The Role of Medicaid in Supporting Employment

Medicaid covers a broad range of medical and enabling services to the nation's most economically disadvantaged populations, including many enrollees with complex health care and social needs. Although there are limitations on the extent to which federal Medicaid funds can be used to cover benefits that are not defined in statute, states have a range of authorities and options that can be used to support employment through Medicaid (CMS 2018c, Witgert 2017, MACPAC 2017). These include:

- specific eligibility pathways that allow working people to maintain Medicaid coverage even if they would be otherwise ineligible due to increases in their income;
- efforts to connect beneficiaries to work, employment supports, or other social services that support their ability to work;
- home and community-based services (HCBS) waiver and state plan options to facilitate the ability of certain individuals with disabilities to work in community-integrated settings.

While a number of states have sought to implement work requirements as a condition of Medicaid eligibility recently, this brief focuses on the ways states can support employment among Medicaid beneficiaries without mandating workforce participation.[1] The brief describes these state options and provides examples of strategies states have used to promote and support work among target populations.

Eligibility Pathways

Medicaid offers two types of eligibility pathways to help maintain coverage for people with disabilities and low-income parents whose earnings increase through work, potentially making them ineligible for Medicaid. These pathways were created to reduce work disincentives for people with health care needs who otherwise may have to reduce the amount they work in order to maintain Medicaid coverage.

Working people with disabilities

Though many individuals with disabilities qualify for Medicaid through receipt of Supplemental Security Income (SSI), states also extend eligibility to working people with disabilities whose earnings are too high to qualify for SSI. Extending eligibility to these individuals—who often have high or complex health care needs—allows them to maintain their Medicaid coverage even as their income rises. States are required to cover working individuals with disabilities who are severely impaired and had previously received SSI and Medicaid, and they have the option to extend eligibility to additional individuals through buy-in programs (MACPAC 2017).[2]

Medicaid buy-in programs allow employed individuals with disabilities to purchase Medicaid coverage with a monthly premium and have different options in terms of eligibility and program design (Table 1). States

can choose from among three Medicaid buy-in options created by the Bipartisan Budget Act of 1997 (BBA 1997, P.L. 105-33) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA, P.L. 106-170) (MACPAC 2018a, b).[3] For example, states offering programs under the TWWIIA buy-in options may establish income and asset limits.[4] Under any of these options, states can impose premiums, copayments, and deductibles on a sliding scale at levels that are not generally permitted in traditional Medicaid (MACPAC 2018b, 2017). As of 2015, 41 states had some kind of Medicaid-buy in program, although they have historically served a limited number of enrollees. (KFF 2015, Kehn 2013).

TABLE 1. State Options for Medicaid Buy-In Authorities

Eligibility group	Description	State options
BBA 1997 eligibility group (§ 1902(a)(10)(A)(ii)(XIII) of the Act)	Individuals qualifying as disabled under the SSI standard with unearned income of less than 250 percent FPL (earned income is disregarded) and resources not exceeding the SSI resource standard	Requires premiums or cost-sharing charges on a sliding scale based on income
TWWIAA basic eligibility group (§ 1902(a)(10)(A)(ii)(XV)) of the Act)	Individuals age 16–64 qualifying as disabled under the SSI standard, with income and resources not exceeding state-defined parameters (earned income is not automatically disregarded)	• Sets income standards above BBA option levels (250 percent FPL) • Sets resource standards above the SSI standard, or set no income or resource standards • Requires premiums or cost-sharing charges on a sliding scale based on income. • Includes the medical improvement group
TWWIAA medical improvement group (§ 1902(a)(10)(A)(ii)(XVI) of the Act)	Individuals who would be in the TWWIAA basic eligibility group, except that their disability no longer meets the SSI standard; only states choosing to offer coverage to the basic group may adopt this option	Same parameters that apply to the TWWIAA basic eligibility group

Notes: BBA 1997 is the Bipartisan Budget Act of 1997 (P.L. 105-33). FPL is federal poverty level. TWWIAA is the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170). SSI is supplemental security income.
Sources: Kehn 2013, MACPAC 2018b, MACPAC 2017.

Transitional medical assistance for parents and low-income caretakers

In 1996, when the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, P.L. 104-193) delinked Medicaid eligibility from family cash assistance, Congress retained transitional medical

assistance (TMA) for families eligible under Section 1931of the Social Security Act (the Act) to ensure that the poorest families could transition from cash assistance to work without losing health insurance coverage. States are required to extend TMA to families with incomes below 185 percent of the federal poverty level (FPL) for a minimum of 6 months and up to 12 months.[5] States have the option to provide TMA through regular Medicaid, or require TMA beneficiaries to enroll in employer-sponsored insurance if it is offered to them, with states paying enrollees' share of premiums and cost sharing. At least 23 states use this premium assistance option, which provides the opportunity for low-income individuals to transition to employer-sponsored insurance rather than abruptly facing the premiums and cost-sharing requirements that might discourage them from working or working more hours (MACPAC 2014).

In 2011, 43 states reported TMA enrollment of over 3.7 million individuals, ranging from 86 enrollees in Oklahoma to 445,481in Illinois (GAO 2013). Although parents who experience an increase in income may be eligible for Medicaid as part of the new adult group enacted under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), TMA continues to provide a Medicaid pathway for low-income parents and caretakers in non-expansion states (MACPAC 2014).[6]

Employment Supports and Resources

State Medicaid programs may refer beneficiaries to existing employment resources, such as job training programs or other support services, or, under certain circumstances, provide individuals with disabilities with employment-related services.[7]

Linking beneficiaries to employment resources

States have several options for connecting beneficiaries with employment-related services or resources, though they generally cannot provide these services directly using Medicaid funds. For example, states can offer case management benefits that include services to assist eligible individuals in accessing employment resources. States also can designate these services for specific populations (e.g., beneficiaries residing in certain geographic areas or with significant barriers to work) using the targeted case management option (42 CFR 440.169).[8]

States have also sought to increase coordination among human services agencies to better meet the needs of beneficiaries and ease the administrative burden. Such efforts have focused on streamlined applications, co-location of services, or integrated systems for eligibility, enrollment, and renewal (Isaacs et al. 2016, Kauff et al. 2011). Some states have developed processes to connect Medicaid beneficiaries directly to employment resources. For example, under the Montana Health Economic Livelihood Partnership-Link (HELP-Link), applicants are surveyed about their work status and barriers during the enrollment process, and are referred to services such as career planning and training offered through the Montana Department of Labor & Industry (MTDLI 2017).

Medicaid managed care plans may engage in efforts to connect or provide beneficiaries with employment supports. Plans are subject to care coordination service requirements to identify and coordinate non-medical services related to a member's health care needs, which may include connections to employment

(42 CFR 438.208). Plan contracts also may cover additional services beyond those covered under the state plan. The cost of these services (including social interventions such as education or services provided through partnerships with other organizations) cannot be included, however, when determining capitation payment rates.[9,10]

Employment supports for people with disabilities

A range of state plan and waiver authorities allows states to provide employment-related services to people with disabilities who are eligible for Medicaid-covered HCBS. Though programs financed by Medicaid represent a small fraction of the many programs designed to support employment for people with disabilities, most states have at least one employment-related program in place for Medicaid beneficiaries who qualify for HCBS benefits (GAO 2012).[11] While goals may vary slightly based on legal authority and program design, such efforts generally seek to help people with disabilities gain and retain employment as part of a larger effort to increase opportunities for them to live and work in community-integrated settings.

States using Section 1915(c) waiver or Section 1915(i) state plan authority to provide HCBS services can include habilitation services as a covered benefit, which can include employment-related services. For example, states can provide supported employment services that help people with disabilities obtain and sustain competitive (at or above the minimum wage) work on the open labor market in settings that include individuals without disabilities. Such services may include help with job applications, arranging workplace accommodations, and coaching to help individuals develop the skills needed for their job.[12] Additionally, states can provide pre-vocational services to help people develop general skills that contribute to employability in integrated community settings (e.g., communication skills or knowledge of general workplace conduct). Prevocational services are provided over a defined period of time with specific goals and outcomes (CMS 2011). The specific supported employment and prevocational services offered are defined by the state, but can be covered by Medicaid only to the extent that such services are not available to the beneficiary through other programs, including the U.S. Department of Education's vocational rehabilitation program (CMS 2018a, CMS 2011).[13,14]

States can also implement self-directed service models through 1915(c) waiver authority, or the 1915(i), 1915(j), or 1915(k) state plan options. These models allow individuals receiving HCBS to manage and make decisions about their own services. Self-directed service model participants or their representatives can—with the assistance of a "supports broker/consultant/counselor"—hire, train, and supervise individuals who provide employment-related services, such as job training coaches or other support staff (CMS 2018b).

Endnotes

[1] Some states have sought to promote work among non-disabled, non-elderly adult beneficiaries by requiring them to work or complete other community engagement activities as a condition of Medicaid eligibility. Work and community engagement requirements have been approved in Arkansas, Indiana, Kentucky, and New Hampshire and will take effect as soon as summer 2018. For more detail on individual state work and community engagement requirement policies and related guidance from CMS, see *Medicaid Work and Community Engagement Requirements* (MACPAC 2018).

[2] The term "severely impaired" as defined by Section 1905(q) of the Act.

[3] Other states that originally received authority through one of these options may since have incorporated these programs into Section 1115 programs (Kehn et al. 2013).

[4] States vary in terms of where they set income and asset limits. In 2015, most states had monthly income limits between $2,000 and $3,000, and income limits ranged from $785 in Virginia to $6,250 in Connecticut. Three states—Arkansas, Massachusetts, and North Carolina—had no income limit. Resource limits ranged from $2,000 in California, Iowa, and West Virginia to $75,000 in Michigan. Five states—Arizona, Arkansas, Colorado, Delaware, and Massachusetts—and the District of Columbia had no asset limit (KFF 2015).

[5] States can choose to extend the initial 6 months of TMA by another 6 months or offer 12 months of coverage at the outset (§§ 1902(a)(52), 1925, 1931(c)(2), 42 CFR 435.112).

[6] Prior to the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, P.L. 114-10), TMA, unlike other statutory Medicaid authorities, was subject to Congressional appropriation and authorization. MACPAC formally recommended in 2013 that TMA be permanently extended, and reaffirmed that recommendation in 2014 (MACPAC 2013, 2014). For more detail on the recommendations and rationale, see Issues in pregnancy coverage under Medicaid and exchange plans in MACPAC's March 2014 *Report to the Congress on Medicaid and CHIP*, and Eligibility issues in Medicaid and CHIP: Interactions with the ACA, in MACPAC's March 2013 *Report to the Congress on Medicaid and CHIP*.

[7] Though CMS has approved some state Section 1115 waivers to implement work and community engagement activities as a condition of eligibility for certain low-income adults who qualify for Medicaid on a basis other than disability, the agency has specified that it will not allow states to use federal funds to finance employment support services for these individuals (CMS 2018c).

[8] States also can offer the optional Health Home benefit, in which eligible providers or health care teams provide comprehensive care management and care coordination to Medicaid enrollees with certain chronic conditions. Such services include referral to a wide range of community and social support services (Section 1945 of the Social Security Act).

[9] Many states leverage their managed care programs to support social determinants of health—including employment—through value-based payments, incentive payment or withhold arrangements, or quality improvement activities.

[10] In some cases, states have used Section 1115 waivers to support social interventions. They can use Section 1115 waivers to generate savings that can be used for costs that are not matchable otherwise or to implement a delivery system incentive reform payment (DSRIP) program. For example, some DSRIP programs (e.g., Massachusetts, New York, Rhode Island, and Washington) establish partnerships with or require managed care plans to contract with community-based organizations that provide social support services related to housing, employment, transportation, and other social needs as a condition of receiving incentive payments authorized under Section 1115 waivers (NASHP 2017).

[11] A 2012 Government Accountability Office (GAO) report found that there were 45 such programs administered by nine federal agencies, many of which overlapped in terms of target populations and services provided. Information on program outcomes is fragmented and limited (GAO 2012).

[12] States can also provide certain recovery-oriented supported employment services to individuals with substance use disorder and other mental health conditions through the Section 1905(a)(13) Medicaid rehabilitation state plan option. These can include social skill building, peer support or counseling, but not education or vocational services (Mandros 2015).

[13] While supported employment services and prevocational services can be offered through both 1915(c) waivers and the 1915(i) state plan option, the state plan option allows states to offer these services to targeted groups of individuals regardless of whether they need an institutional level of care and services provided do not need to be budget neutral. However, supported employment services are not automatically covered under the state plan option, meaning states need to seek approval from the Secretary in order to provide these services (Mandros 2015).

[14] Through the Money Follows the Person (MFP) demonstration, grantee states can use enhanced funding to offer a broader scope of HCBS services to demonstration participants than are typically offered under their HCBS waivers. In many cases, states have chosen to offer MFP participants with additional employment support resources, such as job coaching (Morris et al. 2016). Unless Congress reauthorizes the demonstration, grantee states will stop transitioning new MFP participants no later than December 31, 2018, and will stop providing demonstration services to those participants after an additional year.

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