



Working People with Disabilities

**Report to the Florida Legislature
November 30, 2018**



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Executive Summary

The Agency for Health Care Administration (Agency) serves as the single state agency responsible for administering the Florida Medicaid program. There are federal and state guidelines that identify which individuals are able to participate in the program. Although the Agency administers the Florida Medicaid program, the Department of Children and Families determines Florida Medicaid eligibility.

During the 2018 legislative session, the General Appropriations Act directed the Agency to seek federal approval to operate a program described as “Working People with Disabilities.” The Legislature directed the Agency to provide a report, prior to implementation, on the estimated costs and a status of obtaining a federal waiver, state plan amendment, or other required federal authorization. This report meets that requirement and examines potential opportunities to increase income eligibility limits so that adults who receive services under Florida’s Medicaid waiver programs could maintain Medicaid coverage.

The Agency evaluated three options to implement a Working People with Disabilities program to allow individuals with disabilities to work and earn additional income without losing their Medicaid coverage. These options include the following:

- 1) Submit a state plan amendment to “disregard” certain specified income sources when determining Medicaid eligibility.
 - Florida could waive certain income and resource rules for individuals receiving services through home and community-based services waivers. This would allow the State to disregard earned income to increase the monthly income limit above 300% of the Federal Benefit Rate, which is the maximum allowable through home and community-based services waivers.
- 2) Increase utilization of Miller Trusts/Qualified Income Trusts.
 - Florida could increase outreach regarding Miller Trusts/Qualified Income Trusts to inform more home and community-based services waiver recipients about their potential to utilize a Qualified Income Trust.
- 3) Implement a Medicaid Buy-In program.
 - Florida could implement a Medicaid Buy-In option to allow eligible individuals to pay a premium in exchange for services. A Medicaid Buy-In program could be enacted through either the federal Balanced Budget Act or the federal Ticket to Work and Work Incentives Improvement Act.

This report details the Agency’s evaluation of these options and provides a recommended action for implementing a Working People with Disabilities program upon receipt of legislative approval. While all three options have the potential to allow working adults with disabilities to increase their income limits while retaining Florida Medicaid coverage, the Agency recommends the state plan amendment option as the most effective method to implement this program.

Section I. Background

Purpose of the Report

The 2018 Florida Legislature passed the General Appropriations Act, House Bill 5001, which included:

The Agency for Health Care Administration is directed to seek approval for a federal waiver, a state plan amendment, or other federal authorization to provide a program called Working People with Disabilities, for adults who receive services under Florida's Medicaid waiver programs. Prior to implementation, the Agency shall provide a report on the estimated costs to the Medicaid Program and a status of the federal waiver, state plan amendment, or other required federal authorization. The report shall be provided to the Executive Office of the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than November 30, 2018. Implementation of the program is subject to Legislative approval.

The Agency understands the intent of this provision in the General Appropriations Act to be a direction to explore potential options to enable certain groups of individuals to work and maintain access to Florida Medicaid coverage. This report includes population definitions, implementation plans, and the associated fiscal impacts to the Florida Medicaid program.

Individuals with Disabilities in the Workforce

Maintaining gainful employment is considered an important aspect of adult life. However, many people with disabilities are unemployed or underemployed.

In 2017, the United States Department of Labor, Bureau of Labor Statistics, reported that only 19% of people with disabilities were employed.^{1,2} While part of the reason for this is that more than half of people with disabilities are ages 65 and over, they concluded that across all age groups, people with a disability were less likely to be employed than those with no disability. For example, only 29% of people ages 16 to 64 with a disability were employed in 2017 compared to 74% employment of people ages 16 to 64 without a disability.³

In 2016, Florida's overall prevalence rate of people with a disability was 14% across all ages.⁴ This percentage includes people with hearing, visual, cognitive, ambulatory, and self-care disabilities. For people with disabilities, Florida's employment rate was slightly higher than the national average at 33% in 2016.⁵ Incomes are also significantly lower for people with

¹ United States Department of Labor, Bureau of Labor Statistics (2018). Persons with a Disability: Labor Force Characteristics Summary. Retrieved from: <https://www.bls.gov/news.release/disabl.nr0.htm>

² All percentages cited in this section have been rounded to the nearest percent.

³ United States Department of Labor, Bureau of Labor Statistics (2018). Persons with a Disability: Labor Force Characteristics Summary. Retrieved from: <https://www.bls.gov/news.release/disabl.nr0.htm>

⁴ Erickson, W., Lee, C., & von Schrader, S. (2018). 2016 Disability Status Report: Florida. Ithaca, NY: Cornell University Yang-Tan Institute on Employment and Disability (YTI). Retrieved from: http://www.disabilitystatistics.org/StatusReports/2016-PDF/2016-StatusReport_FL.pdf?CFID=11151456&CFTOKEN=e81f37ab264b0f62-6E372F86-B4B0-2D60-095425A66E9EA979

⁵ Reported for ages 21 to 64.

disabilities. For those employed individuals with disabilities, the median earnings in 2017 for the non-institutionalized population ages 16 and older was \$23,006, compared to \$35,070 for those without a disability.⁶

Medicaid Program Overview

Medicaid is an entitlement program that provides health insurance coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states, in accordance with federal requirements codified in the Social Security Act. Each state operating a Medicaid program has a state plan, which serves as an agreement between the state and the federal government describing how that state administers its Medicaid program.

States and the federal government jointly fund Medicaid. As of August 2018, Medicaid covers nearly 73 million people.⁷ In fiscal year 2017, Medicaid program costs accounted for over \$576 billion in spending in the federal and state budgets.⁸ In state fiscal year 2018-2019, Florida's Medicaid program is estimated to cost \$27.5 billion and is projected to serve approximately 3.8 million Floridians.⁹

Medicaid State Plan

Each state that provides Medicaid services to its residents must agree to provide core health services to recipients through the federal Centers for Medicare & Medicaid Services (CMS) approved Medicaid state plan. The CMS provides the state with funding to provide the services at a percentage of the cost, or the state's federal match. The state may apply to CMS for approval of a state plan amendment when it wants to change its program policies or operational approach, make corrections, or update their state plan with new information.

Medicaid Waivers

States can request approval from CMS for a waiver of certain requirements found in 1902(a) of the Social Security Act. There are several types of waivers, which include:

- **Section 1115 Research & Demonstration Waivers:** Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid program. The purpose of these demonstrations, which give states additional

⁶ United States Census Bureau (2017). Median Earnings in the Past 12 Months (in 2016 inflation-adjusted dollars) by Disability Status by Sex for the Civilian Noninstitutionalized Population 16 Years and Over with Earnings: Civilian noninstitutionalized population 16 years and over with earnings in the past 12 months. Retrieved from: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_B18140&prodType=table

⁷ Retrieved from Medicaid.gov

⁸ Analysis of data from the Henry J. Kaiser Foundation. Retrieved from <https://www.kff.org/medicaid/state-indicator/total-medicaid-spending/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁹ Social Services Estimating Conference Medicaid Caseloads and Expenditures (2018). Florida Office of Economic and Demographic Research. Retrieved from <http://edr.state.fl.us/Content/conferences/medicaid/execsummary.pdf>

flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid eligible;
- Providing services not typically covered by Medicaid; or
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

There are general criteria CMS uses to determine whether Medicaid program objectives are met. These criteria include whether the demonstration will:

- Increase and strengthen overall coverage of low-income individuals in the state;
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- Improve health outcomes for Medicaid and other low-income populations in the state; or
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Demonstrations must also be "budget neutral" to the federal government, which means that during the course of the project federal Medicaid expenditures will not be more than federal spending would have been without the demonstration. An 1115 Research and Demonstration Waiver is the broadest and most flexible authority¹⁰.

- Section 1332 State Innovation Waivers:¹¹ A State Innovation Waiver allows states to implement innovative ways to provide access to quality health care that is at least as comprehensive and affordable as would be provided absent the waiver, provides coverage to a comparable number of residents of the state as would be provided coverage absent a waiver, and does not increase the federal deficit.
- Section 1915(b) Selective Contracting/Managed Care Waivers: States can utilize waiver authority under 1915(b) for selective contracting and to implement a managed care delivery system. There are four 1915(b) waivers:
 - (b)(1) Freedom of Choice - restricts Medicaid enrollees from receiving services within the managed care network.
 - (b)(2) Enrollment Broker - utilizes a "central broker."
 - (b)(3) Non-Medicaid Services Waiver - uses cost savings to provide additional services to beneficiaries.

¹⁰ Retrieved from <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>

¹¹ Retrieved from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers.html

- (b)(4) Selective Contracting Waiver - restricts the provider from whom the Medicaid eligible may obtain services.

The primary differences between a 1915(b) waiver program and a state plan program are:

- States are able to require dual eligibles, American Indians, and children with special health care needs to enroll in a managed care delivery system.
- States must demonstrate that the managed care delivery system is cost-effective, efficient, and consistent with the principles of the Medicaid program.
- The approval period for the state's 1915(b) waiver program is limited to two years. Medicaid state plan authority does not have an expiration date.¹²
- Sections 1915(c) Home and Community-Based Services Waivers: Home and community-based services first became available in 1983 when Congress added section 1915(c) to the Social Security Act, giving states the option to receive a waiver of Medicaid rules governing institutional care. In 2005, home and community-based services became a formal Medicaid State plan option.¹³ States can develop home and community-based services waivers to meet the needs of people who prefer to receive long-term care services and supports in their home or community, rather than in an institutional setting such as a nursing facility or an intermediate care facility for individuals with intellectual disabilities. Individuals enrolled in these programs may limit the amount they work, or choose not to work, to ensure their income does not exceed income limits so that they can retain financial eligibility for the waiver and have continued access to home and community-based waiver services.

Federal waivers offer states flexibility to tailor services to meet the needs of a particular targeted group. Within these targeted groups, states may establish additional criteria to further target the population served through a home and community-based services waiver, including clinical eligibility criteria such as a specific institutional level of care. A level of care is a medical determination that the individual, absent the provision of home and community-based waiver services, would require services in an intermediate care facility for individuals with intellectual disabilities, a nursing facility, or a hospital. Waivers also allow states limit the number of eligible Medicaid recipients served.

Medicaid State Plan Options

- 1915(i) State Plan Home and Community-Based Services:¹⁴ States can offer a variety of services under a state plan home and community-based services benefit. People must meet state-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment, and home modifications) in home and community-based settings. Options include:

¹² Retrieved from <https://www.medicaid.gov/medicaid/managed-care/authorities/index.html>

¹³ Retrieved from <https://www.medicaid.gov/medicaid/hcbs/authorities/index.html>

¹⁴ Retrieved from <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-i/index.html>

- Target the HCBS benefit to one or more specific populations
- Establish separate additional needs-based criteria for individual HCBS
- Establish a new Medicaid eligibility group for people who get State Plan HCBS
- Define the HCBS included in the benefit, including state- defined and CMS-approved "other services" applicable to the population
- Option to allow any or all HCBS to be self-directed
- 1915(j) Self-Directed Personal Assistant Services Under State Plan:¹⁵ Self-directed personal assistance services are personal care and related services provided under the Medicaid state plan and/or section 1915(c) waivers the state already has in place. Participation in self-directed personal assistance services is voluntary. Participants set their own provider qualifications, train their personal assistance services providers, and determine how much they pay for a service, support, or item. States can:
 - Target people already getting section 1915(c) waiver services
 - Limit the number of people who will self-direct their personal assistance services
 - Limit the self-direction option to certain areas of the State, or offer it Statewide
- 1915(k) Community First Choice:¹⁶ The "Community First Choice Option" allows states to provide home and community-based attendant services and supports to eligible Medicaid enrollees under their state plan. This state plan option was established under the Affordable Care Act of 2010 and provides a 6-percentage point increase in federal matching payments to states for service expenditures related to this option.

¹⁵ Retrieved from <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-j/index.html>

¹⁶ Retrieved from <https://www.medicaid.gov/medicaid/hcbs/authorities/1915-k/index.html>

Section II. Florida's Medicaid Program

The Agency for Health Care Administration is the single state Medicaid agency responsible for administering the Florida Medicaid program. Florida provides Medicaid services through the Statewide Medicaid Managed Care program or through the fee-for-service delivery system. The majority of Medicaid recipients who are eligible for the full array of Medicaid services receive their services through competitively selected managed care organizations within the Statewide Medicaid Managed Care program.

The Statewide Medicaid Managed Care program was fully implemented in August 2014 and has three components: the Managed Medicaid Assistance program, the Long-Term Care program, and the Dental program. The Managed Medical Assistance program covers most medical and acute care services for health plan enrollees, including substance use disorders and mental health treatment services. The Long-Term Care program provides long-term care services and supports to eligible individuals with disabilities age 18-64 and elderly individuals age 65 or older, including individuals over the age of 18 with a diagnosis of cystic fibrosis, acquired immune deficiency syndrome (AIDS), or a traumatic brain or spinal cord injury. The Dental program provides dental services to all Medicaid recipients who are eligible to receive the dental benefit.

The Agency partners with other state agencies and entities for various administrative functions, including:

- The Department of Children and Families – Determines Medicaid eligibility in Florida.
- The Agency for Persons with Disabilities – Operates the Developmental Disabilities Individual Budgeting Waiver.
- The Department of Health – Operates the Family Planning Waiver.
- The Department of Elder Affairs – Determines clinical eligibility for the Statewide Medicaid Managed Care Long-Term Care Waiver program.
- The Aging and Disability Resource Centers – Statewide not-for-profit agencies that maintain the waitlist for the Statewide Medicaid Managed Care Long-Term Care program, through contracts with the Department of Elder Affairs.

The Department of Children and Families, Medicaid Eligibility Determinations

In Florida, either the Department of Children and Families or the Social Security Administration determines Medicaid eligibility. The Department of Children and Families determines Medicaid eligibility for:

- Parents and caretaker relatives of children
- Children
- Pregnant women
- Individuals formerly in foster care
- Non-citizens with medical emergencies

- Aged or disabled individuals not currently receiving Supplemental Security Income

Individuals apply for services using the Department of Children and Families' Automated Community Connection to Economic Self Sufficiency (ACCESS) Florida system. The ACCESS Florida system allows customers to connect with their public assistance information 24 hours a day, 7 days a week, through the online application and MyACCESS account. The ACCESS Program also helps to promote strong and economically self-sufficient communities by determining eligibility for food, cash, and medical assistance for individuals and families on the road to economic recovery. The Department of Children and Families transfers applications for individuals determined not eligible for Medicaid to the Federally Facilitated Marketplace or Florida KidCare.

The Social Security Administration determines eligibility for Supplemental Security Income recipients. Florida residents who are eligible for Supplemental Security Income are automatically eligible for Medicaid coverage. There is no requirement to file a separate ACCESS Florida application unless nursing facility services are needed. If long-term care services in a nursing facility or community setting are needed, the individual must identify the need on the application.

As demonstrated in the following table, individuals enrolled in a home and community-based services waiver in Florida currently have a monthly income limit of \$2,250, or \$4,500 for a couple, which is 300% of the Supplemental Security Income Federal Benefit Rate. This is an individual annual income limit of \$27,000, or \$54,000 for a couple.¹⁷ This is the maximum income a person can have and still be eligible for a home and community-based services waiver.

¹⁷ Department of Children and Families (2018). Memorandum of SSI-Related Programs – Financial Eligibility Standards. Retrieved from https://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf

SSI-Related Programs -- Financial Eligibility Standards: October 2018														
PROGRAMS & TYPES OF COVERAGE	INCOME		ASSETS		MAINTENANCE NEEDS STANDARDS / OTHER									
	Individual	Couple	Individual	Couple										
PROGRAMS MANAGED BY SOCIAL SECURITY														
*Supplemental Security Income (SSI) Federal Benefit Rate (FBR) Cash payment of SSI from SSA; Includes Full Medicaid	\$750 (FBR)	\$1,125 (FBR)	\$2,000	\$3,000	Disregards: *Standard Disregard = \$20 *Earned Income Disregard = \$65 + 1/2 Student Earned Income Disregard = \$1,820 monthly, maximum \$7,350 for calendar year Ineligible Spouse Deeming: 1/2 FBR = \$375 Child Allocation = \$375/child (Difference between the couple and single FBR)									
*Low Income Subsidy (LIS) or Extra Help (150% FPL) Helps with costs associated with Medicare Prescription Drug Plans Automatic with full Medicaid or Medicare Savings Programs (QMB, SLMB, QI1). Income asset limits change annually	\$1,518	\$2,058	\$14,100	\$28,150	Parent to Disabled Child Deeming: Parent Allocation = \$750 Disability Substantial Gainful Activity (SGA) = \$1,180 non-blind \$1,970 blind Medicare Part B Premium = \$134.00, Part A free for most or \$422									
PROGRAMS FOR PEOPLE 65+ OR DISABLED (Community Medicaid Programs)														
*MEDS-AD (MM S) (88% FPL) Full Community Medicaid	\$891	\$1,208	\$5,000	\$6,000	* A \$20 General Income Disregard applies to these programs. \$20 will be subtracted from the total of all income, not based on need before comparing the income to the income limit. In addition, \$65 is subtracted from the total of all earned income, and 1/2 the remainder is subtracted before comparing the income to the income limit.									
*Medically Needy (No Income Limit) Medically Needy Income Level (MNIL) Full Community Medicaid when Share of Cost is met	Subtract \$180 from gross income	Subtract \$241 from gross income												
PROGRAMS FOR PEOPLE WITH MEDICARE (Medicare Savings Programs/Buy-In)														
*QMB (100% FPL) Pays Medicare A & B premiums, coinsurance & deductibles only	\$1,012	\$1,372	\$7,560	\$11,340	PERSONAL NEEDS ALLOWANCE <table border="1"> <thead> <tr> <th>Individual</th> <th>Couple</th> </tr> </thead> <tbody> <tr> <td>\$130</td> <td>\$260</td> </tr> <tr> <td>Community NH \$1,012 NH \$130</td> <td>Community NH \$1,372 NH \$260</td> </tr> <tr> <td colspan="2"> PACE / SMMC-LTC in ALF: R&B+ \$202 / \$404 PACE / SMMC-LTC at home: \$2,250 / \$4,500 PACE in NH: \$130 / \$260 iBudget : \$2,250 / \$4,500 References: 2640.0117.01 & 2640.0118 </td> </tr> </tbody> </table>		Individual	Couple	\$130	\$260	Community NH \$1,012 NH \$130	Community NH \$1,372 NH \$260	PACE / SMMC-LTC in ALF: R&B+ \$202 / \$404 PACE / SMMC-LTC at home: \$2,250 / \$4,500 PACE in NH: \$130 / \$260 iBudget : \$2,250 / \$4,500 References: 2640.0117.01 & 2640.0118	
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*SLMB (120% FPL) Pays for Medicare Part B premium only (PBMO)	\$1,214	\$1,646												
*QI1 (135% FPL) PBMO	\$1,366	\$1,852												
*Working Disabled (200% FPL) Qualified Disabled Working Individuals (QDWI) Program Pays for Medicare Part A only. Must have lost SSDI due to employment	\$2,024	\$2,744	\$5,000	\$6,000	SSI Individual \$30 only in NH = \$100 (SPS) Transfer of Asset Divisor = \$9,171 (eff 7/1/2018) Community Hospice Allocations: Spouse only = FBR (\$750) Spouse + Dependents or Dependents Only = CNS Standard Spousal Impoverishment: MMMNA = \$2,058 Excess shelter = \$617 Standard Utility Allowance = \$359 Maximum Income Allowance = \$3,090 Community Spouse Resource Allowance = \$123,600 Family Members Allowance with Spouse = (MMMNA-income) divided by 3 Dependents with no Spouse = CNS Standard Home Equity Interest Limit = \$572,000									
PROGRAMS BASED ON INSTITUTIONAL POLICY – Patient Responsibility and Income Trusts may apply.														
Institutional Care Program (ICP) Pays Nursing Home (NH) room, board & care Pays Medicare A & B premiums, coinsurance & deductibles	\$2,250 (MEDS-AD Institutional Income Limit \$891)	\$4,500 (MEDS-AD Institutional Income Limit (\$1208))	\$2,000 (\$5,000 if MEDS-AD eligible)	\$3,000 (\$6,000 if MEDS-AD eligible)	<table border="1"> <thead> <tr> <th>Individual</th> <th>Couple</th> </tr> </thead> <tbody> <tr> <td>\$130</td> <td>\$260</td> </tr> </tbody> </table>		Individual	Couple	\$130	\$260				
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Hospice Pays Hospice services related to terminal illness Pays Medicare A & B premiums, coinsurance & deductibles														
Home and Community Based Services (HCBS) or Waivers Pays Medicare A & B premiums, coinsurance & deductibles														
STATE FUNDED PROGRAMS														
OPTIONAL STATE SUPPLEMENT (OSS) REDESIGN Maximum Payment = \$78.40 single / \$156.80 Couple Assists with paying room & board at alternate living facilities	\$828.40	\$1,656.80	\$2,000	\$3,000	<table border="1"> <thead> <tr> <th>Individual</th> <th>Couple</th> </tr> </thead> <tbody> <tr> <td>\$54 Provider rate \$774.40</td> <td>\$108 Provider rate \$1,548.80</td> </tr> <tr> <td>\$54 Provider rate \$935</td> <td>\$108 Provider rate \$1,870</td> </tr> </tbody> </table>		Individual	Couple	\$54 Provider rate \$774.40	\$108 Provider rate \$1,548.80	\$54 Provider rate \$935	\$108 Provider rate \$1,870		
Individual	Couple													
\$54 Provider rate \$774.40	\$108 Provider rate \$1,548.80													
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PROTECTED OSS Maximum Payment = \$239 single / \$478 Couple Assists with paying room & board at alternate living facilities	\$935	\$1,870												
HOME CARE FOR DISABLED ADULTS (HCDA) Pays small stipend to caregivers of disabled	\$2,250	\$4,500												

Florida's Medicaid Waivers

The Agency administers a number of waivers through the Florida Medicaid program. The following table provides information on the current waivers in Florida.

Florida Medicaid Waivers			
Waiver	Population	Eligibility Criteria	2018 Enrollment
1915(c) Familial Dysautonomia	Maximum of 15 participants.	<ul style="list-style-type: none"> Have a documented diagnosis of Familial Dysautonomia Be three years old or older Be assessed as having an Inpatient Hospital Level of Care 	6 recipients as of October 2018.
1915(c) Model	Maximum of 20 participants.	<ul style="list-style-type: none"> 20 years of age or younger Determined disabled using criteria established by the Social Security Administration Be at risk for hospitalization as determined by the Children's Multidisciplinary Assessment Team Diagnosed as having degenerative spinocerebellar disease, or deemed medically fragile and have resided in a skilled nursing facility for at least 60 consecutive days prior to enrollment. 	5 recipients as of October 2018.
1915(c) Developmental Disabilities Individual Budgeting (iBudget)	Maximum of 40,818 participants.	<ul style="list-style-type: none"> Meet the eligibility requirements in accordance with Chapter 393, F.S. Meet the Level of Care criteria for placement in an intermediate care facility for individuals with intellectual disabilities Be eligible for Medicaid under one of a variety of categories described in the Florida Medicaid Provider General Handbook Be diagnosed with one or more of the following qualifying disabilities: <ul style="list-style-type: none"> The individual's intelligence quotient (IQ) is 59 or less; or The individual's IQ is 60-69 inclusive and the individual has a secondary handicapping condition that includes: Down syndrome; cerebral palsy; Prader-Willi Syndrome; spina bifida; epilepsy; autism; or ambulation, sensory, chronic health, and behavioral problems; or has an IQ of 60-69 inclusive and the individual has severe functional limitations in at least three major life activities including self-care, learning, mobility, self-direction, understanding and use of language, and capacity for independent living; or The individual is eligible under the category of autism, cerebral palsy, Down Syndrome, Prader-Willi Syndrome or spina bifida and the individual has severe functional limitations in at least three major life activities including self-care, learning, 	34,369 recipients as of October 2018.

		mobility, self-direction, understanding and use of language, and capacity for independent living.	
1915(b)/(c) Long-Term Care	Maximum of 70,702 participants.	<ul style="list-style-type: none"> Individuals with a disability age 18-64 and elderly individuals age 65 or older, or A diagnosis of cystic fibrosis, AIDS, or a traumatic brain or spinal cord injury. 	57,971 recipients as of August 2018.
1115 Managed Medical Assistance	No maximum number of participants.	<ul style="list-style-type: none"> Meet the eligibility requirements in accordance with Chapter 409, F.S. Be eligible for Medicaid under the approved state plan Not be in one of the following excluded categories: <ol style="list-style-type: none"> Individuals eligible for emergency services only due to immigration status Individuals enrolled in the Family Planning waiver Individuals eligible as women with breast or cervical cancer Services for individuals who are residing in residential commitment facilities operated through the Department of Juvenile Justice, as defined in state law. (These individuals are inmates not eligible for covered services under the state plan) 	3,272,646 recipients as of June 2018.
1115 Family Planning	No maximum number of participants.	<ul style="list-style-type: none"> Women age 14 through 55 Family incomes at or below 185 percent of the Federal Poverty Level who are not otherwise eligible for Medicaid, Children’s Health Insurance Program, or health insurance coverage that provides family planning services Lost Medicaid eligibility within the last two years 	140,284 recipients as of June 2018.
1915(b) Non-Emergency Transportation	No maximum number of participants.	<ul style="list-style-type: none"> Be eligible for Medicaid under the approved state plan Not be enrolled in the Managed Medical Assistance program 	1,277,307 recipients as of June 2018.

Working People with Disabilities in Florida

As represented in the table above, Florida currently operates four home and community-based services waivers:

- 1) Familial Dysautonomia Waiver
- 2) Model Waiver
- 3) Developmental Disabilities Individual Budgeting Waiver (iBudget)
- 4) Statewide Medicaid Managed Care Long-Term Care Waiver

Florida Medicaid home and community-based services waivers offer essential services to those in need. These services include services such as occupational therapy or speech pathology

services, critical to the well-being of individuals in this population. Often, these services are not included in private health insurance coverage, making it difficult to afford these services without Medicaid. Individuals who work and receive services through Florida Medicaid home and community-based services waivers may choose to limit the amount of income they may earn to remain eligible to participate in these waivers. As indicated previously, individuals enrolled in a home and community-based services waiver in Florida currently have a monthly income limit of \$2,250.

In 1997 and 1999, Congress enacted legislation to grant states the option to modify Medicaid eligibility policy to help individuals who wish to work maintain their coverage. To date, 46 state Medicaid programs have enhanced eligibility requirements to help individuals in this targeted population maintain their specialized coverage. Florida Medicaid's current policies have not been refined to permit an increase in income for waiver enrollees. Consequently, individuals may choose to limit the amount of income they earn to retain Florida Medicaid coverage.

States have resolved the income limit issue for working people with disabilities through a variety of methods, such as Medicaid Buy-In programs, Medicaid expansion, and home and community-based services waivers.

Section III. Evaluation of Working People with Disabilities Program Implementation Options

The Agency has researched and estimated costs for three options to implement a Working People with Disabilities Program in Florida. These three options are presented below.

Option 1: Medicaid State Plan Amendment to Apply Income Disregards

The Centers for Medicare & Medicaid Services allow states to amend their state plans to disregard certain specified income and resources when determining Medicaid eligibility. Specifically, Florida could waive certain income and resource rules for individuals receiving services through home and community-based services waivers. This would allow the State to increase the monthly income limit to meet financial eligibility above 300% of the Federal Benefit Rate, the maximum allowable through home and community-based services waivers. This option may also require the Agency to submit and receive approval for 1915(c) waiver amendments for the affected home and community-based services waivers, which would likely occur after the Agency receives approval of the state plan amendment.

Proposed Income Disregards

The Agency could apply one of the following approaches to disregard earned income to increase home and community-based services waiver income limits above the current limit, which is 300% of the Federal Benefit Rate.

Home and Community-Based Services Waiver Income Options			
	<i>Current Income Limits (300% of Federal Benefit Rate)</i>	Proposed Income Option 1: 400% of the Federal Benefit Rate*	Proposed Income Option 2: 500% of the Federal Benefit Rate*
Individual Monthly Income	\$2,250	\$3,000	\$3,750
Individual Annual Income	\$27,000	\$36,000	\$45,000
Couple Monthly Income	\$4,500	\$6,000	\$7,500
Couple Annual Income	\$54,000	\$72,000	\$90,000
*Disregard of earned income to allow income equal to the increased percentage of FBR.			

The first proposed income limit approach allows for earned income disregards equal to 400% of the Federal Benefit Rate for individuals who receive services through home and community-based services waivers, which equals approximately 296% of the Federal Poverty Level.

The second proposed income limit approach allows for earned income disregards equal to 500% of the Federal Benefit Rate for individuals who receive services through home and community-based services waivers, which equals approximately 370% of the Federal Poverty Level. This approach would provide the ability for an individual to work more hours and/or at a higher paying position than the first approach.

The Agency has proposed two approaches that appear to meet the intent of the legislation; however, there is no specific federal limit on the income disregards that could be enacted, so the Legislature could decide on a different limit than those proposed here. For example, it could choose earned income disregards equal to 450% or 550% of the Federal Benefit Rate.

Method of Implementation

This option requires a state plan amendment and may require amendments to the affected 1915(c) home and community-based waivers. In order to implement this option, the Agency would need legislative direction on which income limit to implement and submit an amendment to the Florida Medicaid state plan, Part I, Supplement 8a to Attachment 2.6-A to apply income disregards.¹⁸ The amendment would modify the requirements established under section 1902(r)(2) of the Social Security Act. The State has the flexibility to elect to apply income disregards in several different ways, including applying income disregards to:

- Gross income
- Earned income
- Unearned income

Once implemented, the Department of Children and Families would use the earned income disregards when determining Medicaid eligibility for individuals in home and community-based services waivers. To align with the intent of a Working People with Disabilities program, the income disregards will be applied only for individuals who have increased income due to employment, as opposed to other sources, such as Social Security, unemployment benefits, gifts, etc.

The Agency and the Department of Children and Families would create and implement an outreach campaign to make people on waivers aware of this change. Examples of this outreach may include updates to the Agency's Web page and the Department of Children and Families' Web page, the development of informational brochures, webinars to groups who work with the target population.

Several other entities throughout the state provide Medicaid eligibility assistance to individuals applying for or receiving home and community-based waiver services. As part of the outreach

¹⁸ Agency for Health Care Administration, Florida Medicaid State Plan, Part I, Supplement 8a to Attachment 2.6-A. Accessed online at: http://www.ahca.myflorida.com/Medicaid/stateplanpdf/Florida_Medicaid_State_Plan_Part_I.pdf

campaign, the following agencies would also need to receive additional information and training, and to assist individuals with the application process, as needed:

- The Agency for Persons with Disabilities
- The Department of Elder Affairs
- The Aging and Disability Resource Centers
- The Statewide Medicaid Managed Care program managed care plans
- The Agency's Medicaid Recipient and Provider Enrollment staff

Population Impact

In Florida, the Agency estimates increasing income limits may affect approximately 13,397 people enrolled in home and community-based services waivers. This includes approximately 2,200 people who are currently employed and receiving services through the 1915(c) Developmental Disabilities Individual Budgeting Waiver. This also includes approximately 11,197 people who are estimated to have a disability who are receiving services through the 1915(b)/(c) Long-Term Care Waiver. This was determined by taking the total number of individuals enrolled in the Long-Term Care Waiver who are ages 18 to 64; this does not break out the number of individuals who are employed. The Agency anticipates the actual number of disabled individuals who are employed or who are able and willing to be employed will be significantly lower.

Fiscal Impact

The maximum number of individuals who may enroll in the Developmental Disabilities Individual Budgeting Waiver is 40,818, and the Long-Term Care program is 70,702. Both of these programs currently have waiting lists for enrollment. The Agency anticipates that the standard waiting list processes in place for both of these waivers will mitigate concerns related to programmatic expansion.

The maximum number of individuals who may enroll in either the Familial Dysautonomia Waiver or the Model Waiver is 35. The Familial Dysautonomia and spinocerebellar disease-states are such that enrollees in these waivers are unlikely to work. Additionally, the Model Waiver is only available to individuals 20 years of age or younger. As such, the Agency does not anticipate that increasing income limits will have a meaningful impact.

Systematic requirements to enact this change would include adding a poverty level indicator within the ACCESS System to alert the Department of Children and Families if an individual passes the income level test with income greater than 300% of the Federal Benefit Rate. This indicator must function across systems to provide data to the Florida Medicaid Management Information System. The estimated cost to the State to implement this change would be approximately \$160,000. This is based on an estimated cost of \$123 per hour x 1,300 estimated hours.

Timeframe for Implementation

The Agency estimates the full federal approval process could take approximately a year. There are two parts to this approval: state plan amendment and waiver changes. The Agency estimates it would take approximately 210 days to submit and receive state plan amendment approval from CMS. The CMS has no more than 90 days to approve, disapprove, or issue a written request for additional information once the Agency submits a state plan amendment. If CMS submits a request for additional information, the Agency has 90 days to issue a formal response to the request. However, the Agency generally provides a response within 30 days. This starts another 90-day period with CMS.

Additionally, if the Agency is required to submit and receive approval for 1915(c) waiver amendments for the affected home and community-based services waivers, this may have to take place after the state plan amendment is approved. The Agency estimates it would take approximately 150 days to submit and receive approval for 1915(c) waiver amendments, barring CMS submitting a written request for additional information. Prior to submission to CMS, the Agency is required to hold a 30-day public comment period so that interested parties have an opportunity to review the amendment request and comment on its content. CMS has no more than 90 calendar days to approve or deny an initial 1915(c) waiver application, waiver renewal, or amendment request, or alternatively issue a written request for additional information. As a general matter, CMS attempts to resolve problems with a waiver application through informal dialogue with the state rather than a formal request for additional information.

The Agency estimates the full federal approval process could take approximately a year. This would also give the Agency and the Department of Children and Families time to implement the necessary system updates, outreach, and training.

Option 2: Increase Utilization of Miller Trusts/Qualified Income Trusts

The State of Florida is a “Miller Trust State”. A Miller Trust, or Qualified Income Trust, can be used when a Florida Medicaid applicant has too much income to qualify for Medicaid, but not enough to pay for long-term care costs. A person would need a Qualified Income Trust if their income before any deductions (such as taxes, Medicare, or health insurance premiums) is over the limit to qualify for the Institutional Care Program, Institutional Hospice, Program of All-Inclusive Care for the Elderly, or the home and community-based services waivers. If an individual’s income is over the limit to qualify for Medicaid, a Qualified Income Trust allows them to become eligible by placing sufficient income into a special account each month to lower income within program standards for each month that they need Medicaid coverage.

The Qualified Income Trust involves a written agreement, setting up a special account, and making deposits into the account. Individuals may obtain professional help to set up the Qualified Income Trust agreement, but it is not required. A Qualified Income Trust agreement must meet specific requirements and be approved by the Department of Children and Families’ legal offices.

After setting up the account, individuals must make deposits into the Qualified Income Trust account every month for as long as they need Medicaid. The deposit into the Qualified Income Trust account must be enough that the income not included within the account is within program standards. In some instances, an individual may need to make deposits before a Medicaid application is approved. The Qualified Income Trust prohibits deposits for a past or future month. Any income individuals receive back from the trust is counted as income. If an individual fails to make a deposit in any given month, or does not deposit enough income, they are ineligible for Medicaid payment of long-term care services for the month. As long as the individual deposits income into the Qualified Income Trust account in the month it is received, it will not be counted when the Department of Children and Families determines Medicaid eligibility for that month.

Once a Qualified Income Trust is established, the Department of Children and Families is advised to do the following:¹⁹

- Not to consider the corpus of the trust an asset to the individual for any month the Qualified Income Trust exists and eligibility is requested;
- Not to apply penalties for transfers of income placed in a Qualified Income Trust account provided the individual receives fair compensation;
- Not to count income deposited into the Qualified Income Trust account as income when determining if the individual's income is less than the Medicaid program income standard;

¹⁹ Department of Children and Families, “*Program Policy Manual*,” Section 1800- Income (MFAM/MSSI). Accessed online at: <http://www.dcf.state.fl.us/ess/policy/manual/1830.pdf>.

- Not to consider disbursements from the Qualified Income Trust account to third parties as income to the individual;
- Not to count income generated by the Qualified Income Trust account which remains in the trust as income to the individual;
- Count any payments made directly to the individual as their income; and
- Count all income going into the Qualified Income Trust (plus any not going into the trust) in determining patient responsibility, unless protection of income for the month of admission or discharge policies apply.

Important considerations regarding Qualified Income Trusts are that they must be established as irrevocable, and they require that the State will receive all funds remaining in the trust at the time of death, up to the amount of Medicaid benefits paid on the individual's behalf.

Proposed Income Limits

This option utilizes the income limits as described on page 11 that are already in place for home and community-based services waiver participants, and which are used when a Florida Medicaid applicant has too much income to qualify for Medicaid, but not enough to pay for their long-term care costs. If an individual's income is over the limit to qualify for Medicaid, a Qualified Income Trust allows them to become eligible by placing income into an account each month that they need Medicaid coverage. Some important considerations include:

- Since the program is already established, there would be a low financial and administrative burden for the state.
- Individuals utilizing a Qualified Income Trust do not get the benefit of the additional income they are earning, since all extra funds go into the Trust. This does not help with the perceived goal of the proposed program, which is to allow individuals with disabilities who work to increase their income limits and still qualify for Medicaid.
- There is an increased administrative burden on individuals utilizing a Qualified Income Trust. This burden may be present at the time of application due to the complicated process for establishing a trust, as well as throughout utilization due to the requirement for monthly deposits and other administrative tasks required for maintenance of the trust.

Method of Implementation

This option would not require a change to the federal authorities that govern the Florida Medicaid program. As with the previous option, the Agency and the Department of Children and Families would create and implement an outreach campaign to provide information about Qualified Income Trusts as a mechanism to lower income within program standards. The Agency would coordinate with and provide additional information and training for all applicable agencies to implement the outreach campaign.

Population Impact

As with Option 1, the population impact would be no greater than the maximum number of individuals who may enroll in each of the home and community-based services waivers.

An outreach campaign for Qualified Income Trusts may affect the approximately 13,397 people enrolled in home and community-based services waivers identified in Option 1 that are either currently employed and receiving services through the 1915(c) Developmental Disabilities Individual Budgeting Waiver or ages 18 to 64 and receiving services through the 1915(b)/(c) Long-Term Care Waiver.

As of June 2018, there were 6,752 Qualified Income Trusts in Florida. Of the Qualified Income Trusts, 5,199 (77%) were being utilized for people needing institutional or hospice care. Only 1,553 (23%) were being utilized for people needing home and community-based services. Because of the administrative burden and potential risks associated with Qualified Income Trusts, the Agency does not anticipate a large increase in utilization, even with the implementation of an outreach campaign. It is important to note that while Qualified Income Trusts can be utilized outside of the home and community-based services waiver population, the outreach campaign will specifically target this group.

Fiscal Impact

The cost to implement an outreach campaign would be minimal as it could be accomplished with existing state resources. Should Qualified Income Trusts begin to be utilized more frequently among people utilizing home and community-based waiver services, Florida would need to establish better infrastructure for collection of patient responsibility among this population. Additionally, the Department of Children and Families may need additional staff to support a large increase in utilization. However, as previously discussed, upon death of an individual utilizing a Qualified Income Trust, the state will receive the balance of the Qualified Income Trust, up to an amount equal to the total medical assistance paid on their behalf, which would help reimburse the State for the costs of the individual's Medicaid services.

Timeframe for Implementation

As no federal authority is needed for implementation purposes, the Agency estimates it would take approximately three months, in coordination with the Department of Children and Families, to create and implement an outreach plan.

Option 3: Implement Medicaid Buy-In

Federal legislation authorizes states to have flexibility to determine Medicaid income and asset limits by implementing Medicaid Buy-In. A Medicaid Buy-In option allows eligible individuals to pay a premium in exchange for eligibility for Medicaid services. This allows individuals who fall between the eligible coverage group and those who can afford services out of pocket the opportunity to share costs through Medicaid.

Under home and community-based services waivers, states must designate the Medicaid eligibility groups that can be served in the waiver and state plan. In order to increase income limits for working people with disabilities, a state may choose to add Medicaid eligibility groups to the state plan and to the home and community-based services waivers.

An important consideration is that this option cannot be limited to working people with disabilities who receive services through home and community-based services waivers. All working people with disabilities would be eligible to buy-in, not just those already being served by waivers. The legislation directing the creation of the Working People with Disabilities program specifies that it should be limited to people receiving services through home and community-based services waivers. By choosing to add Medicaid eligibility groups to the state plan and the home and community-based waivers, there will be an increase in the number of people who are eligible for Florida Medicaid coverage.

Medicaid Buy-In Approaches

A Medicaid Buy-In program could be enacted through either the federal Ticket to Work and Work Incentives Improvement Act of 1999 or the federal Balanced Budget Act of 1997. These approaches would require significant changes to the federal authorities that govern the Florida Medicaid program and would likely vary based on the specific approach and method of implementation. The table below provides information on these two pieces of Federal legislation.

Medicaid Buy-In Program Legislation		
	Balanced Budget Act	Ticket to Work and Work Incentives Improvement Act <small>Basic Coverage Group</small>
Who can be covered?	Individuals with disabilities	Individuals with disabilities ages 16 – 64
Income Standard	250% Federal Poverty Level. If this condition is met, the applicant’s unearned income must be less than SSI Federal Benefit Rate.	State establishes its own standard; all earned income is disregarded; states can choose not to have an income standard.
Resource Standard	\$2,000 for an individual	State establishes its own standard; state can choose not to have a resource standard.
Rules for determining eligibility	SSI rules and methodologies	If state establishes income and/or resource standards, SSI rules and methodologies apply. If state chooses not to establish income and resource standards, no rules or methodologies apply.
Use of more liberal income and resource methodologies than SSI (SECTION 1902(r)(2))	States can disregard additional income (earned or unearned) and/or resources in either/both the 250% family income test and the individual eligibility determination. States can disregard all income and resources if they choose to do so. Federal Financial Participation limits do not apply to income disregards.	States that establish an income and/or resource standard can disregard additional income and/or resources if they choose to do so. Federal Financial Participation limits do not apply to income disregards.
Premiums and cost-sharing	States <i>may</i> require payment of premiums and other cost-sharing charges on a sliding scale based on income. States are <i>not required</i> to collect premiums or cost-sharing charges.	(1) States may (but are not required to) require payment of premiums and other cost-sharing charges on a sliding scale based on income. (2) For individuals with income over 250% of the poverty level, states may (but are not required to) charge 100% of premiums. If a state chooses to charge 100% of premiums, there is a limit on the total amount of premiums of 7.5% of their income if their income is less than 450% of the poverty level. (3) States must charge 100% of premiums for any individual whose adjusted gross annual income (as defined under IRS rules) exceeds \$75,000. This requirement applies regardless of whether a state charges premiums and cost-sharing under (1) or (2) above.
Maintenance of effort: States must demonstrate that they are maintaining funding for programs (other than Medicaid) to assist disabled individuals who want to work	No requirement	Required

In 2016, the Agency produced a report entitled “Florida Medicaid Buy-In Analysis: A Descriptive Analysis of Potential Program Structure and Options.”²⁰ This report outlined three potential Medicaid Buy-In approaches for Florida, including advantages and disadvantages. These options are included below, within the Ticket to Work and Work Incentives Improvement Act Working Disabled Groups section and the Balanced Budget Act Working Disabled Group section.

Ticket to Work and Work Incentives Improvement Act Working Disabled Groups

The Ticket to Work and Work Incentives Improvement Act allows states to offer Medicaid coverage to individuals who fall into the following groups:

- **Basic Coverage Group.**²¹ This group includes working individuals who are at least 16 but less than 65 years of age who, except for their income and resource levels, are eligible to receive Supplemental Security Income. States may establish their own income and resource standards, and individuals who have never received Supplemental Security Income benefits can be eligible.
- **Medical Improvement Group.**²² This group includes working individuals with a medically improved disability who lose Medicaid eligibility under the above group because they no longer meet the Supplemental Security Income definition of disability. The Medical Improvement Group option is only available to states that also cover the Basic Coverage Group.

States may require payment of premiums or other cost-sharing charges on a sliding scale based on income. This is not a requirement, and many states do not collect premiums due to the belief that administrative costs associated with charging premiums outweigh the expected revenue.²³

The Ticket to Work and Work Incentives Improvement Act aligns with the first and second approaches presented in the Agency’s 2016 analysis. These approaches include:

- 1) Medicaid Buy-In with full Medicaid benefits to people with disabilities whose incomes are below 100% of the Federal Poverty Level. This equals a monthly income below \$1,012, and an annual income below \$12,140.
- **Advantages:** Offering the Medicaid Buy-In program to people with disabilities up to 100% of the Federal Poverty Level would provide people with disabilities, who are

²⁰ Agency for Health Care Administration, “Florida Medicaid Buy-In Analysis: A Descriptive Analysis of Potential Program Structure and Options,” February 2016. Internal workgroup whitepaper. Available upon request.

²¹ Social Security Administration, Compilation of the Social Security Laws, “State Plans for Medical Assistance,” §1902(a)(10)(A)(ii)(XV). Accessed online at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

²² Social Security Administration, Compilation of the Social Security Laws, “State Plans for Medical Assistance,” §1902(a)(10)(A)(ii)(XVI). Accessed online at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

²³ Ireys, H.T., Davis, S.R., and Andrews, K.L. (2007), “The Interaction of Policy and Enrollment in the Medicaid Buy-In Program, 2005,” Mathematica Policy Research, Washington, D.C. Accessed online at: <http://www.nasuad.org/sites/nasuad/files/hcbs/files/119/5944/MIG.pdf>

ineligible for Medicaid and ineligible for Affordable Care Act marketplace premium assistance and Cost Share Reduction, an avenue to health care coverage.

By limiting the program to just those individuals who are not eligible for marketplace subsidies, Florida can ensure this population has access to comprehensive health insurance while encouraging self-reliance.

People with disabilities who are currently on waiver waitlists, or whose impairment is significant enough to limit their income but not significant enough to qualify for other programs, would have an avenue to health insurance.

- **Disadvantages:** By limiting the Medicaid Buy-In program to only individuals below a set income cap, people may be discouraged from earning more income in order to avoid the loss of health insurance. While it would offer access to affordable health insurance for low-income people with disabilities, this may discourage growth in self-reliance past a certain income threshold.

There are costs and administrative burden associated with implementing the Medicaid Buy-In program. Florida could make choices that limited the administrative impact (e.g., not collecting premiums; expanding on current eligibility systems and criteria to determine eligibility for the Medicaid Buy-In program instead of creating new ones), but some cost is unavoidable.

This Medicaid Buy-In option leaves people with disabilities with incomes over 100% of the Federal Poverty Level potentially without insurance. While they are technically eligible for premium assistance and Affordable Care Act/ Cost Share Reduction subsidies, they may still be required to pay between 6% and 27% of their medical costs.

In addition, many of the services that would be required by this group may either not be part of the marketplace plan²⁴ or may be some of the most expensive services the plan offers.

- 2) Medicaid Buy-In with full Medicaid benefits to people with disabilities whose incomes are below 100% of the Federal Poverty Level, and Medicaid Buy-In wraparound coverage (e.g., additional habilitative services that have limited visits or that are not offered under the marketplace plan or paying for co-pays that are not covered under the Affordable Care Act cost share reduction subsidies and premium assistance subsidies in the marketplace plan) to people with disabilities with private insurance whose incomes are between 100% and 250% of the Federal Poverty Level. This equals a monthly income of below \$1,012 to below \$2,529, and an annual income of below \$12,140 to below \$30,350.

- **Advantages:** This option offers additional people health insurance while minimizing costs to the state because Medicaid Buy-In program recipients may also have private

²⁴ The term "marketplace plan" is in reference to the health insurance marketplaces, or health exchanges, that have been set up to facilitate the purchase of health insurance in accordance with the Patient Protection and Affordable Care Act.

insurance. Offering the Medicaid Buy-In program to individuals up to 100 percent of the Federal Poverty Level would provide all of the advantages as the previous option.

In addition, people with disabilities between 100% and 250% of the Federal Poverty Level would have access to health insurance that provides services they might not be able to obtain through a marketplace plan. By covering just the wraparound services for this group, the costs to the state are significantly reduced, and the individual remains responsible for the bulk of his or her health care costs.²⁵

Alternatively, this option could be structured so that Medicaid covers just the out of pocket costs for individuals with a marketplace plan, so that the total cost to Medicaid would be no more than \$2,250 for individuals between 100% and 200% of the Federal Poverty Level, or \$5,200 for individuals between 200% and 250% of the Federal Poverty Level.

The Medicaid Buy-In option also avoids the disincentive to work associated with cutting off all assistance above 100% of the Federal Poverty Level.

- **Disadvantages:** This has the same disadvantages as other Medicaid Buy-In options in terms of costs and administrative burden associated with running the program.

In addition, this program could be more costly since it effectively creates two programs. The Agency would have to increase efforts to ensure Medicaid was the secondary payer or paying only for the set of services not covered by the marketplace plan, and coordination of benefits and services (such as ensuring private providers refer to a Medicaid provider for Medicaid services) could be an added cost.

Covering only out of pocket costs could still leave individuals without guaranteed access to some services if they are not part of the enhanced benefit package offered by their plan.

Individuals between 100% and 250% of the Federal Poverty Level would not be eligible to enroll in the Statewide Medicaid Managed Care Managed Medicaid Assistance health plans because they would not be eligible for full Medicaid benefits. These individuals would be served through fee-for-service Medicaid and would not be able to take advantage of the robust provider networks and expanded benefits offered by these health plans.

Balanced Budget Act Working Disabled Group

The Balanced Budget Act working disabled group, an optional Medicaid eligibility group, has specific rules that must be adhered to:²⁶

²⁵ Wraparound services include additional habilitative services that have limited visits or that are not offered under the marketplace plan or paying for co-pays that are not covered under the CSR in the marketplace plan.

²⁶ Social Security Administration, Compilation of the Social Security Laws, "State Plans for Medical Assistance," §1902(a)(10)(A)(ii)(XIII). Accessed online at: https://www.ssa.gov/OP_Home/ssact/title19/1902.htm

- Net family income must be below 250% of the Federal Poverty Level for a family of the size involved. For a family of one, this equals a monthly income below \$2,529, and an annual income below \$30,350.
- Except for earned income (which is disregarded), the individual must meet all Supplemental Security Income eligibility criteria, including:
 - Unearned income not exceeding the Supplemental Security Income standard (currently \$750 a month for an individual; \$1,125 for a couple in 2018).
 - Resources not exceeding Supplemental Security Income resource standard (\$2,000 for an individual; \$3,000 for a couple in 2018).
 - Disabled as defined under the Supplemental Security Income program.
 - Supplemental Security Income and resource methodologies are used to determine eligibility.

A state may opt to utilize more liberal income and resource methodologies than are used by Supplemental Security Income, and may require payment of premiums or other cost-sharing charges on a sliding scale based on income.

A Balanced Budget Act Medicaid Buy-In program aligns with the third approach that was presented in the Agency's 2016 analysis. This approach includes:

- 3) Medicaid Buy-In with full Medicaid benefits to people with disabilities whose incomes are under 250% of the Federal Poverty Level.
 - **Advantages:** This Medicaid Buy-In option ensures that people with disabilities with limited means will have access to comprehensive health insurance and may reduce indirect costs to the state. The higher income limit allows individuals to work more and seek higher-level employment opportunities without risking loss of health insurance coverage.

The administrative burden in terms of coordinating services is minimized compared to the second Medicaid Buy-In option since there is one program.

- **Disadvantages:** There is a risk that individuals who could or would otherwise purchase an individual plan in the marketplace will be drawn to Medicaid for its potentially richer set of services and lower costs.²⁷

This is also likely the most expensive Medicaid Buy-In option to the state in terms of direct costs, as the number of people eligible would be larger. Overall costs could vary significantly depending on how the program is structured (e.g., asset limits; whether premiums are collected; and, what the premium levels are).

Adding a Medicaid eligibility group will increase the number of people who are eligible for Florida Medicaid coverage. The number of eligible individuals could increase significantly

²⁷ Commonly referred to as "crowd out."

under this option, thus imposing the highest fiscal impact to the state. However, there would continue to be income floors and ceilings for any Medicaid eligibility groups. Many other states currently do not collect a premium. This is due to the high administrative costs compared to the estimated revenue of the premiums.

Method of Implementation

The federal authorities required for implementation would likely vary based on the specific approach and method of implementation. The Agency would coordinate with the Department of Children and Families regarding eligibility for the new coverage group(s), and utilize existing staff as possible to develop the policy, rules, Medicaid state plan amendments, and staff training materials. Implementation will require a change to the FLORIDA system, development and maintenance of policy and procedures for staff to follow, and administrative rules for the eligibility criteria.

Florida Medicaid systems would need to be able to detect new eligibility requirements, determine share of cost, and contain a premium collection system. Additionally, new staff would be required to implement this option, and staff training on the new system and increased outreach would be used to increase awareness of the program to potentially eligible individuals.

Population Impact

There are two main Medicaid eligibility groups that could be added specific to Medicaid Buy-In. These two groups include:

- 1) Balanced Budget Act Working Disabled Group
- 2) Ticket to Work and Work Incentives Improvement Act Working Disabled Groups
Working Disabled Group

Fiscal Impact

The Agency is unable to provide a fiscal impact due to the extensive research and data analysis needed to evaluate Medicaid Buy-In. However, the Agency is able to identify costs that would be associated with implementation. There would be costs associated with programming the ACCESS Florida system, staff to determine eligibility, and staff to handle fair hearing requests related to eligibility and services. Increased training would also be required.

Through implementation of a Medicaid Buy-In program, there would be an increase in the number of Florida Medicaid enrollees. Increased numbers of program enrollees would increase costs substantially to the Florida Medicaid program. In addition to the overall costs associated with the additional enrollees, implementing a Medicaid Buy-In program would involve participation of several state agencies, require significant administrative changes, and would need to have several questions relating to key design elements answered before final structure and costs could be determined.

Timeframe for Implementation

The Agency is unable to provide an accurate timeframe for implementation of this option. However, due to the significant changes required, the Agency anticipates implementation of a Medicaid Buy-In option would require a minimum of two years.

Conclusion

A summary table is included below of the three options presented by the Agency.

Proposed Working People with Disabilities Program Options			
	Option 1: Income Disregard for Home and Community-Based Services Waivers	Option 2: Increase Utilization of Miller Trusts/Qualified Income Trusts	Option 3: Implement a Medicaid Buy-In Program
Covered Population	All individuals enrolled in Medicaid home and community-based services waiver programs	Individuals who meet requirements for Medicaid other than financial and meet the requirements to establish a Miller Trust Fund	Disabled individuals ages 16 to 64
Income Standard	Income disregard	Income above 300% Federal Benefit Rate	State establishes its own standard; all earned income is disregarded; states can choose not to have an income standard.
Eligibility Criteria	Medicaid Supplemental Security Income eligibility rules	Supplemental Security Income eligibility rules and Miller Trust Fund guidelines	Medicaid Supplemental Security Income eligibility rules

While all of the options presented could be utilized to enact a Working People with Disabilities program in Florida to allow individuals with disabilities to increase their income limits while retaining their health insurance coverage, the Agency recommends utilization of a state plan amendment to apply income disregards for programmatic implementation. The Agency has determined this to be the most direct path to implement the program while simultaneously imposing a low fiscal impact to the state and the least administrative burden on individuals who receive services through Florida Medicaid’s home and community-based services waiver programs. The Agency has held preliminary discussions with the Centers for Medicare & Medicaid Services, which grants the federal authorities to operate the Medicaid program, and they have expressed support for the option to apply income disregards using a state plan amendment.