

The Ticket to Work and Work Incentives Improvement Act of 1999:

Implications for the Design and Support of Comprehensive Integrated Health Systems for Persons with Mental Illness and Addiction Disorder Disabilities

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Executive Summary

The Ticket to Work and Incentives Improvement Act of 1999 expands the availability of health care and employment preparation and support services for working-age adults with disabilities. Passage of the Act was part of the fundamental evolution in U.S. social policy regarding the treatment of persons with disabilities. At the core of this evolution lies the belief that no person with a disability should be denied the right to fully participate in society because of external barriers that reasonably can be removed. Using a definition of disability comparable to that found in the Americans with Disabilities Act, approximately 27 million working-age adults were disabled in 1999, and nine million of those adults had a disability severe enough to limit a major life activity.

The Act has particular relevance for individuals who suffer from mental illness and addiction disorders. In June 2001, over 1.2 million working-age persons with severe mental illnesses received Federal Supplemental Security Income (SSI) benefits. Those 1.2 million persons represented nearly one-third of the total number of disabled working-age SSI recipients in that month (3,744,022 persons). Of the 1.2 million working-age persons with severe mental illnesses receiving SSI benefits, 400,610 persons were eligible on the basis of schizophrenia and another 872,357 persons were eligible on the basis of other psychiatric disorders.

Under current law, individuals with a primary diagnosis of addiction disorder are not eligible for SSI or Supplemental Social Security Disability Insurance (SSDI). These individuals may, however, become eligible for Medicaid through a Medicaid “Buy-In” program, administered by the states. There are no existing federal regulations regarding the criteria states must use to determine Medicaid Buy-In eligibility for the non-SSI/SSDI population. Thus, coverage of individuals with a primary diagnosis of addiction disorder is left to the discretion of the states in Buy-In program design.

The Medicare and Medicaid provisions of the Ticket to Work Act are especially important because access to comprehensive and ongoing health care is basic to the ability of persons with disabilities to achieve their full employment potential. Prior to passage of the Act, the options for achieving or maintaining Medicaid coverage with disabled persons returned to work formed a confusing legislative *pastiche*. Disabled persons faced upper income rules and other threats to continued coverage that provided a disincentive to work.

The Ticket to Work Act changed disability benefits and Medicare and Medicaid provisions to remove barriers to work for disabled persons. The Act:

- adds optional Medicaid coverage for disabled workers who no longer meet SSDI/SSI criteria because of medical improvement;
- allows states to extend Medicaid coverage to disabled workers with incomes above 250% of the federal level on a buy-in basis;
- creates a demonstration program for disabled workers who have not yet become so impaired that they cannot work; and

- prohibits states that elect to extend benefits to disabled workers from using Medicaid funds to reduce non-medical assistance services expenditures

The Department of Health and Human Services (HHS) and the Social Security Administration (SSA) have launched a number of initiatives to implement the Act and assist states in program design. HHS has made \$400 million in funding available from 2001-2006 through the Medicaid Infrastructure Grant Program and the Medicaid Demonstration to Increase Independence and Employment. Both of these programs are intended to assist disabled workers in obtaining Medicaid coverage and in removing barriers to work. The SSA has proposed a three-year implementation of the Act through the issuance of “tickets” to eligible individuals, who can take the ticket to an approved employment network to receive assistance in obtaining and retaining work.

Among the key issues in designing Medicaid programs for disabled workers are expansions in eligibility, building interest and awareness of Medicare and Medicaid options among disabled persons, scope of coverage, and the use of managed care for adults with disabilities.

Access to Medicaid for persons with disabilities is an issue receiving extensive attention in the courts. Several recent judicial decisions (and their progeny) confirm that unreasonable limitations on necessary and covered treatment for persons with disabilities are unlawful. Therefore, as efforts to develop more accessible and appropriate health systems grow, the services and supports that such systems provide to disabled working adults will become increasingly important.

The Ticket to Work Act builds on reforms started nearly 20 years ago that were designed to ensure that the lack of health coverage was no impediment to work. The Act offers states significant flexibility to design their health systems to meet the needs of workers with disabilities. The implementation of the Act and demonstration programs offer an important opportunity to learn more about adapting Medicaid to the needs of disabled workers and those who would become disabled without medical care. The Act and its implementation raise many research questions, and the full range of implementation issues remains to be seen.

Introduction

This report is designed to provide an overview of the Medicaid provisions of the Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170. This report considers the implications of the Act for the design and support of comprehensive, Medicaid-financed systems of health care for workers with severe disabilities and impairments, with a specific focus on persons with mental illness and addiction disorder disabilities. The Act, described by advocates for persons with disabilities as the most important piece of disability-related legislation since the enactment of the Americans with Disabilities Act of 1990, expands the availability of health care and employment preparation and support services for working-age adults with disabilities.¹

The Ticket to Work Act can and should be viewed as part of a fundamental evolution in U.S. social policy regarding the treatment of persons with disabilities. This basic shift in national policy began with the American civil rights movement, continued with passage of the federal Rehabilitation Act of 1973 and the Education of Handicapped Children Act of 1974,² and expanded dramatically with the 1990 enactment of the Americans with Disabilities Act.³ At the core of this policy evolution lies the belief that no person with a disability should be denied the right to fully participate in society because of external barriers that reasonably can be removed. Because access to comprehensive and ongoing health care is basic to the ability of persons with disabilities to achieve their full employment potential, the Medicare and Medicaid provisions of the Act represent an important opportunity to advance important national goals.

This report begins with an overview of the extent and characteristics of individuals with disabilities, reviews the role of Medicaid as a source of coverage, and presents statistics on the characteristics of working Supplemental Security Income (SSI) and Medicaid recipients. The report then turns to a discussion of Medicaid, describing eligibility and program design options prior to passage of the 1999 Act, as well as the modifications contained in the new law. The final section outlines the implementation of the act to date as well as the implementation issues that can be expected to arise.

¹ For a general overview of Act and in particular, its employment preparation and support provisions, interested persons may wish to consult the series of issue briefs prepared by Allen Jensen of the Center for Health Services Research and Policy (CHSRP) and Robert Silverstein of the Center for the Study and Advancement of Disability Policy under a project supported by the Robert Wood Johnson Foundation. The materials being produced by this project can be obtained by contacting Mr. Jensen at CHSRP, 2021 K Street N.W. #800, Washington D.C. 20006 (202/296-6922).

² P.L. 94-142. The law, whose most recent reauthorization came in 1999, is now known as the “Individuals with Disabilities Education Act” and has been considerably expanded since its original enactment.

³ For an overview of the ADA and its application to health services and managed care, see Sara Rosenbaum, Joel Teitelbaum, and Robert Silverstein, *The Americans with Disabilities Act: Implications for Managed Care for Persons with Mental Illness and Addiction Disorders* (The George Washington University Medical Center, School of Public Health and Health Services, Center for Health Services Research and Policy, prepared for the Substance Abuse and Mental Health Services Administration, Dec., 1999). Available at: <http://www.gwhealthpolicy.org>.

Profile of Persons with Disabilities and Sources of Insurance Coverage

1. The prevalence of disabilities among the working age population

There is no uniform definition of disability. Depending on the particular set of laws and policies considered, the meaning of the term can vary dramatically and can result in very different estimates of the presence and characteristics of disability among working-age adults.

The National Health Interview Survey (NHIS) provides extensive data on the presence of disability within the population. Applying this definition (which is similar to that used under the ADA⁴), NHIS estimates indicate that approximately 14% of the U.S. non-institutionalized household population (34 million persons) can be considered disabled.⁵ When the entire population is counted, the number with disabilities reaches 54 million persons.⁶

Within this larger group of persons with disabilities are nearly 27 million working age adults (individuals ages 18-64), who in 1996 constituted 17.1% of the nation's 158.5 million working age adults. Of these, nearly 9 million working age adults (5.8% of the total working age adult population and over a third of the total reporting a disability) have a disability that is severe enough to limit major life activities.⁷

The number of Americans with disabilities using the ADA definition is considerably larger than the proportion of persons with disabilities under the far more narrow Social Security Act (SSA). For cash assistance and medical benefits purposes, the Act uses as its test the inability to engage in substantial gainful activity (i.e., the inability to work). According to the Congressional Budget Office, in 1999 approximately 8 million persons with disabilities received Supplemental Security Disability Income (SSDI) benefits, SSI benefits, or both, a far lower number than the proportion who would receive assistance were the inability to work not the defining factor.⁸

2. Types of disabilities

Over half of all persons with disabilities have a physical disability. However, among the low-income population, mental illness and addiction disorders are approximately twice as prevalent.⁹ Similarly, welfare recipients show a significantly higher prevalence of mental disabilities. Thus, as

⁴ Both the ADA and the NHIS effectively focus on the effects of an illness or condition on the ability to carry out major life activities and normal functioning. While the terms are not precisely the same, they are sufficiently close that NHIS provides a reasonably good system for measuring the prevalence of disability as the concept exists under the ADA.

⁵ Dennis McCarty and Helen Levine, "Needs of People with Chronic and Disabling Conditions," *Access to Health Care: Promises and Prospects for Low Income Americans* (Blanton et al, ed.) (Kaiser Commission on Medicaid and the Uninsured, Washington D.C., 1999) p. 62.

⁶ See, e.g., Jack Meyer and Pam Zeller, *Profiles of Disability: Employment and Health Coverage* (Kaiser Commission on Medicaid and the Uninsured, Washington D.C., 1999) p. 1.

⁷ *Id.*, Table 1., p. 6.

⁸ S. Rep.106-37 to accompany S. 331, (March 25, 1999).

⁹ Constance Horgan and Dominic Hodgkin, "Mental Illness and Substance Abuse Among Low Income Populations," *Access to Health Care: Promises and Prospects for Low Income Americans*, op. cit. p. 74.

family income declines, the proportion of persons with mental illness-related disabilities may increase, a factor to bear in mind in the implementation phase of a work incentive program.¹⁰

Data indicate that the presence of mental disabilities is higher among the SSI population generally, as well as among workers who receive SSI. In June 2001, approximately 34% of all working-age adults who received SSI had either a mental disorder (other than mental retardation) or mental retardation (23.4% of the SSI population). Moreover, in the case of SSI recipients who participate in work incentive programs, available data also suggest a far greater prevalence of mental disorders. Social Security Administration 2001 statistical data for adult disabled workers who receive SSI benefits show that 47% had mental retardation, while 25.3 percent had a mental condition other than retardation. Thus, among Medicaid beneficiaries who qualify for coverage based on disability, the prevalence of mental illness and mental retardation is disproportionately high. This heightened prevalence holds true for SSI recipients with disabilities who participate in existing work incentive programs.

Table 1: Disability Diagnosis of SSI and Section 1619 Disability Recipients (June, 2001)

<i>Individuals</i>	<i>All SSI disabled ages 18-64 (3.744 million)</i>	<i>SSI/§1619(a)¹¹ participants (25.02 thousand)</i>	<i>SSI/§1619(b)¹² participants (75.48 thousand)</i>
<i>Diagnoses other than mental illness/mental retardation</i>	42.6%	25.7%	30.6%
<i>Mental illness</i>	34%	32.4%	33.3%
<i>Mental retardation</i>	23.4%	41.9%	36.1%

Source: Social Security Administration, *SSI Disabled Recipients Who Work*, June 2001.

3. Work and disability

Adults with disabilities work (although work may be less than full-time). Fifty-two percent of adults aged 18-64 who report the presence of any disability work, and one third of the working population reports the presence of a specific, chronic disability that limits a major life activity, including work.¹³ The rate of employment for individuals with mental illness, however, is much lower. In June 2001, there were only 89,213 disabled working SSI recipients with mental illness out of a total of 1.2 million SSI disabled recipients with mental illness (seven percent).¹⁴ Nearly half of all disabled working SSI recipients suffer from mental retardation.¹⁵

4. Disability and health insurance

Persons with serious disabilities are less likely to have private health care coverage and are more likely to depend on public sources of coverage. In 1994, only slightly more than half of all persons with *chronic* disabilities who experienced “a lot” of difficulty or interference with normal

¹⁰ The question of whether disability causes poverty or is a consequence of it has been long debated. Regardless of the presence of causation, the data show a significant association between disability and reduced family income.

¹¹ Under Section 1619(a) of the Social Security Act (SSA), an individual whose earnings exceed the Substantial Gainful Activity earnings test for disability can continue to receive SSI cash benefits on a gradually reduced basis.

¹² Under Section 1619(b) of the SSA, a disabled individual whose earnings are too high to receive SSI cash payments can remain eligible for Medicaid.

¹³ Table 3, *infra*.

¹⁴ Social Security Administration, *SSI Disabled Recipients Who Work*, June 2001, at p. 18.

¹⁵ *Id.*

function had any private health insurance. Approximately 20% had Medicaid. Nearly 15% of persons with chronic disabilities had no insurance coverage, compared to the Census Bureau's estimate of 17% of the total population without insurance in 1994.¹⁶

Table 2: Health Insurance Coverage of Nonelderly Persons with Chronic Disabilities

<i>Type of Coverage</i>	<i>Percent Covered</i>
<i>Private</i>	53.7%
<i>Medicaid</i>	19.6%
<i>Uninsured</i>	14.6%
<i>Other Coverage</i>	12.1%

Source: Meyer and Zellner, cited in Schneider et al. "Medicaid Eligibility for Individuals with Disabilities" (Kaiser Commission on Medicaid and the Uninsured, 1999, Figure 1.)

5. Medicaid as a Source of Coverage for Persons with Disabilities

Data from the 1994 Health Interview Survey show that in 1994, 43% of all persons ages 18-64 reporting *any* disability had Medicaid coverage. This figure is far higher than the rate of Medicaid coverage reported for the population as a whole (18.5%).¹⁷ Medicaid expenditures for persons with disabilities are approximately 2.5 times greater than those for persons without disabilities.¹⁸

Despite the fact that Medicaid coverage based on disability limits the availability of benefits for workers, Medicaid nonetheless represents an important source of health care financing for workers with disabilities. Data from the National Health Interview Survey show that in 1989, working adults with activity limitations were significantly more likely than their non-disabled counterparts to have Medicaid and were considerably less likely to have private insurance. That year, slightly more than half of all workers with limitations had private insurance, while nearly 1 in 7 had Medicaid. Among workers without activity limitations, the proportion with private insurance stood at nearly 80%, while less than 3% had Medicaid.¹⁹

Table 3: Medicaid and Private Insurance Coverage for Working Adults with Activity Limitations

<i>Workers</i>	<i>Private Insurance</i>	<i>Medicaid</i>
<i>Workers with activity limitations</i>	54.7%	14.8%
<i>Workers without activity limitations</i>	77.7%	2.8%

Source: National Health Interview Survey (1989) in McCarty and Levine, op. cit.

In sum, using a definition of disability that is comparable to that found in the ADA, about 27 million adults report some level of disability, and about 9 million working-age adults persons have a disability severe enough to limit a major life activity. Consistent with the association between disability and poverty, more than one in four low-income persons report having a condition that is significant enough to impair daily functioning. While persons with disabilities do work, they are also significantly more likely to be unemployed. The majority of working age persons with disabilities

¹⁶ United States Census Bureau, Health Insurance Coverage Status and Type of Coverage by State--People Under 65, available at www.census.gov/hhes/hlthins/historic/hihistt6.html, accessed on October 20, 2001.

¹⁷ Paul Fronstein, Sources of Health Insurance and Characteristics of the Uninsured, *EBRI Issue Brief* (No. 204, December 1998), Chart 2.

¹⁸ "Needs of People with Chronic and Disabling Conditions", op. cit., p. 65.

¹⁹ For a comprehensive discussion of Medicaid eligibility related to disability, see Andy Schneider, Victoria Strohmeier, and Risa Ellberger, *Medicaid Eligibility for Individuals with Disabilities* (Kaiser Commission on Medicaid and the Uninsured, Washington, DC, 1999).

has a physical disability, but mental illness is a significant disabling condition and appears to be increasingly common as income levels decline.

Medicaid Work Incentives Programs for Persons with Disabilities

1. Pre-1999 Medicaid-Related Work Incentives Programs

The options for achieving or maintaining Medicaid coverage when disabled persons returned to work formed a confusing legislative *pastiche*. Moreover, there were no Medicaid options in the case of workers with *potentially disabling* conditions, defined as conditions that do not currently limit a major life activity but could in the future (e.g., multiple sclerosis).

In General: Because access to SSDI and SSI is conditioned on an inability to engage in substantial gainful activity (SGA), a demonstration of SGA (e.g., through increased hours of work) effectively signals the end of cash benefits. The critical question is whether it should also result in the termination of medical benefits.

Access to continued Medicare: Pre-1999 work incentives programs permitted persons receiving SSDI and Medicare to work for an unlimited amount of earnings for a 9-month “trial work period.” This trial work period would be followed by a subsequent 3-month grace period before SSDI would be curtailed. During the ensuing 3 years, an SSDI recipient could automatically be reinstated if his or her work fell below a designated SGA level. In 1999, this figure was set at \$700 per month or higher. Medicare continued for 3 years beyond the point at which cash assistance ceased as a result of SGA, after which a worker could retain Medicare coverage by paying a premium.²⁰

Access to continued Medicaid: Working SSI recipients remained entitled to Medicaid as long as their SSI continued. Once SSI benefits ceased as a result of earnings, however, automatic Medicaid coverage also would end.²¹

Section 1619(a) of the Social Security Act permits an extension of SSI benefits (and thus Medicaid) in the case of individuals who work, for as long as *there is no medical improvement*²² in their conditions. This extension continues until an individual reaches what is known as the “break-even point”. Under this “break-even point” system, SSI benefits are phased out as earnings increase.²³

In addition, §1619(b), as well as Medicaid amendments codified in §§1902(a)(10) and §1905(q) of the Social Security Act, permit states to extend Medicaid to individuals whose incomes surpass the upper limits of the §1619(a) “break-even point.”²⁴ These individuals are known as

²⁰ In 1999, the premium was \$309 per month.

²¹ Workers might still have access to Medicaid through a medically needy or §209(b) spend-down program, but achieving eligibility through spend-down is cumbersome and generally works only for high-cost institutional care.

²² The Ticket to Work Act does not define a standard for medical improvement.

²³ The current “break-even” is \$1247 per month for individuals with no other incomes in states that do not supplement SSI. In a state that supplements the SSI payment, the “break-even” point is adjusted upward to increase \$2 for every \$1 of state supplementation. The current “break-even” point for states that supplemented SSI ranges from \$14,690 in Arizona to \$36,598 in Connecticut.

²⁴ Section 1619(b) of the Social Security Act provides that these individuals will be considered disabled for purposes of the Medicaid program even though their earnings disqualify them from coverage.

“qualified severely impaired” (QSI) individuals.²⁵ Amendments to the QSI program in 1997 set the upper income limit to 250% of the federal poverty level and gave states an option to charge income-related premiums.

The Centers for Medicare & Medicaid Services’ (CMS, formerly HCFA) instructions for implementing the QSI program indicate that in calculating income, states must use a net income test that applies “all appropriate SSI income disregards, including the SSI earned income disregards.”²⁶ The instructions also clarify the applicability of a separate Medicaid option that allows states to effectively increase income levels beyond the 250% cutoff by liberalizing applicable earnings disregards.²⁷ This option, codified at §1902(r)(2) of the Social Security Act, allows states to use more liberal income and resource standards than those used to determine SSI eligibility. Using this option, a state could adopt more liberal earned income disregards for persons who are QSIs that permit them to keep even greater levels of earned income while retaining Medicaid.

Among the relatively few states that as of 1999 had elected to adopt a QSI program, §1902(r)(2) appeared to be in use. For example, Oregon disregards up to \$10,000 in assets, all earned income, and certain retirement and pension payments, while simultaneously charging an income-related premium for workers with higher earnings.

To summarize, as of 1999, Medicaid was mandatory for disabled workers who continued to receive SSI benefits until their earnings surpassed the §1619(a) work incentives “break-even” point. At this point, a disabled worker might be able to spend down to Medicaid eligibility if he or she lived in a state with a medically needy or §209(b) spend-down program, but this option was of limited practical utility. States also had the option to extend Medicaid to disabled workers with excess earnings and could liberalize the financial eligibility standards used to determine the financial eligibility of qualified severely impaired workers.

At the same time, prior law contained three serious limitations. First, the 250% upper income rule limited the utility of the program because of limited use of §1902(r)(2). Second, disabled workers who showed medical improvement would lose coverage. Third, there was no assistance for persons who, while suffering from one or more impairments, were able to work but would be unable to do so without medical coverage.

2. The Ticket to Work Act

The Act builds on prior Medicaid law and also makes changes in the SSI and SSDI programs that can be expected to have effects on access to Medicaid.²⁸

Disability benefit-related provisions

The law:

²⁵ Section 1905(q) of the Social Security Act; 42 U.S.C. §1396d(q).

²⁶ State Medicaid Directors Letter (March 9, 1998). Available at: <http://www.hcfa.gov/medicaid/bba4733.htm>.

²⁷ *Id.*

²⁸ A summary of the Act’s provisions can be found at the Social Security Administration’s web site: http://www.ssa.gov/legislation/legis_bulletin_121799.html.

- establishes a system of regional employment networks whose responsibility it is to assist persons with disabilities who receive public assistance to obtain the services they need in order to be able to work;²⁹
- prohibits the Commissioner of the Social Security Administration from initiating continuing disability reviews during the period that a recipient is “using a ticket to work and self-sufficiency.”³⁰ This change, which is intended to curb the work disincentive practice of evaluating disability as soon as there exists any evidence of ability to work, can be expected to lengthen the time period that SSI/SSDI recipients are enrolled in Medicaid;
- prohibits the use of work activity alone as a basis for continuing disability review in the case of individuals who are entitled to SSDI payments,³¹ thereby potentially extending the time period for Medicaid enrollment for SSI recipients *who also receive SSDI*. However, the Act permits continuing disability reviews for individuals whose earnings exceed the level established by the Commissioner as the upper limit for substantial gainful activity;³²
- establishes an expedited reinstatement system for individuals who are unable to continue to work on account of their medical conditions and who file a reinstatement request within the 60-month period following the termination of benefits as a result of work.³³ This change can be expected to reduce the time during which individuals who can no longer work must await restoration of SSDI/SSI benefits (and potentially Medicaid);
- establishes, effective upon enactment, a work incentive outreach program whose purpose is to provide accurate information regarding work incentives to disabled beneficiaries through grants and contracts to community-based organizations;³⁴ and
- provides funds to state protection and advocacy organizations to support work incentive advocacy.

Medicaid- and Medicare-related provisions

The law makes the following changes in existing Medicaid and Medicare coverage provisions for persons with disabilities:

- Effective October, 2000, the Act extends Medicare part A benefits without payment of additional premiums for persons with disabilities who return to work for an additional 4.5 years beyond the 4 years provided for under current law in the case of eligible persons who receive SSDI.³⁵

²⁹ Social Security Legislative Bulletin (106-15), Dec. 17, 1999. Available at: http://www.ssa.gov/legislation/legis_bulletin_121799.html.

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ Section 226(b) of the Social Security Act, as amended, 42 U.S.C. §426(b).

- The Act permits workers who have Medicare and Medigap to suspend their premiums and benefits if they obtain access to employee sponsored health benefits (and thus do not need the Medigap coverage).³⁶
- The Act clarified the states' option to liberalize financial eligibility criteria for workers in the QSI program whose incomes exceed 250% of the federal poverty level (an option that was little used prior to passage of the Act).³⁷
- Effective October 1, 2000, the law creates a state Medicaid option to extend the existing disabled worker buy-in program to workers *who no longer qualify for SSI or SSDI because of medical improvement*.³⁸ The term “an employed individual with a medically improved disability” means an individual who:
 - (1) is at least 16 but less than 65 years old who is “employed”, and
 - (2) who ceases to be eligible for Medicaid because of a medical improvement that is identified during a disability review, and
 - (3) who continues to have a severe impairment, as determined by the Secretary.³⁹

The term “employed” means work of at least 40 hours per month or being engaged in a work effort that meet substantial and reasonable threshold criteria for hours of work, wages or other measures, as defined by the state and approved by the Secretary.⁴⁰

- In addition to clarifying the option to use more liberal earnings tests than those used in the SSI program, the law expressly creates an option to cover workers with incomes in excess of the 250% QSI countable earnings threshold (with or without use of the §1902(r)(2) option). The law also revises existing premium and cost-sharing provisions to permit premium charges of up to 7.5% of family income in the case of individuals with incomes between 250% and 450% of the federal poverty level. The law also requires individual payment of 100% of the premium in the case of individuals whose adjusted gross incomes exceed \$75,000, adjusted after Calendar year 2000 for inflation. (States may subsidize individual payments out of state funds).⁴¹
- The law requires the Secretary of the Department of Health and Human Services to establish a demonstration program by October 1, 2000, for a Medicaid buy-in for people whose disabilities have not yet reached a severe enough stage to cause them to stop work and apply for disability benefits.⁴² The demonstration program is discussed *infra* at p. 16.

³⁶ Section 1882(q) of the Social Security Act; 42 U.S.C. §1395ss(q).

³⁷ Section 1902(a)(10)(A)(ii)(XV) as added by §201, Pub. L. 106-170.

³⁸ Section 1902(a)(10)(A)(ii)(XVI) as added by §201, Pub. L. 106-170. The Medicaid Buy-In program allows working people with disabilities to pay a premium to participate in their state's Medicaid program, similar to purchasing private health care coverage.

³⁹ Section 1905(d)(v) of the Social Security Act; 42 U.S.C. §1396d(v).

⁴⁰ *Id.*

⁴¹ Section 201, Pub. L. 106-170.

⁴² Section 204, Pub. L. 106-170.

- The law adds a new “anti-supplantation” provision in the case of states that elect to cover disabled workers. The provision requires states to demonstrate that the state’s expenditures for work supports other than medical assistance (e.g., adaptation of workplaces or technology, transportation) is not less than the amount expended by the state in the year preceding the date of enactment of the Act.⁴³

The following Table summarizes the changes to the disabled workers program resulting from the Act.

Table 4: Medicaid Work Incentives for Disabled Workers: Prior Law and the Ticket to Work Act

<p><i>Prior Law</i></p> <p>Mandatory coverage for SSI recipients who work: Individuals who qualify for SSI but for application of the substantial gainful activity earnings test; expanded earnings disregards that phase out once a worker reaches a “break-even “ point.</p> <p>Optional coverage for disabled workers who meet SSI disability criteria and whose earnings surpass the break even point (The QSI program): Individuals who no longer qualify for SSI payments but (1) whose incomes and resources are at or below 250% of the federal poverty level; (2) were disabled at the point at which coverage began and continue to be disabled; and (3) continue to meet all other SSI criteria outside of earnings. States may establish income-related premiums and cost sharing. States may use §1902(r)(2) to establish more liberal earnings disregards in order to allow workers to retain more income without surpassing the 250% of poverty test. Individuals must be disabled within the meaning of the SSI program in order to qualify and can show no medical improvement.</p> <p>Limits Under Mandatory and Optional Coverage. Coverage lost upon a showing of medical improvement; no coverage for persons not yet disabled; no option to cover workers with countable earnings over 250% of the federal poverty level.</p> <p><i>As Amended by the Ticket to Work Act</i></p> <p>New optional coverage for disabled workers who no longer meet SSDI/SSI criteria because of medical improvement: adds optional coverage for individuals who show medical improvement and who otherwise would lose eligibility as disabled workers as a result of a disability review.</p> <p>New buy-in program for workers with earnings over 250% of the FPL: Expressly allows states to extend coverage to workers with incomes above 250% of the federal poverty level on a buy-in basis. Limits cost sharing in the case of persons with earnings between 250% and 450% of the federal poverty level to 7.5% of family income and requires worker payment of 100% of premiums in the case of workers with earnings above \$75,000 in Calendar Year 2000, adjusted for inflation.</p> <p>New demonstration program for disabled workers who have not yet had to stop work: Directs the Secretary of HHS by October 1, 2000 to develop a demonstration program for disabled workers who have not yet become so impaired that they must file for benefits.</p> <p>New anti-supplantation provision: States that elect to extend benefits to disabled workers (with or without medical improvement) must satisfy anti-supplantation requirements that prohibit expenditures on non-medical assistance services that are lower than those made as of the date of enactment.</p>

⁴³ Section 1903(i)(20) of the Social Security Act; 42 U.S.C. §1396b(i)(20).

3. Implementation of the Act

HHS and the Social Security Administration (SSA) have launched a number of initiatives to implement the Act and assist states in program design.

HHS Initiatives

In October 2000, HHS announced two initiatives to facilitate implementation of the Act:

- *Medicaid Infrastructure Grant Program.* This program makes \$150 million available over the first five years of implementation to design, establish, and operate health care delivery systems that allow individuals with a disability to purchase health coverage through Medicaid.⁴⁴ Twenty-four states⁴⁵ and the District of Columbia received grant funding in the first round. Grant funds may also be used to help enhance systems that provide personal assistance services, such as help with bathing, dressing, and other activities at home or on the job. In addition, states can use the funds to assist employers in hiring individuals with disabilities, training staff, and improve transportation.⁴⁶

States are using grant funds in a variety of ways to enhance systems that will assist individuals with mental and physical disabilities:

- Connecticut will explore the programmatic and fiscal impact of expanding personal assistance services beyond the current populations and scope of services within its existing Medicaid waiver program to individuals who have chronic mental illness, mental retardation, or developmental disabilities.⁴⁷
- Minnesota will evaluate the effectiveness of its existing Medicaid Buy-in program, which is the largest in the country with over 4,000 enrollees. The state will also provide local infrastructure grants to agencies and businesses to remove barriers to employment for persons with disabilities. In addition, Minnesota will train local and state human service and provider agency staff on the Medicaid Buy-in and related work incentives programs.⁴⁸
- New Jersey's Medicaid Buy-in program became effective on October 1, 2000, which made it the first Buy-in program implemented under the Act. The state will use grant funds under the program to design and implement case management services for the Medicaid Buy-in population, establish an information system for gathering and reporting data, conduct outreach to potential beneficiaries and employers about

⁴⁴ See HHS TWWIIA Fact Sheet, available at <http://www.hcfa.gov/medicaid/twwiia/factsh01.htm>

⁴⁵ The states receiving first-round funding are Alabama, Alaska, Connecticut, Georgia, Idaho, Illinois, Iowa, Kansas, Maine, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, Utah, Vermont, Washington, West Virginia, and Wisconsin. For a listing of each state and its activities under the grant and demonstration programs, see http://www.hcfa.gov/medicaid/twwiia/inf_dmap.htm

⁴⁶ HHS TWWIIA Fact Sheet, available at <http://www.hcfa.gov/medicaid/twwiia/factsh01.htm>

⁴⁷ See http://www.hcfa.gov/medicaid/twwiia/inf_dmap.htm

⁴⁸ See *id.*

the Buy-in program, and train staff from state and county agencies and local organizations on the Medicaid Buy-in.⁴⁹

- *Medicaid Demonstration to Increase Independence and Employment.* This demonstration, funded with \$250 million from 2001-2006, will allow states to provide health care services and supports to working individuals with potentially severe impairments that are likely to lead to blindness or disability. The program is intended to allow workers to manage the progression of their condition. The program also allows states to evaluate whether providing these individuals with early access to Medicaid services delays the progression to actual disability. States define the number of individuals they will cover and which potentially severe impairments they will cover.

States are using grant funds in a variety of ways:

- Rhode Island will provide a full Medicaid-like benefit package to 100 individuals who have been diagnosed with Multiple Sclerosis but are not yet too disabled to work.⁵⁰
- Mississippi will use its grant funds to provide Medicaid coverage to 500 individuals with a diagnosis of HIV/AIDS who work or who are planning to return to work.⁵¹

HHS has announced new rounds of grant solicitations under the Medicaid Grant Infrastructure Program (February 7, 2001)⁵² and the Demonstration to Maintain Independence and Employment (October 26, 2000).⁵³

In addition, HCFA (now CMS) issued two State Medicaid Directors letters regarding implementation of the program. In the first letter, dated March 29, 2000, HCFA provided general information about the legislation, an overview of implementation plans for the new Medicaid eligibility groups created by the Act, and a description of the grant programs to assist states with infrastructure and demonstration projects.⁵⁴

In the second letter, dated August 29, 2000, HCFA provided additional information about the two new eligibility groups created by the Act and how eligibility is determined for those applying for coverage under these groups.⁵⁵

SSA Initiatives

On December 28, 2000, the SSA published a notice of proposed rulemaking (NPRM) outlining how the agency will implement the Act.⁵⁶ The public comment period closed on February

⁴⁹ See *id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² See <http://www.hcfa.gov/medicaid/smd20701.htm>

⁵³ See <http://www.hcfa.gov/medicaid/smd10260.htm>

⁵⁴ State Medicaid Directors Letter (March 29, 2000), available at <http://www.hcfa.gov/medicaid/smd32900.htm>

⁵⁵ State Medicaid Directors Letter (August 29, 2000), available at <http://www.hcfa.gov/medicaid/smd82900.htm>

⁵⁶ 65 Fed. Reg. 82844 (Dec. 28, 2000).

26, 2001.⁵⁷ The U.S. House Committee on Ways and Means held a public hearing on the proposed regulation on February 28, 2001.⁵⁸

The SSA proposed a three-year implementation of the Ticket to Work Program.⁵⁹ Under the program, SSA will no longer refer beneficiaries directly to state rehabilitation agencies for services. SSA will instead issue “tickets” to eligible beneficiaries, who can then take them to an approved service provider of their choice, called an employment network (EN).⁶⁰ The EN can be a private organization or public agency that has agreed to work with SSA to provide vocational rehabilitation, employment and other support services to assist beneficiaries in obtaining and retaining employment.⁶¹

In the NPRM, the SSA proposed that individuals with a disability who are determined as “Medical Improvement Expected” be denied a “ticket” to work until after their first Continuing Disability Review (CDR).⁶² This may, at a minimum, delay access to a ticket to work for those suffering from severe mental illnesses.

The program is voluntary. Beneficiaries can choose whether to participate and choose the EN to which they will assign their ticket. Beneficiaries can also change their EN. An EN can choose whether it will serve a beneficiary under the program.⁶³

After a beneficiary and an EN agree to work together, they will develop and sign an individual work plan outlining the specific services the EN will provide to the beneficiary.⁶⁴ They then submit the work plan to the program manager (PM) to record the beneficiary’s decision to assign the beneficiary’s ticket to the EN.⁶⁵ On September 29, 2000, the SSA contracted with Maximus, Inc. of Reston, Virginia, to serve as the PM for five years.⁶⁶

The EN can choose one of two methods of payment for serving beneficiaries under the program:

- Under the *outcome payment system*, the EN will receive a payment for each month (up to a maximum of 60 months) during which the beneficiary is not paid a federal disability benefit because of the beneficiary’s work and earnings.⁶⁷

⁵⁷ *Id.*

⁵⁸ The hearing materials are available from the Ways and Means Committee at <http://waysandmeans.house.gov/socsec/107cong/ss-1wit.htm>

⁵⁹ See “Ticket to Work Program” in *Disability Notes*, SSA Office of Disability, Issue 1 (No. 28), 2001, at 3.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² See 65 Fed. Reg. 82844 (Dec. 28, 2000). Once an individual is determined eligible for SSI or SSDI, the disability determination service in each state assigns the individual to one of three categories: Medical Improvement Expected (MIE), Medical Improvement Possible (MIP), or Medical Improvement Not Expected (MINE). The categorizations are for the purpose of determining the frequency of an individual’s CDR.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Id.*

⁶⁷ *Id.*

- Under the *outcome milestone system*, the EN will receive payment for helping the beneficiary achieve one or more milestones toward permanent employment, as well as up to 60 months of outcome payments. The total amount of outcome-milestone payments to an EN must be less than would be payable under the outcome payment system.⁶⁸

Under either payment system, outcome payment months do not have to be consecutive, and they can occur after the termination of disability benefits (if benefits terminate due to the beneficiary's work and earnings).⁶⁹ State vocational rehabilitation agencies can choose to be paid as an EN or reimbursed for the cost of rehabilitating the beneficiary to go to work.⁷⁰

On November 14, 2000, the SSA announced the thirteen states⁷¹ in which the agency will begin the program in 2001. Implementation in the remaining states and the District of Columbia will occur in 2003-2004. On April 20, 2001, the SSA issued a Request for Proposals (RFP) from providers of services to be ENs under the program.⁷²

4. The New Freedom Initiative

In February 2001, the Bush Administration announced The New Freedom Initiative, a new program to remove barriers to community living for people with disabilities. The goals of the program are to:

- Increase access to assistive and universally designed technologies;
- Expand educational opportunities;
- Promote homeownership;
- Integrate Americans with disabilities into the workforce;
- Expand transportation options; and
- Promote full access to community life.⁷³

In support of the new initiative, the President issued an Executive Order directing a number of federal agencies (HHS, SSSA, Labor, HUD, Education, and Justice) to collaborate Social Security Administration (SSA) to:

- Work together to assist states in achieving the goals of Title II of the ADA;
- Ensure that existing federal resources are used in the most effective manner to swiftly implement the *Olmstead* decision and support the goals of the ADA;
- Evaluate the policies, programs, statutes, and regulations of their

⁶⁸ *Id.*

⁶⁹ *Id.* at 3-4.

⁷⁰ *Id.* at 4.

⁷¹ See the SSA Ticket to Work Program fact sheet, available at <http://www.ssa.gov/work/ResourcesToolkit/ticketprogram.html>. The thirteen states are Arizona, Oregon, Illinois, Oklahoma, Florida, Delaware, Massachusetts, South Carolina, New York, Vermont, Wisconsin, Colorado, and Iowa. *Id.*

⁷² The RFP is available at <http://www.epl.gov/spg/SSA/DCFIAM/OAG/SSA-RFP-01-0010/Attachments.html>

⁷³ For a complete description of the initiative, see HHS's website at www.os.dhhs.gov/newfreedom/

respective agencies to determine whether any should be revised or modified to improve the availability of community-based services for qualified individuals with disabilities; and

- Ensure that each agency's self evaluation includes input from consumers, advocacy organizations.⁷⁴

The Order required agencies to submit the results of their evaluations through HHS to the President by October 16, 2001. How the initiative will affect working individuals with mental illnesses or addiction disorders remains to be seen.

Key Issues in Designing Medicaid Programs for Disabled Workers

1. Eligibility, enrollment, and case-finding

Experts in disability and work invariably point to access to comprehensive, affordable health insurance coverage as one of the major factors that causes an individual with a disability to either pursue or forego work opportunities. Expanded Medicaid is thus integral to economic self-sufficiency. Not only does the retention of Medicaid ease a principal concern among persons with disabilities, but employers who might not otherwise consider hiring workers with severe disabilities might be more willing to do so if adequate health coverage is assured.

a. Expanding eligibility

It is difficult to calculate the significance of the 1999 amendments, particularly in states that offer a spend-down program for workers who no longer qualify for Medicaid automatically by virtue of their receipt of SSI.

As noted, at the time of enactment of the 1999 legislation, few states had taken advantage of prior law options. In its cost estimates for the Act, the Congressional Budget Office (CBO) estimated that only about 1000 workers were already enrolled in the QSI program but that the amendments would cause states to expand their activities sufficiently to reach an additional 2500 workers annually.⁷⁵ CBO estimated the cost of the coverage to be \$6500 per capita in FY 2000, rising to \$9000 by 2004.⁷⁶

As with all Medicaid expansions, the cost question is complex. Particularly in the case of disabled workers, however, the case for expansion would appear to outweigh the risk of increased cost. The logic of the Act is that it allows people to work to a significant degree without losing Medicaid. The value of work extends far beyond the immediate cost of the incentive under state Medicaid program. Furthermore, the Act permits states to offset at least a portion of their costs through the use of premiums. Finally, there are other possible cost offsets. Some portion of the workers aided through a liberalization of Medicaid coverage would also qualify for the Medicare buy-in program and might also qualify for employer benefits.

⁷⁴66 *Fed. Reg.* 33155-33156 (June 21, 2001).

⁷⁵ S. Rep. 106-37, op. cit.

⁷⁶ *Id.*

In the case of the “medical improvement” option, CBO estimated this cost as lower than the cost of extending coverage to disabled workers who meet the SSI test, because the agency assumes that only 5% of all workers would show enough improvement during any year to lose benefits.⁷⁷ This low number suggests that once a state decides to aid disabled workers, the cost of adding the “medical improvement” component would be relatively nominal.

b. Case-finding

The case finding provisions of the law underscore Congressional intent to invest significant resources in building interest and awareness among persons with disabilities regarding Medicare and Medicaid options and benefits. As case finding increases over time, states may expect a considerable increase in the demand for expanded Medicaid benefits. Therefore, it is important for Medicaid programs to be actively involved in planning from the outset. As states begin to put together follow-up initiatives under the Act, Medicaid agency participation is key, as is participation from potential collaborating employers.

2. Coverage and benefits

Because of their needs, working disabled SSI recipients and qualified severely impaired persons are entitled to the same items and services covered for categorically need individuals. Existing coverage options, with or without use of Medicaid waiver authority, allow coverage of key benefits not typically found in employer benefits or Medicare that could effectively wrap-around whatever basic coverage is available to a disabled worker. This is significant for individuals with mental illness or an addiction disorder because those individuals receiving SSDI who are without Medicaid coverage cannot receive services that are especially useful for mental illness and addiction disorders, such as psychiatric counseling, rehabilitation, and targeted case management. Planning for these additional benefits means consultation with consumers, experts in work and disability, and insurers offering employee benefit plans in order to determine the areas in which Medicaid wrap-around services are the most important.

3. Use of managed care

In the case of non-dually Medicare and Medicaid eligible adults with disabilities, states have the option to require enrollment in managed care as a condition of coverage without obtaining federal waivers under either §1915(b) or §1115 of the Social Security Act.⁷⁸ States also can mandate enrollment through one of these two waiver programs.

Use of managed care systems for adults with disabilities who receive only Medicaid is increasingly common. A 1998 analysis of Medicaid managed care for persons with disabilities found that 36 states operated one or more Medicaid managed care programs that enrolled non-elderly persons with disabilities, for a total of 58 separate programs. At this point approximately 1.6 million

⁷⁷ *Id.*

⁷⁸ Section 1932 of the Social Security Act allows mandatory enrollment of disabled adults as a state option. However, most states continue to use either §1915 or §1115 as the legislative basis for their mandatory programs.

persons with disabilities were enrolled, representing 27 percent of all non-elderly persons with disabilities.⁷⁹

For behavioral health care, 42 states (including the District of Columbia) operated some form of public managed behavioral health care in 1999.⁸⁰ This was a three-fold increase in the number of public managed behavioral health care programs since 1996.⁸¹

Perhaps the most striking aspect of the programs covered in the 1998 survey of Medicaid managed care for persons with disabilities is their similarity to programs operated for persons without disabilities. The majority used capitation payment methods to at least some degree to compensate providers; the majority of persons with disabilities were enrolled in capitated systems.⁸² Most programs used enrollment brokers, and all mandatory programs used auto-enrollment to ensure assignment to a managed care system.

In sum, beyond the issue of eligibility and basic program enrollment, program design requirements and options in Medicaid for working adults with disabilities are virtually identical to those used for any other Medicaid population. The techniques of managed care – e.g., contractual arrangements with health care providers and integrated delivery systems, comprehensive service and case management obligations, and risk-based payment arrangements – are nearly as prevalent among the population of beneficiaries with disabilities as is the case with beneficiaries without disabilities.⁸³ Risk-sharing and service-specific payment arrangements may, however, vary.

States that elect to pursue disabled workers programs that employ managed care-style insurance arrangements may wish to consider several separate issues:

- Special added qualifications for companies that wish to participate in Medicaid as contractors for persons with disabilities that entail an ability to demonstrate the capabilities necessary to support a disabled worker in a job. Examples of such added capabilities are: 1) expanded office hours; 2) access to medical consultation and administrative services by telephone and other means that do not require in-person contacts; 3) network providers skilled in the provision of medical and health services to individuals with serious disabilities who work; and 4) network providers with an ability to work with employers to assist them to understand and make the reasonable accommodations that may be required in order to employ a disabled worker (e.g., helping design work arrangements that permit workers with disabilities the added time and workplace flexibility necessary to address health needs appropriately while on the job).

⁷⁹ Marsha Regenstein and Christy Schroer, “Medicaid Managed Care for Persons with Disabilities: State Profiles.” (Kaiser Commission on Medicaid and the Uninsured, Washington D.C., 1999).

⁸⁰ SAMHSA, Managed Care Tracking System, *State Profiles, 1999, on Public Sector Managed Behavioral Health Care*, at p.1.

⁸¹ *Id.*

⁸² Marsha Regenstein and Christy Schroer, “Medicaid Managed Care for Persons with Disabilities: State Profiles.” (Kaiser Commission on Medicaid and the Uninsured, Washington D.C., 1999), at p. 3. Behavioral health, pharmacy, dental, long term care and hospice typically were carved out of the capitation rate. In addition, it is typical for managed care contracts to exempt altogether from contractors’ service duties certain types of long term care services, which remain accessible through the traditional Medicaid fee for service system. *Negotiating the New Health System, op. cit.*

⁸³ Regenstein and Schroer, 1999. *op. cit.*

- In the case of behavioral health and addiction disorders, such added qualifications might include: 1) employee assistance programs with specific capabilities for mental health/addiction disorders; 2) access to counseling and therapy to address workplace requirements and coping skills; and 3) coordination of mental health and addiction disorder treatment with treatment of physical conditions.
- Consulting with employers that offer health insurance regarding the companies with which employers do business and the development of special Medicaid managed care products that use the services of these companies so that a single blended premium and contract can be negotiated for all employer-sponsored and Medicaid covered items and services.
- Developing an ombudsman program to assist workers with disabilities who have access to employer benefits to enroll and pursue benefits.

4. Recent court decisions with program design implications

Access to Medicaid benefits for persons with disabilities is currently an issue that is receiving extensive attention from a litigation point of view. Several recent judicial decisions, specifically *Olmstead v L.C. by Zimring*,⁸⁴ *Cramer v Chiles*,⁸⁵ and *Benjamin v Obl*,⁸⁶ are of particular relevance.

In *Olmstead*, the United States Supreme Court held that the Americans with Disabilities Act prohibits as discriminatory the inappropriate institutionalization of individuals with disabilities. This case involved persons with mental disabilities. There is no reason to think that the central holding regarding the requirements of the ADA would be confined to persons with mental disabilities, although inappropriate institutionalization for persons with mental illness may be more common. The Court held further that the reasonable modification requirements of the Act which apply to publicly funded programs require that states have “a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated.”⁸⁷ The need to move inappropriately institutionalized persons into community setting can be expected to lead to a greater focus on the systems of care that would have to be in place to ensure that community placements are not themselves inappropriate.

The *Cramer* and *Benjamin* cases involved legal challenges by children and adults with disabilities who reside in the community to waiting lists for both ICF/MR services and alternative home and community based waiver services. In the cases, the plaintiffs, children and adults with severe mental and physical disabilities, challenged their states’ lengthy waiting lists for both ICF/MR and community services. Both courts held that various provisions of the Medicaid statute, including the plaintiffs’ basic entitlement to services and the prohibition against relying on budget considerations as a defense to limiting the benefits to which enrollees are entitled, prohibit unreasonable denials on access to care and ordered defendants to develop *Olmstead*-like plans for

⁸⁴ 119 S. Ct. 2176 (1999).

⁸⁵ 33 F. Supp. 2d 1342 (E.D. Fl., 1999).

⁸⁶ 1999 U.S. Dist. LEXIS 22453 (S.D. W. Va. July 15, 1999).

⁸⁷ *Olmstead*, 119 S. Ct. at 2183. For an analysis of the *Olmstead* case, see Sara Rosenbaum, “*Olmstead v L.C.*: Implications for Persons with Mental Illness and Addiction Disorders,” (Prepared for the Substance Abuse and Mental Health Services Administration, July 1999).

moving individuals into appropriate care settings. As of May 2001, The *Cramer* decision has been cited and followed in federal and state courts in six states.⁸⁸ As states implement *Olmstead*, we expect to see additional case law interpreting access to Medicaid benefits for persons with disabilities.

Thus, whether viewed from the vantage point of an individual who has been inappropriately institutionalized (as in *Olmstead*) or one who languishes untreated in the community, the ADA, as well as the Medicaid program itself, prohibit unreasonable limits on necessary and covered treatment, whether in a community or residential setting. As the import of these “bookend” decisions becomes clearer, the effort to develop more accessible and appropriate managed care systems for adults with disabilities can be expected to grow. As these systems develop, an increasingly important set of issues, discussed below, will be the services and supports that they should be expected to provide in the case of adults with disabilities who work.

Conclusion

The Ticket to Work and Work Incentives Improvement Act reflects the continuing change in U.S. social policy toward the full integration into society of persons with disabilities, including those persons with disabling mental health and addiction disorder conditions. The Act builds on reforms begun nearly 20 years ago that were designed to ensure that the lack of health coverage was no impediment to work. Taken together, the Act allows states to extend Medicaid to virtually any working individual with a disabling impairment, as the term is used under the Social Security Act, as well as working individuals whose disabilities have improved. The demonstration provisions of the Act also offer an important opportunity to learn more about adapting Medicaid to the needs of workers who would become disabled without medical care.

The provisions of the Act offer states significant flexibility to design their health systems to meet the needs of workers with disabilities. Implementation of these changes should be viewed as part of a more comprehensive, across-the-board effort to improve a state’s overall work incentive policies in the areas of employment assistance, training, personal supports, and other matters.

The widespread use of managed care for Medicaid beneficiaries with disabilities means that adapting managed care to the needs of disabled workers will necessarily be a part of any design strategy. States should consider including contractors who serve persons with disabilities in any ongoing discussions around implementation of the employment incentives, so that the companies can in turn adapt their own operations where necessary to a working population that has significant disabilities.

⁸⁸ See *Boulet v. Cellucci*, 107 F.Supp 2d 61 (D.Mass. 2000) (finding that Massachusetts had failed to provide Medicaid-mandated residential habilitation services with reasonable promptness); *Delong v. Houston*, 2000 U.S. Dist. LEXIS 16060 (E.D. Pa. Oct. 25, 2000)(denying a summary judgment motion and noting that a failure to provide services to all developmentally disabled individuals eligible under a waiver could violate Medicaid’s freedom of choice provisions); *Meachem v. Wing*, 77 F.Supp. 2d 431 (S.D.N.Y. 1999)(citing *Cramer* in support of a private right of action by beneficiaries); *Benjamin v. Ohl*, 1999 U.S. Dist. LEXIS 22469 (S.D. W. Va. July 15, 1999)(discussed in text, *supra*); *Makin v. Hawaii*, 114 F.Supp. 2d 1017 (D. Haw. 1999)(denying a summary judgement motion, in part, because Hawaii failed to demonstrate why slots were not filled in the state’s Medicaid program for home and community-based services for the developmentally disabled or mentally retarded); and *Sanon v. Wing*, 2000 N.Y. Misc. LEXIS 139 (N.Y. Sup. Ct. Feb. 25, 2000)(vacating New York’s decision to terminate Medicaid home health care services for individuals who would then have to enter nursing homes).

To date, state response to the Medicaid work incentive options has been limited. Because the cost of expanded Medicaid would appear to be offset at least in a global sense by the value of increasing work. It is clear that implementation of this option involves more than simply expanding eligibility and raises a series of program design questions in the area of coverage, cost sharing, and use of managed care. Of particular importance is considering the relationship between Medicaid and employee benefits, so that where feasible, access to employee benefits becomes possible, with Medicaid playing a supplemental role. In this regard, Medicaid supplementation raises two separate policy considerations: 1) Medicaid as a source of coverage for benefits that are not part of employee health plans; and 2) Medicaid as a source of additional coverage for benefits that are included in employee plans but only up to a limited degree. This is particularly important in the case of mental health and addiction disorder-related benefits, which are often either excluded or quite limited in employee plans. The increased access to such benefits through Medicaid supplementation (either as the prime or additional source of coverage) would benefit those with severe mental illness or addiction disorders and provide an incentive for them to return to work.

Future research questions regarding implementation of the Medicaid work incentives options are as follows:

- What are the financial and administrative costs of adopting the work incentives options? To what extent are these costs offset by earnings or other economic advantages that flow from work?
- What earned income disregards, financial eligibility standards, cost sharing rules do states adopt, and how do state choices affect enrollment?
- How do employers respond to the availability of Medicaid on a continuing basis? Does the presence of Medicaid increase the likelihood that they will offer employment?
- How well do potential beneficiaries understand the expanded Medicaid work incentives options, and what role do consumers and consumer advocacy groups play in their advocacy and implementation at the state level?
- What changes do managed care entities make to accommodate workers with disabilities?
- Can Medicaid be made to function as a “wrap-around” to employee benefits, and how are coverage and costs shared? What are the total costs of the combined programs?
- Do states exercise the option to allow workers to retain Medicaid following medical improvement? What are the costs of this option and its impact on continued work?

In addition, the demonstration program for workers at risk for disability will raise implementation issues as CMS continues implementation of the program.