

Using Medicaid Funding to Support the Employment of People with Disabilities: A Federal Framework

State Medicaid agencies fund a multitude of supports and services for individuals with disabilities. As national public policy has recognized and emphasized the ability of individuals with disabilities to work, states have begun to integrate employment supports into the continuum of long-term care in Medicaid. This brief discusses the federal legislative and regulatory framework for funding employment supports in Medicaid, and highlights examples of state innovations and best practices for using Medicaid to promote positive employment outcomes.

Introduction

Medicaid was established in 1965 under the federal Social Security Act as a health insurance program for the nation's poor. Medicaid was designed to provide coverage for low-income families, people with disabilities, and the elderly. As such, it covers a wide array of acute care services, including physicians, emergency rooms, and prescription drugs. Additionally, Medicaid pays for long-term care, such as nursing home care or personal care services at home or in the community. Over the past 45 years, Medicaid has added new eligible populations, including some employed individuals, and new services. Today, the Medicaid program provides health insurance to more than 59 million low-income children, adults, elderly, and individuals with disabilities annually.¹ In 2007, state and federal spending on Medicaid exceeded \$330 billion. During that time period, although three quarters of Medicaid enrollees were adults or children, individuals with disabilities and the elderly accounted for nearly 70% of the program's expenditures. In aggregate, Medicaid accounted for nearly 15% of the nation's overall health care spending and over 40% of total long-term care spending during 2006.²

Medicaid policy is authorized by the federal government, but is established and administered by individual states. The federal government, through the Centers for Medicare and Medicaid Services (CMS), establishes Medicaid's overarching policy framework. States, however, have significant flexibility when defining eligibility, benefits, and payments for services.³ When a state administers Medicaid, there are some medical services that must be covered, and some medical services that states have the option to cover. Table 1 provides examples of mandatory and optional Medicaid-covered services. Similarly, there are some groups of individuals that the state must include in Medicaid, and some groups of individuals that each state can choose to include. Mandatory groups include categories such as low-income children and some people with disabilities; optional categories include groups such as working adults with disabilities and certain targeted low-income children.

All of the services provided as part of each state's Medicaid program are included in a "Medicaid state plan." Each state submits a state plan to CMS that outlines the mandatory and optional services provided and populations covered through the state's Medicaid program. When an individual accesses these Medicaid benefits, it is often called using state plan services.

Table 1. Medicaid Mandatory and Optional Services

Examples of Medicaid Mandatory Services	Examples of Medicaid Optional Services
Hospital Services, X-Ray	Outpatient Pharmaceuticals
Physician, Nurse Practitioner, Nurse Midwife	Vision, Dental
Nursing Facility	Home- and Community-based Long-term Care
Clinic, Lab	Rehabilitation, Case Management
Federally Qualified Health Center	
Early, Periodic Screening, Diagnosis, and Treatment for Individuals Less than 21 Years of Age	

States are not required to establish a Medicaid program; however, every state has participated in Medicaid since 1982.⁴ Once a state establishes a Medicaid program that fulfills federal requirements, CMS matches state expenditures for medical services based on a specific rate that is calculated individually for each state. The amount of available matching funds is uncapped; states can continue to receive federal matching for Medicaid services regardless of overall expenditure levels.⁵

In addition to Medicaid, states also operate a health insurance program for children called the Children's Health Insurance Program (CHIP). CHIP was designed to support children in households that do not qualify for Medicaid, but that require assistance to obtain medical coverage. CHIP is similar to Medicaid in many ways, including the federal- and state-shared policy and financing structure; however, it is not an open-ended entitlement. Each state has an annual allocation of federal funds for the program. When that allocation is reached, states must either discontinue spending on the program or finance services with 100% state funds. Additionally, many states construct a benefits package within CHIP that is less comprehensive than Medicaid.⁶ Due to the target population of CHIP, as well as the construction of benefits packages, Medicaid remains the primary public coverage option for individuals with disabilities and other significant health needs.

With the passage of national health reform legislation in 2010 through the *Patient Protection and Affordable Care Act* (P.L. 111-148) and the *Health Care and Education Reconciliation Act* (P.L. 111-152), Medicaid will continue to provide a significant portion of health care coverage to a broad range of individuals throughout the nation. According to the Congressional Budget Office, under the provisions of health reform, approximately 16 million additional individuals will receive coverage through either Medicaid or CHIP.⁷ Although the 2010 federal legislation contains significant expansions to Medicaid eligibility, the service package provided to individuals who become eligible due to the 2010 health reform laws will be different from existing Medicaid groups. As of the writing of this brief, many of the technical details regarding the scope of services that are likely to be included within the Medicaid expansion are awaiting regulation and policy clarifications from the U.S. Department of Health and Human Services.⁸ Detailed information about the services for newly eligible individuals will not be available until the regulations are promulgated.

Medicaid Eligibility Requirements

Medicaid is a means-tested program that is targeted to low-income individuals and individuals with chronic disabilities. Eligibility is determined by both categorical and financial considerations. Categorical requirements mean that an individual must fall into a certain defined population, such as individuals with disabilities, children, or parents. Financial requirements are measured through the income and resources of the individual. Income includes money that a person receives from sources such as his or her work, Social Security benefits, gifts, child support payments, and other places. Resources include bank accounts, cash, stocks, land, and other things that either are worth money or can be quickly sold for money. Resources do not include the home the individual lives in or one's vehicle.

Twenty-five mandatory categorical eligibility groups have been established through Section 1902 of the Social Security Act. Examples of mandatory eligibility groups include children age 6 to 18 up to 100% of the Federal Poverty Level (FPL),⁹ children age 0 to 5 up to 133% FPL, pregnant women up to 133% FPL, Supplemental Security Income recipients, and low-income Medicare beneficiaries, to name a few.¹⁰ In addition to these mandatory categorical eligibility groups, the Social Security Act includes over 25 optional eligibility groups that states may choose to include in their programs.¹¹ Two optional eligibility groups have particular relevance for individuals with income above the mandatory Medicaid limits:

1. *Adults with Disabilities who are Employed (Buy-In Option)*. There are three optional categorical eligibility groups that allow adults with disabilities, who are employed, to buy into Medicaid. Under these groups, states may allow workers with disabilities to pay a premium in order to access Medicaid if they have earnings that are too high to qualify for basic Medicaid. To be eligible, an individual must meet the definition of "disabled" under the Social Security Act, must be employed, and must fall under the income and asset limits established by each individual state. If the person does not have a disability determination from the Social Security Administration, the state determines if the individual has a disability using Social Security's criteria.¹² As of 2010, 44 states have established a Medicaid Buy-In program and 2 states have legislative authority to enact a Buy-In program. Prior to the inception of state-administered Buy-In programs, individuals with disabilities would risk losing Medicaid coverage if their earnings were too high. However, with a Buy-In program, people with disabilities can earn enough money to become self-sufficient, and retain necessary medical benefits, such as home health care, that may not be provided through private insurance.¹³
2. *Medically Needy*. States also have the option to have a medically needy program. This option allows states to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. Generally speaking, these individuals have high medical bills. This optional group allows individuals to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the medically needy income standard allowed by that state's Medicaid program.

States may also allow individuals or families to establish eligibility as medically needy by paying the state the amount of their spend-down obligation. This amount is equal to the difference between the individual's or family's income (reduced by unpaid expenses, if any, incurred for medical care) and the state's medically needy income standard. This option is called pay-in-spend-down.

Eligibility for the medically needy program does not have to be as extensive as the categorically needy program. However, states that elect to cover the medically needy under their state Medicaid plan are required to include certain children under age 18 and pregnant women who, except for income, would be eligible as categorically needy.

States may choose to provide coverage to other individuals under their medically needy programs: for example, aged, blind and/or disabled persons, children, and the parents or caretaker relatives of children. Currently, 35 states have medically needy programs. However, Texas does not cover aged, blind, or disabled individuals as medically needy.

Health Benefits Available Under Medicaid

State Medicaid programs have flexibility when determining what medical services to provide. States are required to provide some services through Medicaid, and can elect to provide other types of services. When individuals are in Medicaid, they can receive any of the mandatory as well as optional medical services covered by their particular state's Medicaid program. For a Medicaid-eligible person to receive medical services, a doctor or other health care provider must decide that the service is "medically necessary." Medically necessary means that the services are needed to diagnose or to treat the individual's disease or injury. Medical necessity does not mean that people are entitled to an unlimited amount of medical services. States can choose to put limits on the care that Medicaid-eligible residents can receive.¹⁴ For example, states can make rules so that people in Medicaid-financed health care cannot stay in a hospital for more than a certain number of days each year.

In addition to mandatory medical services, every state offers some optional services (such as prescription drugs) while other services are less common (such as dental care). Optional benefits that are included in a state's Medicaid program under state discretion include many services commonly used to support individuals with disabilities, including physical and psychosocial rehabilitation, case management, and personal care in the home.¹⁵

The Louisiana Medicaid Buy-In Program

The Louisiana Medicaid Purchase Plan allows eligible Louisiana residents with a disability to earn up to 250% of the Federal Poverty Level and to save up to \$25,000 in assets. In addition to the \$25,000 asset limit, individuals can deposit money in retirement accounts and savings accounts for medical services and devices. Individuals in the program must be between the ages of 16 and 64, and must be actively employed to participate. Upon enrollment in the program, individuals must pay a monthly premium that ranges up to \$110 and is based upon the person's countable income.

When individuals access the Medicaid Purchase Plan, they receive the standard Louisiana Medicaid benefits package. This includes services such as personal care, home health care, mental health rehabilitation, and prescription drugs.¹⁶

To learn more about the Louisiana Medicaid Purchase Plan, visit: <http://new.dhh.louisiana.gov/index.cfm/page/228>.

Medicaid Waivers

Waivers are a mechanism for states and the federal government to alter the rules of Medicaid in order to deliver services in more flexible ways. A waiver is developed by the state within federal guidelines, and then approved by CMS. When applying for a waiver, states must prove that the cost to the federal government will be less than or equal to the projected cost of operating without the waiver.¹⁷ There are three kinds of waivers that states commonly request and implement:

1. *Research and Demonstration Waivers (also known as 1115 waivers)* provide a broad authority for states to alter their Medicaid programs. These waivers can be used to expand eligibility, alter the types of services provided, or change the way that medical services are delivered. For example, Oklahoma used a Research and Demonstration waiver to expand eligibility for a number of individuals, including workers with disabilities who cannot access employer-sponsored care.¹⁸
2. *Managed Care/Freedom of Choice Waivers (known as 1915[b] waivers)* allow states to limit which medical providers individuals can see, and allow states to waive the ability of individuals to access services from any Medicaid provider. These waivers are typically used by states to enter into contracts with Health Maintenance Organizations, or to implement various other types of managed care service agreements. States generally use managed care systems as a way to control Medicaid costs.¹⁹
3. *Home and Community-based Services Waivers (1915[c] waivers) or HCBS²⁰* provide long-term care for individuals who would receive institutional care without a waiver. HCBS waivers were created by the *Omnibus Reconciliation Act of 1981* (P.L. 97-35) as a way for states to provide long-term care in the community rather than in institutions. In order for individuals to qualify for HCBS waiver services, they must meet state financial eligibility requirements, and they must also require care in an institution, such as a nursing home, if HCBS were not provided. Services available through HCBS waivers are more comprehensive than those available in standard Medicaid benefits packages. Services that states can choose to include in HCBS waivers include employment-focused supports (through a service known as habilitation), transportation to locations other than medical care, educational supports, and modifications that improve the accessibility of an individual's home. States may establish enrollment caps and waiting lists for HCBS waivers.²¹

One limitation of HCBS waivers is a restricted ability to serve individuals with mental illnesses. Since its inception, Medicaid has been unable to provide institutional care related to mental health diagnoses; this policy is known as the Institutions for Mental Disease (IMD) exclusion. Due to the cost-neutrality requirements of waivers, states cannot use HCBS waiver funds for individuals who meet the institutional level of care requirements due to a mental illness. Community-based medical care for individuals with mental illnesses has historically been furnished primarily through state plan services and not under HCBS waivers. Therefore, many services that can support employment to individuals with mental illnesses are unavailable through the Medicaid program since habilitation services are unavailable through the state plan.²² A recent option known as the 1915(i), however, allows states to provide some HCBS services, including habilitative services, to individuals with disabilities who do not meet the institutional level of care criteria.

Types of Medicaid Waivers

Research and Demonstration Waivers (1115)

Alter the delivery of Medicaid, CHIP, and other programs

Managed Care/Freedom of Choice Waivers (1915[b])

States choose to allow their Medicaid recipients to only receive services from specific providers

Home and Community-based Services Waivers (1915[c])

Provide non-medical support to those who would otherwise be institutionalized (e.g., nursing home facility)

Waivers are optional and states may choose to implement any number of each of these waivers. Most states simultaneously operate several 1915(c) waivers. States have broad flexibility in designing waivers, resulting in variance from one waiver to another. Unlike other Medicaid categories, waivers are not an open-ended entitlement due to cost-neutrality requirements. Services provided through waivers have different requirements than many state plan services, and can provide different benefits packages than are available through the state plan.

Medicaid and Employment Overview

When Medicaid was first established, long-term care was delivered primarily in institutional settings, such as nursing homes and hospitals.²³ Beginning in 1971, intermediate care facilities for individuals with mental retardation were covered by Medicaid as well.²⁴ Institutional care remained the primary way of delivering long-term care until the 1980s, when states began utilizing opportunities to deliver community-based care through HCBS waivers. Through the 1980s, and into the 1990s, HCBS services grew at a slow pace. The growth of HCBS enrollment accelerated in the mid-1990s through the 2000s, partially due to landmark legislation and legal decisions that placed greater emphasis on community integration.²⁵

In 1990, the Americans with Disabilities Act (ADA) was signed into law establishing protections against discrimination for people with disabilities as well as the right for equal access to employment opportunities, transportation, and public services.²⁶ In 1999, the U.S. Supreme Court ruled that the ADA requires states to serve individuals with disabilities in “the most integrated setting appropriate to the needs of qualified individuals with disabilities,” and that unnecessary institutionalization “constitutes a form of discrimination based on disability.”²⁷ Known as the Olmstead decision, this ruling prompted states to increase efforts to move individuals with disabilities from institutions to the community. Experiences with deinstitutionalization efforts have shown that successful community living requires the coordination of a variety of social supports, including programs that support housing availability, educational attainment, and employment.²⁸ Medicaid can support many of these efforts, either directly or indirectly, through a variety of options available to states.

Since the Olmstead decision, CMS has issued a series of issue briefs, guidance letters, and other policy documents to clarify the options available to states when funding long-term care in the community. Additionally, several CMS grant programs, including Medicaid Infrastructure Grants, Real Choice Systems Change Grants, and Money Follows the Person Grants, have provided states with resources to engage in systems change and programmatic development that supports individuals with disabilities in the community. These efforts include the development of services and supports that enable individuals with disabilities to work in the community, as well as establishing relationships with other programs and agencies that provide employment supports.²⁹

When determining the Medicaid funding options available for supporting an individual with a disability in the community, the first distinction that must be made is whether the services will be provided through the state plan or through a waiver. There is a distinction between medical services that also assist with employment activities as a secondary benefit, and services that are primarily intended to assist with employment. Most services that have employment as a specific outcome, such as vocational education, workplace skills training, or assistance with job-related duties, are not available through the state plan. Instead, waivers provide states with the greater opportunity to offer services that specifically support an employment goal or outcome, through what are called habilitation services. CMS defines habilitation as “services designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.”³⁰ Habilitation services are flexible in nature, and can be specifically designed to fund services and supports that assist an individual to obtain or maintain employment. It is important, however, to note that employment services available to an individual through other programs, such as Vocational Rehabilitation, cannot be provided through Medicaid. Therefore, state agencies must coordinate the eligibility and services between HCBS waivers and other agencies.

New York’s Medicaid Infrastructure Grant: Support for Customized Employment Projects

New York State’s Medicaid Infrastructure Grant — New York Makes Work Pay (NYMWP) — is a statewide initiative intended to significantly improve the rate of employment among people with disabilities. One of NYMWP’s strategic goals is to improve the use of promising and evidence-based employment practices. To help achieve this goal, NYMWP has provided support to customized employment demonstration projects in Hempstead and Utica, building on efforts begun under a demonstration funded by the Office of Disability Employment Policy at the U.S. Department of Labor.

Both projects are based upon collaborations among community stakeholders, including the workforce development system, and engage diverse state and local partners. A local Workforce Investment Board or One-Stop Career Center was the lead and convener for both projects. Each project has supported training, technical assistance, and consultation to these projects as well as project coordinators at the sites. These efforts are beginning to foster improvements in the use of customized employment practices within the workforce system and disability services agencies, and greater coordination across agencies. NYMWP aimed to demonstrate the effectiveness of the customized employment model as well as promote the sustainability of the Hempstead and Utica projects. Concurrent with these primarily wage-based customized employment applications, customized employment-based training for entrepreneurship continued to be provided in Syracuse and in Manhattan.

NYMWP was developed as part of a collaborative effort that includes the New York State Office of Mental Health through the Research Foundation for Mental Hygiene, Cornell University and Syracuse University (as management partners), the New York State Department of Health, and organizations that make up the membership of the Governor’s Most Integrated Settings Coordinating Council’s Employment Committee. To learn more, visit <http://www.nymakesworkpay.org/>.

As noted earlier, habilitation is not available through the state plan, except in the 1915(i). Therefore, unless individuals qualify for HCBS waivers, they cannot be provided with services that are specifically intended to facilitate employment outcomes. States, however, can provide medical services, subject to the requirements regarding medical necessity, that also assist an individual achieve employment outcome. In this type of scenario, the care provided is a medical service, but also the assistance with employment is a secondary benefit.³¹ An example would be providing personal care services at an individual's work or job site.

Options for Funding Services that Support Employment through Medicaid

There are several service categories that states can use to finance services to directly and indirectly assist with the employment goals of an individual with disabilities. They include:

Case Management

CMS defines case management as “services which will assist individuals...in gaining access to needed medical, social, educational, and other services.”³² Although case management does not involve the direct provision of these services, it does provide states with an option to ensure that individuals are able to access necessary services from other sources, including those that lead to employment. The provision of case management includes the identification of individuals' needs, the development of a plan to address those needs, assistance with accessing the required services, and ongoing support to ensure that the plan is being implemented and is addressing the identified needs.³³ Case management is an allowable service both for individuals in state plan services and waiver services.

Habilitation

The most prominent way that state Medicaid programs fund employment-focused services is through habilitation services in HCBS waivers. Habilitation services are services that generally cannot be covered through the state plan. One notable exception, the 1915(i), is discussed below. Therefore, in most states, only individuals with disabilities that are significant enough to qualify for institutional care can access these habilitative services. These services have historically been targeted toward individuals with developmental disabilities; however, states can provide these services to any individual or population it includes within a HCBS waiver.³⁴ Habilitation includes a broad variety of services and supports that can enable an individual to obtain or maintain employment; these include:

1. *Educational Supports.* States may pay for educational supports and services that are not available through other programs, such as programs funded through the Individuals with Disabilities Education Act or Vocational Rehabilitation.
2. *Prevocational Supports.* States may pay for services that assist individuals to acquire a skill that is not job-specific, but is needed at the workplace, such as attendance, motor skills, and workplace safety.

3. *Supported Employment.* States may pay for services that assist individuals to acquire or maintain employment. These supports can involve job search activities, training to perform a specific task or duty, and on-the-job assistance. Transportation to and from the worksite can also be included as a component of supported employment services.³⁵
4. *Customized Employment.* One of the recent trends in employment services involves the provision of customized employment. Customized employment is a process wherein individuals go through an extensive planning phase, known as discovery, to identify their goals, desires, and support needs. Upon completion of the planning, individuals use this information to guide their employment searches and negotiate individualized employment relationships with employers.³⁶ Although customized employment is not an explicit and distinct allowable service in Medicaid waivers, the activities that comprise the overall approach can be included as Medicaid services. For example, the discovery phase of the model can be included either as a component of case management through assessment of the individual's needs and development of a plan to access employment supports and services, as a core function of supported employment services, or as a prevocational service. Similarly, the job search and negotiation activities, as well as any necessary follow-along services at the workplace, can be included as supported employment services or career planning within a waiver.

More recently, the 1915(i) option has created new opportunities to provide habilitation services to a wider range of individuals with disabilities. The 1915(i) was created by the *Deficit Reduction Act of 2005* (P.L. 109-171), and was subsequently amended by the *Patient Protection and Affordable Care Act* (P.L. 111-148). The 1915(i) allows states to provide the same services as are available through HCBS waivers without demonstrating cost neutrality. Additionally, individuals do not need to qualify for an institutional level of care before receiving these services. These design features remove some of the historical barriers to providing HCBS to individuals with mental illnesses. In April 2010, four states were operating 1915(i) programs.³⁷ Notably, Iowa utilized the 1915(i) to provide habilitation services, including supported employment services, to individuals with mental illnesses. Information about Iowa's 1915(i) is available at: <http://www.ime.state.ia.us/HCBS/HabilitationServices/Info.html>.

Wisconsin Vocational Futures Planning

Wisconsin uses the flexibility of habilitation and case management services to provide comprehensive employment supports to individuals with physical disabilities and the elderly. The Vocational Futures Planning program provides a wide array of supports that enable an individual to plan for employment, including assessment, assistance with job search activities, and a comprehensive analysis of the impact that working will have on public benefits. Individuals in the Vocational Futures Planning program also receive assistance coordinating employment activities with other necessary health care services, including long-term care.

Through the program, employment is included as a component of the individual's care plan under the Medicaid waiver. Employment barriers are identified and a plan to address those barriers and engage in employment is created. The Vocational Futures Planning program then coordinates services that are available through the waiver with other health, social, and vocational services, such as Vocational Rehabilitation.³⁸

To learn more about Vocational Futures Planning, visit: <http://dhs.wisconsin.gov/disabilities/physical/futures.htm>.

Maryland Supported Employment Services

Maryland's Medicaid, Vocational Rehabilitation, and mental health agencies collaborate to provide supported employment services for individuals with mental illnesses. Due to disparate programmatic responsibilities and restrictions on funding, each agency would be unable to fund the entire supported employment model without some kind of additional support. To address that issue, this program coordinates Medicaid-funded mental health rehabilitative services with services that facilitate job training, placement, and retention.

Using a braided funding model, Maryland's service delivery system maximizes the available funding sources. Programmatic funding is coordinated in a manner that enables a single provider to offer the necessary supports and bill the appropriate agencies responsible for each discrete service. This model allows for costs to be effectively shared without fracturing the delivery of the services themselves.

To learn more, visit: <http://www.cms.gov/promisingpractices/downloads/MD%20Supported%20Employment.pdf>.

Rehabilitation Services

Rehabilitation services are available to individuals both through the state plan as well as through Medicaid waivers. Although rehabilitation cannot directly fund services that focus on employment outcomes, it can be used to provide discrete components of employment programs for individuals with disabilities, including mental illnesses. These programs must be coordinated across multiple funding streams, a process known as "braiding" funds.³⁹ For example, states can coordinate funding for employment services, such as Vocational Rehabilitation, with funding that is available for medical services. Using the rehabilitation option, states can fund services such as counseling, psychosocial rehabilitative services, or other therapeutic interventions. While these interventions may have a secondary benefit of supporting an employment opportunity, such as assisting an individual with stress and medication management in an employment setting, they remain medical services.⁴⁰

Personal Assistance Services

Personal assistance services (PAS) are available to individuals through both the Medicaid state plan as well as Medicaid waivers. PAS provide caregiver support to individuals with physical limitations that prevent them from performing basic functions of everyday life, such as meal preparation, eating, bathing, and other similar activities. PAS can be provided in a variety of settings, including the individual's home, a community-based location, or a place of employment. As with rehabilitation services, PAS cannot be provided in a manner where it is directly intended to assist an individual to obtain or maintain employment or to provide support when completing job tasks. PAS, however, can be provided as a medically necessary support that also enables a person to be employed, such as assistance with eating at a place of employment.⁴¹

Utah Employment Personal Assistance Services (E-PAS) Program

Utah's E-PAS program was established in 2002, through a state plan amendment to the Medicaid program. Individuals who access the E-PAS program must be eligible for Medicaid in Utah, must be employed, and must require personal assistance services to assist with their employment. The program is available to both individuals with physical disabilities and individuals with mental illnesses.

E-PAS includes a variety of services that support individuals as they conduct their daily lives. Services have included assistance with dressing, eating, laundry, budgeting, shopping, and many others. While these supports are not designed to provide direct training and on-the-job supports, individuals and officials in Utah noted that E-PAS was an important support that enabled participants to remain employed, and to increase hours and wages.⁴²

To learn more, visit: <http://www.workabilityutah.org/healthcare/epas.php>.

In addition to the core services listed above, Medicaid agencies can use other supports and services that aid the employment efforts of individuals with disabilities. For example, treatment at a medical clinic, including community mental health programs, can be coordinated and integrated within programs that support the employment efforts of individuals with disabilities. An employment training program funded by other sources could also have some therapy-related components that are colocated in the clinic. Alternately, when a state implements a managed care waiver, it can use any savings to expand services beyond those available in the Medicaid state plan, which could include services such as vocational training, supported employment, or other job-related supports.⁴³ Finally, some services can provide and coordinate the provision of transportation for individuals with disabilities. Transportation to medical appointments and treatments is a required Medicaid service; however, when it is provided in the state plan, it must be medical in nature. States have the option to provide non-medical transportation, including transportation to a workplace, as a service in HCBS waivers.⁴⁴

Conclusion

As states continue efforts to both move individuals with disabilities out of institutions and into communities, and work to support independent living and employment for a wide array of individuals, there will be an ongoing need to coordinate a variety of medical and social services that enable sustainable independent community living. Services that support the employment and community integration of individuals with disabilities will continue to be an important part of Medicaid's benefit package. Although habilitation services in HCBS waivers remain one of the primary mechanisms to finance services that assist individuals with disabilities to become employed, a variety of Medicaid financing strategies can be used to promote the employment of individuals with disabilities.

As demonstrated, states have a significant amount of flexibility through both state plan and waiver services when designing Medicaid program services and supports, and when defining who is covered in their programs. State policymakers can use a broad range of options to design initiatives that support the employment efforts of individuals with disabilities using Medicaid funds along with an array of other federal and state resources. Important steps needed to design comprehensive initiatives that include multiple agencies and funding streams, including but not limited to Medicaid, involve:

1. Identification of the supports and services that individuals with disabilities seeking employment in the state need to be successful;
2. Clarification of the eligibility requirements and available services across state agencies that provide employment supports to individuals with disabilities;
3. Collaboration between the state Medicaid agency and other state agencies that assist individuals with disabilities to obtain and maintain employment (such as but not limited to the state Vocational Rehabilitation, workforce development, developmental disability, or mental health service agencies), and to coordinate policies and financing strategies that support the employment efforts of individuals with disabilities; and
4. Written documents (such as memoranda of agreement or other mechanisms) that identify agreed-upon actions (such as financing of a particular activity) that support and foster the employment of individuals with disabilities.

The state examples in this brief represent a small sampling of a broad range of employment supports that states include in their Medicaid programs. To learn more about the eligibility requirements and covered services in a particular state's Medicaid program, visit: <http://finder.healthcare.gov>. To view existing demonstration projects and waivers in each state, visit: <http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp>.

As new health reform efforts increase the role of Medicaid in the American health insurance system, funding pressures and the changing dynamics of the health care market will likely continue to reshape the populations that Medicaid covers and the services it provides. Much of the technical detail about the services and supports that will be available to individuals covered by health reform's Medicaid expansion is still awaiting regulation. However, the role of Medicaid as a crucial source of acute medical care as well as long-term supports and services will remain. State policymakers will need to continue to balance cost considerations with the desire to provide coordinated supports that enable individuals with disabilities to live and work in the community.

Useful Resources

The *Centers for Medicare and Medicaid Services* at the U.S. Department of Health and Human Services establishes national Medicaid policy and approves each state's Medicaid plans. For more information, visit: <http://www.cms.gov/>.

The *National Association of State Medicaid Directors* represents all state Medicaid programs, and provides information about state-specific Medicaid programs, as well as links to Web sites for each state's Medicaid programs. More information can be found at: <http://www.nasmd.org>.

The *Kaiser Family Foundation* conducts a wide range of research on Medicaid and hosts an extensive library of information and reports about Medicaid programs: <http://www.kff.org/>.

The *Clearinghouse for Home and Community-Based Services* is a comprehensive library of state and federal programmatic information as it relates to HCBS services, as well as a broad range of academic research relating to the delivery of HCBS. Visit <http://www.hcbs.org/> for additional information.

The *Medicaid Infrastructure Grants — Research Assistance to States* Web site offers an array of information about state-based initiatives to improve the provision of employment services in Medicaid, and to increase the collaboration between Medicaid and other disability employment services. Learn more at: <http://www.mig-rats.org/>.

Endnotes

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Learn more at: <http://www.mobile-barcodes.com/qr-code-software/>

About ODEP

The Office of Disability Employment Policy (ODEP) provides national leadership on disability employment policy by developing and influencing the use of evidence-based disability employment policies and practices, building collaborative partnerships, and delivering authoritative and credible data on employment of people with disabilities. Learn more at: <http://www.dol.gov/odep/>.

About the NTAR Leadership Center

Founded in 2007 under a grant/contract with the Office of Disability Employment Policy at the U.S. Department of Labor, the NTAR Leadership Center's mission is to build capacity and leadership at the federal, state, and local levels to enable change across workforce development and disability-specific systems that will increase employment and economic self-sufficiency for adults with disabilities. Learn more at: <http://www.ntarcenter.org>.

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