Grants to promote outreach and education about the MBI and successful employment outcomes for people with disabilities. The program should convene stakeholders to address barriers to earnings and employment experienced by people with disabilities, who often rely on HCBS to allow them to work. Services include addressing transportation barriers, skills training, and employer outreach.

Conclusion

With executive action, issuing guidance in the short-term, and regulations in the mid-term, permanent enhancements could improve employment outcomes for workers with disabilities and their access to the American dream. CMS should have the opportunity to clarify current law and provide opportunities for states, advocates, and other experts to comment on proposed regulations to help improve opportunities for working individuals with disabilities. Changing the characterization of the program as an MBI at the federal level to Medicaid for Workers with Disabilities will help clarify the group and mitigate confusion with unrelated groups utilizing the "Medicaid Buy-in" descriptor. These recommendations would support increasing the number of states with MBI for workers with disabilities and support more earning-friendly policies and programs inclusive of workers with disabilities of all ages. Over the longer-term, legislation to streamline and simplify Medicaid for Workers with Disabilities would address program complexities, including being inclusive of workers 65 and older and encouraging states to provide further opportunities for working people with disabilities.

Appendix I – State Spending on Medicaid Beneficiaries

Figure 7: Medicaid Per Capita Expenditure Estimates by State Based on Enrollment Group (2018)[lii]

State	Per Capita Average	Children	Adult: Non-expansion, Non-disabled, Under Age 65	Aged	People with Disabilities	Adult: ACA Medicaid Expansion
Alabama	$5,328	$1,914	$2,110	$12,867	$11,375	-
Alaska	$10,019	$6,066	$7,119	$23,047	$32,615	$8,787
Arizona	$6,258	$3,171	$4,227	$9,590	$20,939	$6,165
Arkansas	$7,186	$4,894	$3,818	$22,083	$18,411	$1,410
California	$6,449	$2,789	$2,812	$14,548	$23,462	$5,545
Colorado	$7,475	$2,982	$4,779	$22,929	$28,453	$5,162
Connecticut	$8,890	$3,715	$5,446	$18,012	$30,321	$6,917
Delaware	$9,315	$4,603	$8,645	$21,703	$22,799	$7,476
District of Columbia	$11,031	$4,732	$6,172	$23,780	$31,193	$6,428
Florida	$5,601	$2,072	$2,721	$14,242	$12,566	-
Georgia	$5,356	$2,807	$4,905	$10,333	$10,772	-
Hawaii	$6,436	$2,997	$4,558	$13,383	$22,397	$5,630
Idaho	$7,349	$2,743	$6,771	$14,468	$19,424	-
Illinois	$6,562	$2,532	$5,586	$17,879	$18,274	$4,027
Indiana	$8,605	$4,096	$7,268	$12,344	$12,321	$12,679
Iowa	$8,355	$3,060	$6,920	$23,217	$23,665	$5,986
Kansas	$8,999	$2,137	$4,109	$27,765	$23,633	-
Kentucky	$6,813	$3,637	$6,597	$10,383	$11,986	$6,629
Louisiana	$6,523	$3,531	$6,187	$10,869	$12,086	$6,326
Maine	$10,673	$4,505	$4,520	$14,031	$21,439	$5,038
Maryland	$9,132	$3,699	$7,404	$19,733	$24,653	$8,434
Massachusetts	$10,386	$3,915	$4,006	$25,688	$20,180	$6,381
Michigan	$6,922	$2,787	$4,909	$19,257	$15,912	$5,797
Minnesota	$11,591	$3,172	$5,580	$39,148	$47,050	$7,329
Mississippi	$7,556	$4,053	$5,212	$13,486	$12,859	-
Missouri	$9,410	$4,248	$6,129	$20,207	$24,244	-
Montana	$7,175	$4,380	$5,661	$19,223	$15,672	$6,341

Nebraska	$11,360	$5,580	$8,355	$30,973	$23,327	-
Nevada	$5,854	$2,882	$5,718	$8,472	$14,277	$6,673
New Hampshire	$9,905	$4,007	$6,183	$24,451	$21,609	$9,355
New Jersey	$9,420	$3,196	$8,028	$24,595	$31,284	$6,103
New Mexico	$6,381	$3,757	$3,693	$10,706	$22,184	$5,637
New York	$11,831	$3,838	$7,091	$29,530	$32,447	$7,394
North Carolina	$6,565	$2,873	$2,716	$15,177	$17,776	-
North Dakota	$14,387	$6,847	$6,931	$64,964	$54,325	$828
Ohio	$8,248	$3,510	$6,025	$21,536	$16,909	$7,422
Oklahoma	$6,940	$3,934	$4,430	$14,900	$16,379	-
Oregon	$10,920	$6,604	$11,921	$25,176	$23,040	$11,581
Pennsylvania	$11,654	$3,356	$5,774	$37,702	$25,852	$3,757
Puerto Rico	$1,807	$2,108	$2,162	$726	$955	$2,281
Rhode Island	$7,928	$3,482	$5,254	$18,272	$15,406	$6,711
South Carolina	$4,983	$2,839	$2,936	$10,742	$13,318	-
South Dakota	$8,286	$3,256	$6,228	$18,188	$20,464	-
Tennessee	$6,509	$3,376	$4,659	$14,473	$14,124	-
Texas	$9,247	$3,885	$7,108	$27,168	$27,600	-
Utah	$9,566	$4,151	$7,608	$21,147	$28,619	-
Vermont	$9,305	$6,241	$5,728	$14,828	$12,450	-
Virginia	$8,219	$3,140	$4,074	$19,671	$21,323	-
Virgin Islands	$3,848	$3,000	$3,849	$3,019	$7,476	$3,823
Washington	$6,934	$2,724	$6,876	$19,748	$20,076	$5,928
West Virginia	$7,232	$2,869	$4,698	$23,013	$13,983	$5,080
Wisconsin	$8,126	$2,792	$4,013	$16,037	$22,940	-
Wyoming	$8,790	$3,735	$6,192	$20,571	$22,683	-
Min	$1,807	$1,914	$2,110	$726	$955	$828
Median	$8,106	$3,646	$5,517	$19,434	$20,934	$6,208
Max	$14,387	$6,847	$11,921	$64,964	$54,325	$12,679
Total	$429,640	$193,219	$292,421	$1,030,000	$1,109,527	$211,060

Note: These estimates include total spending reported by states to the Medicaid Budget and Expenditure System and the number of enrollees and their expenditures reported by states in the Transformed Medicaid Statistical Information System but exclude all CHIP spending and enrollment information.

The accuracy of the numbers presented here is directly related to the accuracy of state-reported data. States are assigned one of three data usability assessments to evaluate the usability of each state's data to produce the per capita expenditure estimates: high level of data usability, moderate level of data usability, and low level of data usability.

Appendix II – Medicaid Eligibility Pathways for Individuals With Disabilities

Figure 8.1: Mandatory Medicaid Eligibility Pathways for Older Adults and Individuals With Disabilities[liii]

Group	Eligibility Pathway	Description	Eligibility Age(s)
Current SSI	SSI Recipients in 1634 States or SSI Criteria States	Aged, blind, or disabled individuals receiving SSI who live in states that use SSI criteria to determine Medicaid eligibility	Children under age 18; other individuals aged 18 and older
	SSI Recipients and Other ABD Individuals in 209(b) States	Aged, blind, or disabled individuals (including SSI recipients) who live in states that use criteria more restrictive than SSI criteria to determine Medicaid eligibility	Children under age 18; other individuals aged 18 and older
	Individuals Receiving Mandatory SSPs (closed to new enrollment)	Aged, blind, or disabled individuals receiving mandatory SSPs under Section 212 of P.L. 93-66 due to the implementation of SSI in January 1974	Individuals who were aged 18 and older in December 1973
	Individuals with Earnings Above Certain Limits	- 1619(a) status: Disabled individuals who receive special SSI payments because their earnings exceed the substantial gainful activity (SGA) standard - 1619(b) status: Blind or disabled individuals with income above the SSI income standard but are deemed to receive SSI because they need Medicaid to continue working	Children under age 18; other individuals aged 18 and older

Special Groups of Former SSI	Recipients of Social Security COLAs After April 1977 ("Pickle Amendment")	Aged, blind, or disabled individuals who would continue to be eligible for SSI/SSP if not for increases in their Social Security benefits due to cost-of-living adjustments (COLAs) applied after April 1977	Children under age 18; other individuals aged 18 and older
	Disabled Widow(er)s Receiving Benefit Increases under P.L. 98-21, or "ARF Widow[er]s" (closed to new enrollment)	Blind or disabled individuals who (1) have been continuously entitled to Social Security disabled widow(er)'s benefits since January 1984, (2) would continue to be eligible for SSI/SSP, except for increases in their disabled widow(er)'s benefits due to the elimination of the additional reduction factor (ARF) under P.L. 98-21, and (3) applied for Medicaid continuation generally before July 1, 1988	Individuals who were at least aged 50 in April 1983
	Disabled Adult Children	Blind or disabled individuals who (1) receive Social Security child's benefits due to a disability that began before age 22 and (2) would continue to be eligible for SSI/SSP if not for entitlement to (or an increase in) their Social Security benefits on or after July 1, 1987	Individuals aged 18 and older
	Widow(er)s Not Entitled to Medicare Part A ("Early Widow[er]s")	Blind or disabled individuals who (1) receive Social Security widow(er)'s benefits due to age or disability, (2) would continue to be eligible for SSI/SSP if not for their Social Security benefits, and (3) are not yet entitled to Medicare Part A	Individuals aged 50 to 64
	Recipients of a 1972 Social Security COLA (closed to new enrollment)	Aged, blind, or disabled individuals who (1) were entitled to Social Security in August 1972, (2) received cash assistance under a state plan for such month or would have been eligible for such assistance in certain instances, and (3) would be eligible for SSI/SSP if not for an increase in their Social Security benefits due to a COLA enacted under P.L. 92-336	Individuals of any age who were entitled to Social Security in August 1972
Other SSI-Related Groups	Grandfathered 1973 Medicaid Recipients (closed to new enrollment)	Essential spouses, institutionalized individuals, and blind or disabled individuals who were eligible for Medicaid in December 1973 and continue to meet the eligibility requirements in effect for that month	Individuals who were at least aged 18 in December 1973
	Individuals Who Would Be Eligible for SSI/SSP if Not for Criteria Prohibited by Medicaid	Aged, blind, or disabled individuals who would be eligible for SSI/SSP if not for an eligibility requirement used in those programs that is prohibited by Medicaid	Children under age 18; other individuals aged 18 and older

Figure 8.2: Optional Medicaid Eligibility Pathways for Older Adults and Individuals With Disabilities[liv]

Group	Eligibility Pathway	Description	Eligibility Age(s)
Current SSI Recipients	Individuals Eligible for Only Optional SSPs	Aged, blind, or disabled individuals receiving only optional SSPs because their income is at least equal to the SSI income standard but less than the SSP income standard	Children under age 18; other individuals aged 18 and older
Other SSI-Related Groups	Individuals Who Are Eligible for but Not Receiving SSI/SSP	Aged, blind, or disabled individuals who meet the financial eligibility criteria for SSI/SSP but are not receiving such benefits	Children under age 18; other individuals aged 18 and older
	Individuals Who Would Be Eligible for SSI/SSP if They Were Not Institutionalized	Aged, blind, or disabled individuals who are ineligible for SSI/SSP because of the lower income standards used to determine eligibility for institutionalized individuals but would be eligible for SSI/SSP if they were not institutionalized	Children under age 18; other individuals aged 18 and older
Poverty-Related ABD	Individuals Who Have Income Up to 100% of the FPL	Aged or disabled individuals who have family income at or below 100% of the FPL	Any age
Special Income Level ABD	Individuals in Institutions under a Special Income Level	Individuals who require care in a medical institution (e.g., nursing facility) for no less than 30 consecutive days and whose income does not exceed 300% of the SSI federal benefit rate (FBR)	Any age
Special Home and Community-Based Services Waiver Group	Individuals Receiving HCBS Under Institutional Rules	Individuals receiving HCBS waiver services who have an institutional level-of-care need and would be eligible for Medicaid if institutionalized	Any age
Home and Community-Based Services State Plan	Individuals Receiving State Plan HCBS	Individuals who are not otherwise eligible for Medicaid and are eligible for and will receive services through a state's approved §1915(i) HCBS state plan option	Any age (may be targeted toward certain populations)
Katie Beckett	Katie Beckett Waiver	Children with disabilities who have an institutional level-of-care need and would be eligible for Medicaid if they were in a medical institution	Children under age 19

Buy-in Groups	Balanced Budget Act of 1997 (BBA 97) Group	Blind or disabled individuals who (1) have earned income; (2) are in families whose incomes are less than 250% of the FPL; and (3) would be considered to receive SSI, if not for their earnings	Any age
	Ticket to Work (TWWIIA) Basic Eligibility Group	Blind or disabled individuals who (1) have earned income and (2) would be considered to receive SSI, if not for their earnings	Children aged 16 to 18; other individuals aged 19 to 64
	Ticket to Work (TWWIIA) Medical Improvement Group	Individuals who have earned income and lose eligibility under the TWWIIA Basic group, due to an improvement in their medical condition such that they are no longer considered to have a disability	Children aged 16 to18; other individuals aged 19 to 64
	Family Opportunity Act (FOA)	Children with disabilities whose family income is up to 300% of the FPL	Children under age 19
Medically Needy	Medically Needy	- Children, adults, and aged blind or disabled individuals who are otherwise eligible for Medicaid but whose incomes are too high to qualify as categorically needy - Medically Needy blind or disabled individuals eligible in 1973	Children under age 18; other individuals, any age

Endnotes

i Kaiser Family Foundation, Medicaid Eligibility through Buy-In Programs for Working People with Disabilities October 3, 2019. Available at: https://www.kff.org/other/state-indicator/medicaideligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0.

ii Denise Hoffman, Kristin Andrews, and Valerie Cheh, "Characteristics and Service Use of Medicaid Buy-In Participants with Higher Incomes: A Descriptive Analysis," May 31. 2013. Available at: https://www.mathematica.org/our-publications-and-findings/publications/characteristics-and-service-use-of-medicaid-buyin-participants-with-higher-incomes-a-descriptive-analysis

iii U.S. Bureau of Labor Statistics, Table 1. Employment status of the civilian noninstitutional population by disability status and selected characteristics, 2019 annual averages, February 26, 2020. Available at: https://www.bls.gov/news.release/disabl.t01.html

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

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

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

vii Ibid.

viii U.S. Department of Health and Human Services, FY 2021 - CMS Congressional Justification for Estimates for Appropriations Committees, 95. Available at: https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/FY2021-CJ-Final.pdf.

ix Congressional Budget Office, Medicaid—CBO's Baseline as of March 6, 2020, 2. Available at: https://www.cbo.gov/system/files/2020-03/51301-2020-03-medicaid.pdf.

x Kaiser Family Foundation, COVID-19: Expected Implications for Medicaid and State Budgets, April 2020. Available at: https://www.kff.org/coronavirus-policy-watch/covid-19-expected-implications-medicaid-state-budgets/.

xi BPC Analysis Centers for Medicare & Medicaid Services, NHE Projections 2019-2028 - Tables (ZIP), Table 03 National Health Expenditures by Source of Funds. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

xii Centers for Medicare & Medicaid Services, Medicaid Per Capita Expenditures, October 2020. Available at: https://www.medicaid.gov/state-overviews/scorecard/how-much-states-spend-per-medicaid-enrollee/index.html.

xiii Centers for Medicare & Medicaid Services, Home and Community Based Services 1915(c). Available at: https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html.

xiv Centers for Medicare & Medicaid Services, Home and Community Based Services 1915(i). Available at: https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915i/index.html.

xv Centers for Medicare & Medicaid Services, Community First Choice (CFC) 1915 (k). Available at: https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/community-first-choice-cfc-1915-k/index.html.

xvi U.S. Department of Health and Human Services, 2015 CMS Statistics, December 2015. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/2015CMSStatistics.pdf.

xvii Centers for Medicare & Medicaid Services, Health Care Experiences of Adults with Disabilities Enrolled in Medicaid Only: Findings From a 2014 – 2015 Nationwide Survey of Medicaid Beneficiaries, November 2017. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/namcahpsdisabilitybrief.pdf.

xviii Medicaid and CHIP Payment and Access Commission, People with Disabilities, March 3, 2020. Available at: https://www.macpac.gov/subtopic/people-with-disabilities/.

xix Ibid.

xx Social Security Administration, Supplemental Security Income (SSI) Eligibility Requirements, 2020. Available at: https://www.ssa.gov/ssi/text-eligibility-ussi.htm.

xxi Social Security Administration, Supplemental Security Income (SSI) Eligibility Requirements, 2020. Available at: https://www.ssa.gov/ssi/text-eligibility-ussi.htm.

xxii U.S. Department of Health and Human Services, Using Medicaid to Support Working Age Adults with Serious Mental Illnesses in the Community: A Handbook, January 2005. Available at: https://aspe.hhs.gov/system/files/pdf/74111/handbook.pdf.

xxiii Congressional Research Service, based on the following sources: Title XVI of the Social Security Act; Social Security Administration, SSI Federal Payment Amounts. Available at: https://www.ssa.gov/oact/cola/SSIamts.html; and U.S. Department of Health and Human Services (HHS), Poverty Guidelines. Available at: https://aspe.hhs.gov/poverty- guidelines.

xxiv Medicaid and CHIP Payment and Access Commission, People with disabilities, 2017. Available at: https://www.macpac.gov/subtopic/people-with-disabilities/.

xxv Medicaid and CHIP Payment and Access Commission, People with disabilities, 2017. Available at: https://www.macpac.gov/subtopic/people-with-disabilities/.

xxvi Allen Jensen, Robert Silverstein, Donna Folkemer, and Tara Straw, Policy Frameworks for Designing Medicaid Buy-In Programs and Related State Work Incentive Initiatives: Executive Summary, U.S. Department of Health and Human Services, May 2002. Available at: https://aspe.hhs.gov/execsum/policy-frameworks-designing-medicaid-buy-programs-and-related-state-work-incentive-initiatives.

xxvii Social Security Administration, Disability Evaluation under Social Security. Available at: https://www.ssa.gov/disability/professionals/bluebook/general-info.htm.

xxviii Ibid.

xxix Social Security Administration, Annual Statistical Supplement, 2019: Highlights and Trends, 2020. Available at: https://www.ssa.gov/policy/docs/statcomps/supplement/2019/highlights.html.

xxx Section 4733 of the Balanced Budget Act of 1997, P.L. 105-33.

xxxi Section 201 of the Ticket to Work and Work Incentive Improvement Act of 1999, P.L. 106-170.

xxxii Center for Medicaid and Medicare Services, Olmstead Update No. 5: New Tools for States, January 10, 2001. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd011001b.pdf.

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

xxxiv Administration for Community Living, "Medicaid Buy-in Opens Doors to Employment for People with Disabilities," October 29, 2014. Available at: https://acl.gov/news-and-events/acl-blog/medicaid-buy-opens-doors-employment-people-disabilities.

xxxv Allen Jensen, Robert Silverstein, Donna Folkemer, and Tara Straw, Policy Frameworks for Designing Medicaid Buy-in Programs and Related State Work Incentive Initiatives, U.S. Department of Health and Human Services, May 2002. Available at: https://aspe.hhs.gov/basic-report/policy-frameworks-designing-medicaid-buy-programs-and-related-state-work-incentive-initiatives.

xxxvi Administration for Community Living, "Medicaid Buy-in Opens Doors to Employment for People with Disabilities," October 29, 2014. Available at: https://acl.gov/news-and-events/acl-blog/medicaid-buy-opens-doors-employment-people-disabilities.

xxxvii U.S. Bureau of Labor Statistics, Table 1. Employment status of the civilian noninstitutional population by disability status and selected characteristics, 2019 annual averages, February 26, 2020. Available at: https://www.bls.gov/news.release/disabl.t01.htm

xxxviii Ibid.

xxxix Sally Lindsay, Elaine Cagliostro, Mikhaela Albarico, Neda Mortaji, and Leora Karon, "A Systematic Review of the Benefits of Hiring People with Disabilities," Journal of Occupational Rehabilitation 28, no. 4 (2018): 634–55. Available at: https://doi.org/10.1007/s10926-018-9756-z.

xl U.S. Bureau of Labor Statistics, Table 1. Employment status of the civilian noninstitutional population by disability status and selected characteristics, 2019 annual averages, February 26, 2020. Available at: https://www.bls.gov/news.release/disabl.t01.htm.

xli Ibid.

xlii Kaiser Family Foundation, Medicaid Eligibility through Buy-in Programs for Working People with Disabilities, June 2019. Available at: https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22-

sort%22:%22asc%22%7D.

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

xliv Denise Hoffman, Kristin Andrews, and Valerie Cheh, "Characteristics and Service Use of Medicaid Buy-In Participants with Higher Incomes: A Descriptive Analysis," May 31. 2013. Available at: https://www.mathematica.org/our-publications-and-findings/publications/characteristics-and-service-use-of-medicaid-buyin-participants-with-higher-incomes-a-descriptive-analysis

xlv Ibid.

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

xlvii Kaiser Family Foundation, Medicaid Eligibility through Buy-in Programs for Working People with Disabilities, June 2019. Available at: https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-withffffgessegsgedisabilities/?currentTimeframe=0&sortModel=%7B%22colId%22:%22location%22,%22sort%22:%22asc%22%7D.

xlviii Center for Medicare & Medicaid Services: Sally K. Richardson to State Medicaid Director, November 24, 1997. Available at: www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD112497.pdf; Sally K. Richardson to State Medicaid Director, March 9, 1998. Available at: www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD030998.pdf; Timothy M. Westmoreland to State Medicaid Director, March 29, 2000. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd032900.pdf; Timothy M. Westmoreland to State Medicaid Director, August 29, 2000. Available at: https://www.medicaid.gov/Federal-Policy-Guidance/downloads/smd082900.pdf.

xlix Administration for Community Living, "Medicaid Buy-in Opens Doors to Employment for People with Disabilities," October 29, 2014. Available at: https://acl.gov/news-and-events/acl-blog/medicaid-buy-opens-doors-employment-people-disabilities.

l Social Security Administration, "Welcome to the Ticket to Work Program!". Available at: https://www.ssa.gov/work/.

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

lii Centers for Medicare & Medicaid Services, Medicaid Per Capita Expenditures, October 2020. Available at: https://www.medicaid.gov/state-overviews/scorecard/how-much-states-spend-per-medicaid-enrollee/index.html.

liii Congressional Research Service analysis of the Social Security Act; U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), List of Medicaid Eligibility Groups, February 2018. Available at: https://crsreports.congress.gov/product/pdf/R/R46111.

liv Ibid.

Bipartisan Policy Center

1225 Eye Street NW, Suite 1000
Washington, D.C. 20005

IDEAS. ACTION. RESULTS.