

2002 Leadership Challenges on Employment Policy

Audio Conference Series



Medicaid Buy-In: Current State Experiences

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Allen Jensen: Good afternoon, I'm Allen Jensen the Director of the Work Incentive Project here at George Washington University in Washington D.C. I am one of partners of the Rehabilitation, Research and Training Center on Workforce Investment Employment Policy for Persons with Disabilities. This ROGC is headquartered at the University of Iowa as a number of partners, of which I am one.

As indicated, this is the audio-conference on Medicaid Buy-In: Current State Experiences. Before the members of the panel speak today, I want to, and introduce themselves, I want to urge those who are listening, if they haven't already done so, to go to the website at the University of Iowa, The Law, Health Policy and Disability Center. It was identified in the notice that you received from the University of Iowa. I would urge you to download, if you have not done so already, the items listed under 5, 6, 7, and 8. These are outline and summary materials I've prepared especially for this audio-conference. Much of the summary is taken from the papers listed under items one and two, which are longer papers dealing with some of the details on Medicaid Buy-In. I will be referring to some of these documents, these summaries in my introductory marks.

In addition you will have presenters today from Oregon, Minnesota, and Connecticut. The common format or outline of the case studies that have been written on these states is the first item under Number Four in that list of resource documents. The complete case study for each of these states can also be downloaded from Number Four. As is the case usually with the audio-conference you will have a chance to ask us questions. In this audio-conference, we've decided that we will want to have questions from you, after each presenter. We will each present for about ten to twelve minutes at the most and then, if a question is asked that could be better answered after all the presentations, we will hold it for that time. There will be time just for questions after complete all the presentations. That will be the main time for the questions.

We are also going to try something else as an experiment here. You have my e-mail address in the material listing of presenters. If you would like to send me a question by e-mail please do so. If that it is a question that should be answered in the context of general information for this conference we will do so, but whatever is sent to use of course we can get answered at a later time.

Under the heading of the material that was sent to you called "Websites Noted During The Call", there is also a website which is based here at the University of Iowa that has specifically been devoted to Comprehensive Person-Centered State Work Incentive Initiative. This website was developed beginning about two years ago and has information not only on the some of the background information for developing a Medicaid Buy-In Program, but also information about the various states who have developed, or are developing a Medicaid Buy-In Program. That website, especially the state documents, are being updated at this point and time.

More recently, with support from a number of sources, including this RRTC, which is supported by the NIDRR at US Department of Education, but also from the Office of the Assistant Secretary of Planning and Evaluation at Federal HHS, and the Robert Wood Johnson Foundation. I have directed a study which is really an in depth look at nine of what we call “early implementer states” and that includes the three states that you will be hearing from later this afternoon. That study was conducted by a team and myself, people from the National Conference of State Legislatures, Donna Folkemer, and Bobby Silverstein with the Center for Study and Advancement of Disability Policy. Here again, those documents are a result of that study that is just recently completed are shown in items one through three in the source material you have there. We will not go into a lot of depth in those documents, that’s the kind of thing that is really best handled on a state by state base basis or in a more face to face conversation.

I think that one of the things that also, even as we were doing those case studies of the states as compared to states that were developing their Medicaid Buy-In programs in 1998 and 1999, is that the states that are currently contemplating developing a Medicaid Buy-In program are faced with real fiscal challenges. In all the states the impact of the increase in Medicaid, the downturn in the economy as far as the tax receipts, these have all caused severe problems for states. Of the people signed up for this audio-conference, and there is about 25 states, people in 25 states that have signed up, about half the states already have a Buy-In program and another half do not yet have a Buy-In program. Of course there are a number of people there in those states that I have met and have dealt with over the years.

Before I begin our discussion on some of the details on Medicaid Buy-In, I will kind of give a little more background about myself, then introduce the other people who are participating as presenters in this conference.

As I indicated I’m Allen Jensen, I’m at George Washington University, actually it’s called the Center for Health Services and Research and Policy. My interest and experience in this area goes back, quite frankly about 25 years, when I was with the Committee on Ways and Means of US Congress. At that point in time, people with disabilities were coming to the Congress to say that they were concerned about work incentives. We are talking about here with the Medicaid Buy-In as far as trying to solve that problem. So, I’m sure that a number of you who are listening are aware, the section 16-19 Work Incentives that relates to the people on SSI and Medicaid were enacted. I was heavily involved in the development of that legislation in 1980 and then when it was made permanent in 1987. Since then I have worked with a number of states with support from various sources, especially the Robert Wood Johnson Foundation to provide assistance to states as they have tried to utilize the current work incentive. But, also as states had developed the Medicaid Buy-In programs, over the last five years. Some of the states that you will be hearing from later today were involved in this even in the mid-nineties before the Balanced Budget Act was enacted allowing the states to establish Medicaid Buy-In programs.

Then I would like to ask those who will be presenting today. First is Scott Lay from Oregon and Scott tell us something about yourself.

Scott Lay Well good morning, or good afternoon as the case may be. Presently I work for the State of Oregon, in the Department of Human Services as Medicaid Infrastructure Grant Coordinator. I have been involved almost as long as Allen has been in this endeavor. I'm a quadriplegic myself; I broke my neck back in '69. So needing personal assistance services and trying to go to work, there was a real disconnect there, so that's what got me involved. I worked through the development of our, Oregon's Medicaid Buy-In policy and now I'm involved with Medicaid Infrastructure Grants. To move on. You want more Allen?

Allen Jensen: Well, I think that's enough. You'll have a chance to talk more about how the whole process was developed when you get into your presentation.

Mary Alice Mowry from Minnesota. Mary Alice?

Mary Alice Mowry: Hi there. Good day to you all. Yes, I'm Mary Alice Mowry, and I am currently the Director of the Minnesota Medicaid Infrastructure Grant, from the Ticket to Work, Work Incentive Improvement Act Legislation. I have been actively involved in the connection between health care, work incentives and the connection between health care and employment since 1996, when the Robert Wood Johnson Foundation funded a Feasibility Study with Employment Resources Incorporated in Wisconsin. In my work in Wisconsin, Vermont and Minnesota, this is my second at the Department of Human Services in Minnesota. We have done a lot of work connecting people who are using the programs in various other consumer and stakeholders in our work and that's some of what I am going to be talking about today.

Allen Jensen: Larry Carlson from Connecticut.

Larry Carlson: Hi everyone. I am Larry Carlson. I am a Public Assistance Consultant with the Connecticut Department of Social Services. I am responsible for program policy and development and operations for the various assistance programs for persons over the age 18 in Connecticut. My connection with Work Incentives and eligibility for Medicaid for disabled persons goes back to around 1992, when my Director told me to talk to this fellow named Allen Jensen, about what our agency was doing to facilitate persons with disabilities as far as their eligibility for state entitlements. I dealt from that time with a group of advocates in Northwest Connecticut at the Northwest Regional Mental Health Board, who brought to light issues regarding the problem that was caused for persons who were willing and able to work, but could not because of the negative impact that their earnings would have on their eligibility for necessary entitlements. From that we did some work to modify our Medicaid informant eligibility for persons on our state supplement program and then with the advent of the BBA and the Ticket to Work Act, we instituted a Medicaid Buy-In, that I will be talking about.

Allen Jensen: Thank you very much.

I will be beginning this discussion this afternoon and as I indicated, I hope that a number of you on the call here again will be thinking about your questions or what is of most interest to you as we are talking this afternoon. This is a very broad topic that is not limited to this category of eligibility under the Medicaid Buy-In program and I think this is one of the most important things to understand. As Tom Hamilton, who was the man who instigated this program up in the state of Wisconsin and is now the Director of the Adult Disability Services part of CMS, formally HCFA said that the Medicaid Buy-In program is essential but not sufficient. The whole approach that must be talked about with the Medicaid Buy-In program, is that it is a part of a comprehensive, person-centered employment initiative. With Medicaid Buy-In being one piece of that.

I know that a number of people that have signed up for this audio-conference are not in effect those in the Medicaid agencies. Many of you are connected with the state vocational rehabilitation programs: Others with Private Rehab Agencies. Others with the Governor's Committees on Persons with Disabilities. Others with Independent Living Centers. A variety of folks out there, who are not necessarily Medicaid experts should I say. I think that what took place in the beginning states that got into this whole area of trying to reduce work disincentives. In the mid-nineties there was a group of states who individually were trying to figure out how do to reduce these work disincentives from what we have right now. Especially people on the SSDI program, as compared to those on SSI, because of the severe work disincentives for people with the cash cliff, and then the eventual loss of Medicaid, if they were eligible for Medicaid under their State Medicaid program.

So Medicaid Buy-In is in fact a program, which is based on the idea of proving protection against loss of Medicaid when an individual works. The other components of a Comprehensive Person-Centered program of course will include benefits counseling. I imagine a number of you out there have, or either involved yourself, or know the people who are involved with grants from the Social Security Administration, or have other forms of support for benefits counselors. I think this is one of the things that was included in the Ticket Legislation, was funding for this kind of activity. I think this is one of the things that have been going on for a number of years and I think this is a very important part of the whole effort of having a Comprehensive Person-Centered, because while there are programs on the books as far as laws under 16-19, of the Medicaid Buy-In program.

The intricacies and the details of entitlements under SSI, SSDI, Medicaid and Medicare requires us to have an almost H & R Block, shall we say version in Medicaid and work incentive in order for people to understand what their options are and so that they don't get hurt. As I know that both the State of Oregon and Minnesota have in their manuals to say Medicaid Buy-In is not for everybody. I think that one of the things that is talked about to be impressed on people who are considering the Medicaid Buy-In is to sort out who does this program serve and who is it intended to serve?

Other elements of course, of a comprehensive initiative are to enhance Vocational Rehabilitation Services and other types of services. A number of states—and you'll hear some of that today—there's an integrated link between the Vocational Rehabilitation Services activities and the Medicaid Buy-In program. This is important, as far as not only having the vocational rehabilitation counselors be better informed about the entitlements and work-incentive, but also that they have a linkage with the people who are out there actually making determinations of eligibility, so that there is a coordinated voice as far as the information provided to people in determining whether or not they should be employed.

The other parts of this are employer involvement is the whole matter of collaboration and coordination among these various agencies. Then the piece, quite frankly that is missing, but with part of the Ticket Legislation that a number of states are continuing to advocate for, is the whole issue of providing for demonstration projects, which are authorized in the Ticket Law of December 1999, for a gradual reduction in SSDI benefits as compared to the cash cliff. The Medicaid Buy-In does not protect people who do go about the SGA and then could eventually lose their SSDI cash benefits.

Going on as far as some of the details—and those of you have printed out some of the documents that I sent you—one of the things, which we have, one of the things that need to be dealt with in a state considering developing a Medicaid Buy-In program. Or, as states and there are states in this situation now trying to determine whether or not to make some changes in their current Medicaid Buy-In program. That includes states who are both trying to liberalize their current program, as far as enabling more people to be eligible or to keep up additional resources. Also states who are considering that they have a limit as far as enrollment, or the fiscal exposure to this state. So, one of the issues that states have to deal with is—and this is a point that we try to make in our policy papers that have been developed in our case studies—is that you can't look just to another state to say how do you do it, we are going to copy you, because each state is starting from a different starting point. That is, what is the current eligibility standard in that state? Some states have State SSI supplementation, some do not. Some states have a poverty level program, where people are eligible on a categorical basis up to the Federal Poverty Level or even above. Other states have quite a higher Medical Needy Program than other states. That makes a big difference as far as what the impact would be in moving to a Medicaid Buy-In program.

So, in part of the effort in, and part of the process in developing a “where to go with a Medicaid Buy-In program” is to sort out what are your policy trade-offs? How do you target the program to what you want to accomplish? While the Medicaid Buy-In Legislation, federal legislation, both in the Balanced Budget Act of 1997, and in the Ticket Legislation of 1999, that does not allow for a state to explicitly say that you must have a certain amount of earnings to qualify. Or, there are ways states have found to have, in effect, targeted the program toward people with significant earning. Or, if you don't have that, then in effect, one of the results of a Medicaid Buy-In program can be that people who are limiting their work now because they would lose their Medicaid, or they would just have to pay it back to the state at a spend-down under the Medical

Needy Program. If they can obtain eligibility for Medicaid without a spend-down, have some earnings, the amount of the disposable income will go up a great deal.

So, one of the things that, and here again some of the details of this we will not go into now, but there are ways that states can use eligibility criteria to effect enrollment and fiscal exposure that they might have. Or, they can use premiums to effect enrollment in the fiscal exposure. In the discussion of some of the state programs that you will hear later, you will have some of that. I also think that in the documents that have been available to you on the University of Iowa website, and also on the website within that University of Iowa website, is material which gives some comparison of the eligibility criteria for state Medicaid Buy-In programs and also the resources limits and exclusions that states have in their Buy-In programs. Also cost-sharing, such as minimum income levels and premium methods. Then there are a number of states which, and we were discussing this even before we started the conference here, some states where you'd have a higher resources limit for your Medicaid Buy-In program and then someone would have to stop work because of their health or for other reasons. Can they maintain their eligibility under Medicaid, even if they have accumulated resources? There are states that are now gradually making some changes as far as that is concerned.

I am going to stop now and move to other participants as far as the audio-conference is concerned. I think one of the things we wanted to emphasize today was that in addition to some of the policy issues within Medicaid Buy-In, with all sorts of talk about, especially with those of you who have signed up for this audio-conference, how consumers and advocates, other state agencies have been involved in the development, the planning and actually the implementation of the Medicaid Buy-In programs. So, I think that we have a unique opportunity from the people who are going to be presenting today. Especially from Scott Lay, who has the experience. When I first met him in 1997 was an SSDI recipient and advocate and consumer and then has moved to be one of those who now does training and development of the regulations and of interactions with consumers as far as the use of the Medicaid Buy-In program in Oregon. So, Scott, you've got the microphone.

Scott Lay All right, I thank you Allen. I think as Allen mentioned, a good place to start is what the benefit or the Medicaid Buy-In is all about and that goes to what the need is. As I alluded to in my introduction, I broke my neck just out of high school, back in the late 60's. I started through the rehab process and I used Voc-Rehab Services and Plans for Achieving Self-Support to get myself through school and being lucky enough to be living Oregon, Personal Assistant Services, to some degree, had been provided since, well, as long as I needed them, and then it was under the Home and Community Based waiver, after '81. So I was going along somewhat blindly, naïvely going through school, getting my degree, expecting to go to work. Then, when I graduated reality set in and it was, as Allen said, I needed to make the choice. Do I go to work and potentially lose the state assistance for the Personal Assistant Services? Or, do I not work and virtually guarantee the continue to receive the Personal Assistant Services and other Medicaid assistance.

I started being that squeaky wheel that many people talk about in the early 90's, and I certainly wasn't alone. There was a lot of other consumers and advocates out there at the same time, saying the same thing. In the mid-nineties, the policy people in the state of Oregon began to say we need to do something about this. So, some of us formed a committee to see what could be done to help remove the barriers for persons with disabilities that want to go to work. Because, work is a good thing, obviously. So, we got together and we were looking at various methodologies on how to do it. At that time we were going to focus on that one population, because this was before the BBA, this was before the Ticket. So, the only mechanism we really thought we had at that time was a Social Security waiver. We were going to look at strictly dealing with people who were on SSDI, who had high-earned income over the SSI amount, and who received personal assistant services because, they have the most to lose. If they went to work and lost Medicaid because, that's one of the most high cost benefits of Medicaid. So we looked at the options and came up with a waiver and just as we were talking with Social Security and the agency formally known as HCFA, Allen Jenson was involved, many other people were involved, the Balanced Budget Act of 1997 came out and within that was the opportunity for the Medicaid Buy-In. Already having advocates, consumers, and policy makers on board saying this is something we need to do, the opportunity under the Balanced Budget Act, we just jumped on it with both feet. Being the first, we made guesses; we pulled numbers out of the air to see how we can make the system work.

So, using the same population of our target, we assumed that if we could develop a program that would meet the needs of those people, it would be valuable for the rest of the population of persons with disabilities for this to work. So, this committee went to work trying to figure out what policies would best fit the need. At the same time we were having discussions about policy, we also realized that the field staff could be doing more on a one-to-one basis. So, it became very clear that really we were starting to head into two different directions. One direction was the policies, which lead to the development of the Medicaid Buy-In, which we in Oregon call the Employed Persons with Disabilities Program. The other direction was what became known in Oregon as the Employment Initiative. And was, the field staff in the Disabilities Services office, and the Voc Rehab offices, started to look at the employment of persons with disabilities in a different light and started to develop procedures that would be more beneficial to the persons as they are moving toward employment. In particular, in the Disabilities Services offices, we had specialists called Employment Initiatives Specialists, who work with, the only people they work with, were people who were either working and wanted to maintain their employment, or people who were thinking about working and really didn't know what to do. So, Oregon started going in these two separate paths. As Allen said, the Buy-In is just a piece of a puzzle. The Employment Initiative is much broader than the Buy-In, and we will get more into the issues of the other aspects of the entire initiative, but today we are going to focus on the Buy-In.

What we did—and again with the SSDI population in particular—because if you are on SSDI, you don't need the Buy-In, because, well, if you are eligible you don't need the

Buy-In because in most states you're automatically eligible for Medicaid, if you are on SSI. There are some states that are called 219B states, Allen? So, if you are eligible for Medicaid, you don't need the Buy-In, because as Allen said, 1619 policies of SSA, make you Medicaid eligible, which is exactly what the Buy-In does, and there is no cost for if you are under 1619, where there may be for the Buy-In. So, looking at the DI population, with the first thing we knew we needed to do, we knew we had to exclude unearned income from eligibility determination, because the Buy-In regulation said the person must except for earnings, the person must otherwise eligible for SSI. So, if a person would have unearned income over the SSI standard, this year I think it's \$545, the person would be ineligible for the Buy-In. So, it was a kind of Catch-22. It didn't exclude the unearned income; they wouldn't be eligible for SSI, or the Buy-In. So, they would be stuck no matter what their earnings were. So, we excluded the unearned income to at least get them in the door.

Then, the definition of work came in and under both the Buy-In or the Balanced Budget Act of 1997, and the first category under the Ticket, and in Oregon back then we work under BBA, we could not define work. That was a major stumbling block because there was a concern that people would get to work and earn \$10 per month mowing their neighbors lawn and say I am working, I am eligible. But, the agency formally known as HCFA, CMS, said you cannot define work. Congress did not define work; therefore, we cannot define work. So, we defined work. We didn't clarify work as being any ongoing activity for which income is being received and potential tax liability is incurred. That at least said, ok, you have to have some kind of bonafide work activity to be able to show pay stubs, self-employment contracts, book-keeping that kind of thing. So you had to be able to verify to the state that indeed you are working in some activity that is more than mowing your neighbor's lawn. So those two pieces were the main criteria for the EPD program. Certainly, you had to meet the definitions. Disability had to meet the definition used by Social Security. Those were the main criteria for the program.

Once we got those things straightened out, we did develop what's called a cost-share and it was strictly looking at the unearned income. As I said earlier, we excluded unearned income for eligibility purpose, but then post-eligibility we have a cost-share, and that cost-share is any unearned income over the SSI standard, the person would give to the state. As it turned out, that really defines work, because if the person has, say a \$200-\$300 cost-share, that person would have to be earning enough to make paying that \$300 cost-share to the state worthwhile. If they were only making \$100 and the cost-share was \$300, being on the program would not make sense unless they had significantly high medical costs. Even though at the time when we developed the cost-share, we didn't see it as a method to define work, we developed it strictly as a mirror of our Home and Community Based Services spend-down methodology. It is, as Allen said, a way to determine how wide the door is going to be open as far as consumers coming on. We also developed a premium, which is based on total income, earned and unearned income, except for that which you give to the state, but it's a very small premium. It's the sliding scale of 2-10% of income over, countable income over the 200% of the Federal Poverty Level. We have a significant number of deductions to income when it comes to calculating premiums. Since we want people to be able to

earn and save as much as possible, we developed, well. First we put, Medicaid presently has a \$2000 asset tax, and we raised that to \$12,000 in Oregon. We also developed what are called approved accounts, which allows the individual to save for disability related items or services, modified vans, computers, whatever, so any money in those approved accounts, would also be set aside and exclude from that \$12,000 resource tax.

Under the BBA, the person must have a countable income less than 250% of the federal poverty level. The key word there is countable. The standard calculation is usually the same calculation used by SSI, you take the gross minus 20, minus 65, divide by two and that's your countable. We also developed what are called employment and independence expenses, I almost forgot there, which are similar to IRWEs, Impairment Related Work Expenses, and Blind Work Expenses under Social Security, but they are more liberal. They are any expense that can be reasonably expected to enhance the person's independence, employment independence potential, very vague. We wanted the individual to be able to earn as much money as possible, and not have to have money they use to pay for disability related expenses used against them, so to speak, and eligibility, and on premium calculation. So, we figured a way to exclude those during the process.

The basic philosophy of the Buy-In and the whole employment initiative is the person's with disabilities should have the ability, and the same opportunity, to go to work, to pay taxes, to have savings, to have retirement accounts as the rest of society, and not be concerned that because they earn and save they lose necessary assistance from the state. Certainly it is a belief that once a person has sufficient earnings that they no longer need the assistance, they will take themselves off, assuming that there are tax incentives that they could use to make up the difference.

So, Allen I think I will ask for questions there unless you have some specifics. I am not sure how long I have been talking.

Allen Jensen: That was great Scott and I don't know if you actually said that you are a Medicaid Buy-In....(interrupted)

Scott Lay: Yes I am.

Allen Jensen: That supplements what I assumed the health insurance you have from the state of Oregon.

Scott Lay: Yes, and that's a good point. I did. I was not the first, even though I was lucky enough to be in the right place at the right time, I was deeply involved in the development of the Buy-In and those under contract when we were developing it. I was then hired, and once we got the Buy-In approved, I was able to actually go to work and make sufficient money and basically not have that held against me. So I was able to accept the full-time position and then I was able to write the

administrative rules and do the trainings and implement the program. As Allen said, I talked to consumers and advocates all the time about the program. So, it's been nice, it's been long, but it's been an evolution of policy and my life at the same time, using plans for receiving self-support. I was using the system as it should be used, even though I had to help create the program that allowed me to go to work, it's been very beneficial.

Allen Jensen: All right, well let's open up for questions, I think Jason, who is on the line can give directions as far as how people can dial in if they want to ask a question. Let's see if any questions have come up at this point and time.

Jason (moderator): Thank you. If you have a question at this time, please press the one key on your touch-tone telephone. If your question has been answered, or you wish to remove yourself from the queue, please press the pound key.

There are not questions at this time, please continue.

Allen Jensen: Ok, I would like to introduce, Mary Alice Mowry, who introduced herself earlier and here again, has had the opportunity to be involved in the Medicaid Buy-In implementation and development in three states. Now is back in the state of Minnesota. So Mary Alice?

Mary Alice Mowry: All right. Hi there. I wanted to first make a little clarification in something that Scott said around the issue of if you are on SSI, and your need for the Buy-In vs. just using your, because you would be eligible for Medicaid because of your disability status: one of the ways or people on SSI, that the Buy-In has been very helpful in a number of the states, is for those people who want to save, and so we do have a small number of people in Minnesota, who are on SSI, who no longer receive a cash payment, who are now moving to the Buy-In, because they are at a level of earning that they want to save for their future, and they would not be able to save on the SSI program. Does that sound right to you Scott?

Scott Lay: Absolutely, I totally agree that transitioning from SSI to the Buy-In is terrific, what I was urging is for people to stay on SSI until they get over the \$2000 resource in transition to the Buy-In.

Mary Alice Mowry: Exactly.

Scott Lay: I agree with you completely.

Mary Alice Mowry: And this little discussion that Scott and I have had is starting back in the mid-90's in Wisconsin and also through teleconference between Wisconsin and Minnesota. We began to look at the issues regarding how can we keep health care access, and allow people to go to work without spending all their earnings on their health care. For those states, for those of you who know about this, even people who are not in Medicaid agencies, know the awful word, spend-down, meaning all of your

money that you are earning above a certain point, you have to spend that first on your healthcare before you become eligible for medical assistance. One of the things that I have been very fortunate to be a part of is that in these policy discussions that happen, there are real live people who need, or will use a program to help tell their story, because their story leads you to what might be unintended consequences of a good idea. As a policy maker, unfortunately I have had a number of good ideas that when you start walking them, ten steps down the road you find out that your good idea at the beginning really left a dead end somewhere else, or a cliff, or something that you couldn't anticipate.

In Wisconsin, we had any number of features that we wanted to see happen in a Buy-In, in a waiver from Social Security that we even named after individuals. This is the "Scott Lay" waiver, this is the "Dan Johnson" part. There were people who were already on the track and their months were counting down, and we needed to come up with a different kind of solution so that something positive could happen in terms of that the consequence was not, you were not quitting your job in order to have health care. In 1995, in Minnesota, it was in fact the Work-Incentives Committee of the Consortium of Citizens with Disabilities, who lobbied effectively with the Minnesota Legislature, authorizing the Department of Human Services to seek an 11-15 waiver. This was before the Balanced Budget Act that Scott had talked about. So, the only way that we knew at that point to address this issue, was that we would have to go to CMS, then known as HCFA, for a waiver which would establish an earned income disregard for people eligible for Social Security Disability Insurance, and receiving personal care services under Medicaid. So it was very narrow, but it was the only way we knew. Then the Balanced Budget Act was passed and that allowed Minnesota to go forward with what is now known as our MAEPD program (Medical Assistance for Employed Persons with Disabilities).

Throughout our history in Minnesota with the Buy-In, we have had very, very active involvement of consumers, at the legislature, and in meetings and really helping to facilitate, and bringing forth helping specific elected officials, to bring forth very specific legislation regarding how our MAEPD program would work. There's been compromise. We've needed to have, as the State Department of Human Services, we've needed to have there be a way that we can come together, to look at the difference between a budget bill that had gone in, or issues related to specific legislation from the department vs. what the advocates in the community had helped to get put on the table in our Human Services Committee. We have been able to do that successfully. At this point, we have close to 6,000 people on our program and in fact last month, we crossed the threshold of we have had total over 10,000 people use the MAEPD program in the state.

Since the beginning of the Medicaid Infrastructure Grant, what we have done is to continue to work very closely with the Work-Incentive Sub-Committee, of the Minnesota CCD group. We meet with them about once a quarter. We use them as a vehicle to walk through both policy and implementation issues. So, for example, last summer when the Governor, or last fall, when the Governor was announcing the budget. We

arranged with our legislative and budget people in both Continuing Care and Health Care, because both of those areas are very actively involved in the service delivery and the eligibility side of MAEPD. We had our budget people meet with the CCD Work Incentives Group, literally ten minutes after the Governor announced the budget, so that we could talk through at that point, issues related to changes, proposed changes in MAEPD. Those changes did not get implemented, but what was important in that process, was to really be able to hear from each other and to acknowledge that we may not remain on the same page the whole time. That the consumers could give us their input, we could listen to that in terms of how we went forward. Also, we could talk about how it is that those things had happened. We had done a fair amount of work with the group before that.

The other way that we use the CCD Work Incentive Sub-Committee group is that once we get to implementation—like in November we began implementation of a new premium structure—in Minnesota we have moved from a premium structure initially in which about 20-25% of the individuals on our program paid a premium, meaning 75%-80% had no premium. Today we have 75%-85% of people paying a premium and 20-25% not. We have literally worked with our consumers about going through each step of how we create our bulletin. Getting feedback of what kind of examples we should use with financial workers, what is the best way to do this? Initially we had set up an automation system that counted a different premium on the months that you had three and not two paychecks and this had a very adverse effect. It was at the CCD group that the volume rose high enough, that we could go back in and override what had been a systems kind of fix that didn't really work for real people. It worked for the computers but not for anyone that was using it. So that's one way in which we continue to use that group, who has historically been kind of the grandmothers and grandfathers of our program. We also have an advisory group that's associated with all of the initiative of our infrastructure grant. They too, work with us on the development of our materials. They have had an extensive amount of training and work with our staff. Where they will be, starting this fall, going with the infrastructure staff and advisory committee members, will be going around the state to do community meetings. They will provide outreach and ask questions and answers, and begin to solicit real stories about how MAEPD has affected the lives of people in Minnesota with disabilities.

The third way in which we have a whole linkage with our consumers is that the work incentives connection—which is the State Partnership Initiative Program Demonstration Project, in the Department of Economic Security—they have a Work Incentives Center, the Work Incentives Connection. We work with them around getting specific stories and we now have the staff of the Work Incentive Connection in our infrastructure staff, are starting to meet quarterly to really go over any issues and complications that are happening around the overall benefit planning and issues related to MAEPD. We have found that it is the person who uses the programs who best knows how this is going to work for them. It has proved fruitful for us to include them in all of the ways that we do.

I think with that I will stop Allen.

Allen Jensen: That was excellent Mary Alice. I think it is a wonderful example of where a program has moved from, you said '95 when the consumers and the advocates were taking the lead and now where you continue to have them so much involved in some of your examples were excellent. I think just on the side here, is that on the Minnesota page on my website, that you can actually go and take a look at their Medicaid Buy-In regulations in their manuals and they do have examples in there. The fact that you are using consumers and the advocates for helping develop the right examples was certainly a wonderful example.

At this point and time, is there anyone who has a question at this point and time?

Moderator Jason: Once again, if there are any questions please press one.

We have a question from Michelle Morehouse. Please go ahead.

Michelle Morehouse (Bill Nelson): Yes, this is Bill Nelson. I have two questions for Scott.

Allen Jensen: Which state are you from?

Bill Nelson: Alaska. One question is about the threshold. When a person gets over \$2000, can we change our level of threshold, or get rid of this threshold all together?

Scott Lay: You are talking about as a state to go into the Medicaid Buy-In?

Bill Nelson: Yes.

Scott Lay: Yes, I have to chuckle, because Allen and I talked about brining up the 1902R(2) policies of Social Security. Under that section under the Social Security Act, states can develop more liberal asset and income limitations for their Buy-In program that is set by Social Security. For example, in Oregon we use that opportunity to raise our Buy-In threshold to \$12,000.

Bill Nelson: How do you go about getting rid of it all together.

Scott Lay: Do you have absolutely no asset limitation?

Bill Nelson: Yes.

Scott Lay: You can do that under the Ticket to Work and I don't see any reason why you couldn't do it under the Balanced Budget Act. Allen, am I correct on that?

Allen Jensen: As far as I know, I know that under some of the children's program—of course I believe some states do not have asset checks. I think that the only issue you would have there is political feasibility. I think that one of the things to be considered is the fact that, well Larry is going to be talking next here, Connecticut is actually collecting information on how many people have assets over \$10,000 is pretty small. So, here again there is issues on assets. There, the standard accountable income of whether you have \$2,000 or \$12,000, but then there is also as Scott talked about, the matter of having other types of resources which are excluded, which is quite similar to exclusion of certain kinds of assets under a plan for achieving self-support program. So, you have a lot of flexibility on that. It's really a question of whether you do something like Oregon did, which is a \$12,000 limit compared to a \$2,000. Then some specified resources that are excluded such as retirement accounts and so forth. Or, you go more like Minnesota, which has a \$20,000 limit, which I think is still the case.

Mary Alice Mowry: Yes, absolutely.

Allen Jensen: Then you have a few exclusions, but you don't have some of the details of the independent accounts. Issues of simplicity compared to more specific exclusions.

Mary Alice Mowry: Allen, I think that one of the things that in our work with other states that we have found, is that it's important to look at how it is now in other programs and what are the ways in which you can mirror the kind of exemptions and things like that you have in your individual state. Because, our numbers sound high to some states that we have exempted, retirement accounts and a number of things. And, there is a \$20,000 asset limit. However, when you look at other types of healthcare programs that receive some state support, it looks very similar. So, that's an important thing in terms of looking and trying to advocate in your own states.

Allen Jensen: That is a great point. Any more questions from Alaska there on that issue? Or comments.

Bill Nelson: I have another question. I am thankful for you answering that first question. A lot of us clients have growing needs, but they still want to go to work, which has a really, really low threshold. But the Medicaid Buy-In Alaska is not connected with the waiver. Is that something that could be added on to the Medicaid Buy-In?

Scott Lay: The first part of your question was scabbled on my end. It sounded like you were asking how does the Home and Community Based waiver interact with the Buy-In? Is that your question?

Bill Nelson: Well, yes, and no, because right now the Medicaid waivers are not connected with the Medicaid Buy-In. At least in Alaska's level. Can we add that into the Medicaid Buy-In?

Scott Lay: What we did in Oregon, as I said in my discussion, persons with disabilities who are had high entered income and need those in-home supports as personal supports services, or the primary population we first started looking at, we made sure that we kept that population in mind. What we did, was when we got our state plan amendment or Buy-In approved by, at that time, HCFA, now CMS approved, we submitted an amendment to our Home and Community Based waiver, to just add the Buy-In population as a third population. So, in Oregon, the three populations are persons on SSI, what I call the 300 percenters, those that have total income less than 300% of the SSI standard, and the third population is down under the other category, we put in the Medicaid Buy-In population. So, it actually worked out fairly simple in Oregon for us. I am not sure how it worked in other states.

Larry Carlson: This is Larry from Connecticut. We actually did the same thing. Our personal care assistance is only available through a waiver and we added our Medicaid Buy-In people as a separate categorically eligible group under our waiver also. So, certainly it's something that's been done and that CMS is receptive to.

Scott Lay: Yes, absolutely. One thing that I liked about it is, when once you are on the Medicaid Buy-In, then if you need the services you can get them without another set of eligibility criteria, you had to go through the assessment process, as you would for any wavered service, but you didn't go through the post eligibility premiums or cost or whatever they call it, under the 300 percenters. So, at least in Oregon, its really clean. If you are in the Buy-In and you need the services, you are eligible.

Larry Carlson: Yes, same in Connecticut. You are subject to the premium rules under the Buy-In, but all the applied income rules under the waiver are superseded.

Scott Lay: Exactly.

Mary Alice Mowry: It's the same in Minnesota.

Scott Lay: Yes, it is a very clean process.

Larry Carlson: In fact, on the CMS website, under the Ticket to Work, they actually have a section where they talk about making a waiver eligible people part of your extended Buy-In eligibility to your waivers, so they talk about it and they actually encourage that kind of thing. Especially for PCA services, which in a lot of states are only available under a waiver.

Allen Jensen: If you could send me your e-mail address, then we can perhaps you send you specific information for your use there in Alaska. Could you do that?

Bill Nelson: Yes, I will definitely do that. I will send you both of them. My home and my work e-mail.

Allen Jensen: Great. Then I can send it out to Mary Alice, and Larry, and Scott. Then they can provide you with information that you can use in your state.

Is there another question at this point and time?

Jason (Moderator): We have a question from Nicholas Rose. Please go ahead.

Nicholas Rose: Yes, this question is a follow up to that last conversation and the question is if you have people on waivers that are participating in the Buy-In, is case management still a mandated service for those individuals?

Scott Lay: I am trying to think if it is mandated, it's certainly a service under the waiver. I am not an expert on case management in Oregon, so Larry or Mary Alice?

Mary Alice Mowry: I can jump in here. In Minnesota, in the cases where it is through the waiver and mandated service, it still remains mandated even though they are using the MAEPD option.

Larry Carlson: In Connecticut it's just our PCA Waiver Services that carry eligibility through the Buy-In, so any services are approved under a plan of care by the PCA waiver people, continue through the Buy-In. It's just the financial eligibility rules are that of the Buy-In as opposed to the financial eligibility rules that are normally used under the waiver.

Scott Lay: Yes, in Oregon it is exactly the same. The waiver stays exactly the same, the service providers stay exactly the same, it's only the person getting into it through the Buy-In rather than through one of the other populations.

Allen Jensen: Nicholas, is there more background to your question on that you want give?

Nicholas Rose: No that will do it, thank you.

Allen Jensen: Ok, and your state was?

Nicholas Rose: New York, sorry.

Allen Jensen: You are in New York, okay. Is there any more questions at this point Jason?

Jason (Moderator): There is a question from Scott Steinbrecher. Please go ahead.

Scott Steinbrecher: Can you hear me? This is for Scott. Scott, you said that you thought that there was no need for the Buy-In before SSI folks do to 1619b but wouldn't it be helpful for the people who make above the threshold for 1619b to be able to Buy-In to the Medicaid.

Scott Lay: Oh, absolutely. Obviously there might be a little confusion. What I am saying is if the individual is on SSI, they should take advantage of all the work incentives under SSI, such as 1619b and the thresholds, and the individualized thresholds, and the Impairment to Work expenses, wait a minute. All the opportunities available under SSI, and then at that point, their earnings either go over the 1619b threshold. In Oregon I think it's right around \$25,000 for the standard, or an individualized threshold, which could be \$30,000-\$35,000, stay on SSI until they reach that threshold. Then they'd transition into the EPD program. Or, if they have savings over that \$2,000 resource, then they would transition on into the Buy-In. It's a point of eligibility. If you are still eligible for the SSI, use it, but as soon as your earnings or assets go over the eligibility standard, transition into the Buy-In.

Nicholas Rose: Thank you.

Mary Alice Mowry: Scott, I want to share a little story in Vermont, when the Buy-In went into effect. I was working, directing their SSA State partnership demonstration project in their VR agency. There were several consumers that really had very clear goals about their earnings and they made the determination that even though they had not reached the asset level yet, that it was a part of how they were going to get to their goal, was to let go of SSI. So, I think that what is important is that we have the best ways we can to really lay the information out so that consumers can make the decisions that work best for them in this area. There are some states that do not allow consumer choice. If you are eligible for the SSI, you are not eligible for the Buy-In. So, it varies from state to state.

Scott Lay: Yes, consumer choice is critical and consumer education is critical. It only goes to benefits planning and all that good stuff. Like Mary Alice says, whatever works for the consumer?

Larry Carlson: If I could just jump in. What we do in Connecticut, our computer system is programmed to track the clients eligibility through the various levels of disability related Medicaid. So, we actually start out with a state supplement recipient if they fail to meet the state supplement eligibility criteria. They go into the 1619b, or we also have a 1905q category here, which is similar to 1619b, but it is tied strictly to state supplement as opposed to SSI eligibility and it uses the same thresholds as 1619b. Once a person fails those eligibility requirements, our computer system places them into our Medicaid for employed disabled category. So the client circumstances are just plugged into the system and it does require a little bit of eligibility worker intervention, but based on the clients circumstances, the category is picked and they end up with the appropriate Medicaid coverage.

Allen Jensen: This is Allen Jensen. I think also another variable here of course, is that maybe you have someone who didn't know about the Section 1619b work incentives and were SSI recipients. There may be some people that don't want to lose their attachment with the cash assistance program. That is an advantage of the Section 1619 program. So, comparing going to work and they can stay on 1619 and keep their attachment to SSI if they have to quit working, compared to going to Medicaid Buy-In and accumulating and losing their attachment to SSI eventually if they have excess resources. Then they have to make those kinds of choices as far as what is best for them, what is the risk they can take, or not take. As Mary Alice talked about in Vermont, there is some folks who said I am ready to take that risk. On the other hand there may be other people who are not willing to take that risk. I think that is a very important part of it, and that is when we talked about the comprehensive system—the whole matter of having well informed benefits counselors, those who can really walk it through, as far as what are your options, what are your risks, what are your goals. I think that's the very important part of it.

Let's get Larry Carlson here. There are other people ready to ask questions, where are we at on the questions?

I think he left us, so Larry why don't you take off. You have the input already from these discussions, but why don't you talk about Connecticut right now.

Larry Carlson: Again, I am Larry Carlson from the Connecticut department of social services. Here in Connecticut we have been hearing from disabled individuals and their advocates that our system has some major holes. A person could go to work, but as soon as their countable income exceeded our medically needy income limit every penny their excess income was paid back to the state in the form of a Medicaid spend-down. We also had people who were in need of personal care assistance services, but if their income was above our 300% of federal poverty level income limit for our personal care assistance waiver, they couldn't qualify for Medicaid PCA services, because they are only available for waiver eligible persons. So, what we did, feeling that there were no other alternatives, especially in the early 90's, our legislature passed two programs which were entirely state funded. We had a state funded pharmacy program called ConnPace, which covered a lot of individuals on SSDI and some also employed individuals who, although they couldn't get Medicaid or were at a Medicaid spend-down, they qualified for the state funded pharmacy service. We also had working persons who needed PCA services who were on a state funded PCA program. So, the State of Connecticut was paying, or helping these individuals meet their needs over and above what would be covered and federally matched through the Medicaid program.

With that background, in our 1999 legislative session, once we became of what Oregon was doing with the Balance Budget Act, Medicaid Buy-In, Buy-In legislation was introduced, but it was done a little bit late to get on the legislatures radar screen and it died in committee in 1999. However, as most of you know, in the fall of 1999 the Ticket to Work Act was passed and was signed by President Clinton. Efforts continued at the

legislature to re-introduce legislation to allow for Medicaid Buy-In. At the same time, a client here in Connecticut, who happened to live in a district of a legislator who is a key member of and a key political ally of our Governor, were able to convince the Governor that the Medicaid Buy-In program, or Work Incentive Program to allow disabled people to work, was something the Governor would want to support. Meanwhile, our Human Services Committee was also advocating for the same type of legislation. So, when the 2000 Session came in we had all political sides pretty much in favor of Medicaid Buy-In program. At that time the State of Connecticut's state fiscal resources were looking a lot better than they are today, but it was kind of a "right place, at the right time" situation back in 2000.

So, in the 2000 Legislature, since Ticket to Work Act had been enacted, we were able to formulate a program jointly between the Governor's people and the Human Services Committee people. They were able to come up with a program formulated under the provisions of the Ticket to Work Act. That became important because we were able to use the 1902(r)(2) provisions where by the state, CMS will allow a state to set whatever income and asset limits the state so chooses, which is basically what we did. So, with that, we came up with what's called our Medicaid for the Disabled program. We started out in October of 2000, by converting 409 Medicaid spend-down people who were employed and spend-down based on their employment. At this point, as of June 30th, we have 2306 individuals on the program.

What I am going to do is go over some of our highlights of our program as to how it operates. It's similar in many respects to what's being done in Minnesota, but there are a few differences. Without throwing a lot of figures at you, I will just go over what our eligibility rules are and what that does as far as allowing persons to become employed without losing the needed coverage.

First of all, we just look at the income of an individual to establish eligibility. The individual has to have total income of \$75,000 per year or less. We do apply a limited SSI, or we do apply SSI methodologies to that \$75,000 for persons who have gross income above \$75,000, we do give credit for impairment related work expenses, and apply the SSI earned income \$85 and half the balance disregard. If we need to bring a persons countable income down below limit, we do have a couple of people with income above \$75,000, but who have high impairment related work expenses. Basically, what they do to gain eligibility under our program is, meet their own impairment related work expenses to get them down below the \$75,000 figure. We do not look at a spouse's income in the initial eligibility determination. Once we find a person is income eligible for the program, we then subject them to a second test by which we compute our premium liability. If a person has between the individual and their spouse, we charge them a premium based on 10% of income above 200% of the federal poverty level for their appropriate family size. So if they have an individual and spouse and three minor children, we would use 200% of the poverty level for a five-person household, however we would not count the children's income, we would only count the income of the individual and spouse when computing a premium.

Our definition of employment is, as Scott mentioned earlier, CMS will not allow states to define employment by a specific number of hours worked per month. What they will allow and what we do have is a definition of employment, as a person must be engaged in a reasonable work effort and receive cash remuneration, and pay all applicable payroll or self-employment taxes.

Our definition of disability is what's allowed under Ticket to Work. The individual must have a disabling impairment as defined by Social Security Act, except for provisions related to substantial gainful activity. So, if you have a person who would qualify for Social Security Disability or SSI based on the physical or mental condition, but they are ineligible for those benefits due to performance of SGA, they meet the disability criteria under our program. What we have noticed and what we have for a lot of individuals is persons have lost their Social Security Disability benefits, due to SGA, but continue to receive Medicare benefits under the Medicare extension allowed under Ticket to Work Act. Those people categorically meet our definition of disability, because the Ticket to Work Act rules for extending Medicare are very similar regarding continued substantial gainful activity.

We do have an asset test in Connecticut. Our asset limit is \$10,000 for an individual, \$15,000 for a couple. Over and above that, we do exclude monies held in retirement accounts, IRAs, 401Ks, etc. Monies in medical savings accounts and monies held in accounts that have been found to help establish to allow the individual to save for expenses to increase their employability.

Allen did mention that we track assets. Being a 209b state, our normal asset limit for other Medicaid coverage groups is \$1600, but under our program, as I've said, it's a \$10,000 asset limit and then we exclude retirement accounts. As of June 30, as I've mentioned, we have 2306 individuals on the program. Out of those, 2086 actually still have the assets below our \$1600 asset limit. We have 208 people who are above \$1600, but below \$10,000, then we have 12 individuals who have assets above the \$10,000 asset limit. So, those are 12 people with money in retirement accounts or employability accounts, etc.

As I mentioned, we do allow for eligibility for our Personal Care Assistance waiver, based on eligibility for our Medicaid for our employed disabled program. We do have, again as of June 30; we had 39 people who gained PCA waiver eligibility, through the Medicaid for employed disabled program. Ironically we had approximately, I believe the number was 35 people who were on that state funded PCA program part implementation of our new Medicaid Buy-In. So, pretty much it's not a one-for-one relationship there, but most people who are now on the Medicaid or the PCA waiver by virtue of their Medicaid for employed disabled eligibly were people who we were previously paying under state funded program. So if you are looking to implement and you have those kinds of state funded programs that you can replace with Medicaid, which is at least 50% reimbursable, that's a good selling point. That is something to keep in mind.

We also have a temporary job-loss provision under our programs. Whereby, if you have an individual on the Medicaid Buy-In coverage group and they temporarily lose work through no fault of their own, whether it be a physical, or temporarily physical, or health problem, or they have just lost their job because of a normal lay off, or they are unable to do that particular job duty, maybe they tried and that particular job was something they couldn't handle, they could retain their eligibility under the more lenient eligibility rules of our Buy-In for up to 12 months. As long as they can establish that they lost the employment through no fault of their own and are planning to return to work when the health crisis stops, or if they continue for search for new employment if their loss of employment was due to lay off, etc.

Those are basically the highlights with that, if there are any questions.

Allen Jensen: Ok, do you have any specific questions for Larry, or any other questions for any of us at this point?

Jason, are you there?

Jason (Moderator): Thank you. Once again, if you do have a question, please press one.

And our first question is from Michelle Morehouse.

Bill Nelson: This is Bill again (Bill Nelson). Couple of other people have been asking me, when people are Diabetic and want to get on the Medicaid Buy-In, but not on SSI, if they are previously working, can they just go ahead and get on the Medicaid Buy-In without going through the process of getting SSI.

Allen Jensen: Scott, why don't you take that one.

Scott Lay: The Buy-In requires that the person's disability must meet the definition used by Social Security. So, no, the person does not have to go through the process of applying for SSI or SSDI, but the state must use an equivalent process for determining if the person's impairment meets that definition. So, in Oregon, when a person such as what you are describing comes in and wants to apply, but does not have a history with Social Security, the eligibility worker would collect medical records, psych. evals, or whatever is appropriate for the consumer and send them down to the central office, where they are reviewed by the same individual that reviewed for Social Security. They are just separate by contracts. They use the same procedure, the same process; it's just not Social Security.

Allen Jensen: But they don't have to pass the earnings test.

Scott Lay: Right. As was mentioned earlier, the first step for that process is whether or not the person is earning over SDA, under the Buy-In. That step

is completely eliminated. It goes directly to Step 2, which is must be severe, and must have lost it a year and you just go through the rest of the process.

Allen Jensen: Scott, do you actually use the Disability Determination Service as compared to a separate.

Scott Lay: We contract with two of the doctors that also work for the Disability Determination Service. Since SSA contracts with the DDS to do the SSA determinations, we have to make sure that we are not using Social Security funding to pay for the Medicaid Buy-In determination process. So, we contract separately with the same doctors, they just do it on their different time.

Allen Jensen: Scott, do you have any indication of the people in Oregon that are not on SSI or SSDI, that came into your Medicaid Buy-In program, as far what were the primary characteristics as far as disability and so forth?

Scott Lay: What I do know, I asked the question of the person that is the gatekeeper for the records that come in that go to the contracted experts. I believe it was like February 1st, we had 107 people apply for the program that did not have a history with Social Security, so had not had the determination made. I think 37 of those were denied, so what is that, a little over...108 applied and 37 were denied, so about a 1/3 were denied. With those, we have many persons with mental health issues and across the board of types of disabilities or impairments that persons have when they are applying for the program.

Allen Jensen: Larry, do you have a feel, as far as in Connecticut? How many people and what their characteristics were that came in not being on SSA, SSI, or SSDA before?

Larry Carlson: We have asked our workers to track that data, but unless we are actually doing a medical determination, we are kind of at the mercy of Social Security. I do know this, that out of our 2306 people on our program, 151 of them have no unearned income. So, the assumption is that pretty much everybody else is receiving Social Security Disability, or primarily Social Security Disability, any person receiving SSI, would still be within our categorical limits because of our formula. So, I would say that it is about 151 people who more than likely have come through by us making the disability determination. We do have a separate contractor here in Connecticut that does our disability determinations, but they are all pretty much from what I understand, former DDS employees.

Allen Jensen: Mary Alice, do you have anything further to add on to this?

Mary Alice Mowry: No. That's essentially the same here. We are trying to do a little more pulling out now of the number of people who go through this separate process who are denied. I will say that we've done a fair amount of communicating with other states because about 25% of our enrollees have not been SSDI or SSI in the past.

There is some question in other states, what happens once they have gone through this process, where their income has not been considered, but the state has determined them to be disabled, what happens when they lose their jobs? Do they then apply for regular MA? Regular Medicaid? Would they qualify? And the answer in Wisconsin is yes. The answer in other states may not be yes.

Allen Jensen: Ok. Well, I have my first e-mail question here. So now that someone responded I need to answer it. The question is from Nanette Goodman. I know is with Cornell University and working on the D.C. Medicaid program development. The question was, I am having trouble understanding why Minnesota has 6,000 enrollees, Connecticut 2,300 and Oregon 541? I know that Oregon has a 200% of the poverty income threshold, will Minnesota has no threshold, and Connecticut has a \$75,000 threshold. Each has slightly different asset limits. I also understand the whole concept of starting points, but this doesn't seem to explain the difference either. Are these three states serving very different populations?

Scott Lay: You know, that's a great question.

Mary Alice Mowry: It is.

Scott Lay: In Oregon I think we have basically defined working, although we didn't mean to, with what we call the cost-share, where as Larry said, the vast majority of the people are probably on SSDI, so many of them will need to pay the difference between the SSI standard and the total amount of unearned income, so that could be significant. We feel that is precluding many people from being on the program and we are definitely looking at our cost-share premium structure, trying to figure out a way to not swing the door wide open, a lot more people to take advantage. I think another issue the amount of outreach. We have not done a lot of outreach in the last year or so, primarily because of the budget constraints. Where there is concern that if we do outreach, the numbers will significantly increase and we all know what that means. So, I think that is why our numbers are lower in Oregon than the rest. Mary Alice, why are yours higher than the rest?

Mary Alice Mowry: We started off in the first, well; we had 1400 people who essentially in the first 30 days of the program came on. We kept climbing at an astronomical rate for almost a year and a half. So, what we had was no income limit, and we have a premium structure that up until the end of last year, remember I said 75% didn't have a premium. We also have in terms of our work effort, the way in which we can determine if people have earnings, we have made some exceptions regarding the issue of the withholding of taxes. So we have a certain amount of people who have a relatively low income that are on the program. So all those reasons together make for a larger enrollment.

Allen Jensen: Let me just add one thing, is that Mary Alice talked about the major involvement by the advocated and consumers in the development of the program, and there was a survey sent out back in I guess it was 1997 and 1998, would you work

if you could keep your healthcare? Well, 1200 people responded. So, you had an outreach program before the program even started.

Mary Alice Mowry: Yes, absolutely.

Allen Jensen: I think that's a major impact as far as enrollment. Plus, your Minnesota CCD, or Consortium of Citizens with Disabilities, have been out there advocating, here are some work incentives under current law, or here's the limitations under current law and the SSDI side, and so no state has done more as far as information on work incentives and work disincentives I say, before the Medicaid Buy-In program started in Minnesota.

Mary Alice Mowry: Yes. And I think that one of the things is, that because of the high visibility that we had of consumers, advocates, service providers, and other stakeholders, there was a high degree of trust that this program was something that would work for people. We also worked in partnership with the Work Incentive Connection, that went out and in their community meetings, they also really discussed this program and they talked with individual providers and individual consumers about making sure that they made the connection between taking care of this isn't the only thing you have to look at. So there was a much more coordinated and integrated connection between the issues of benefit planning, consumer involvement and the program itself.

Allen Jensen: Larry, you talked about the fact that actually there was an outreach effort in Connecticut by way of your advice to the eligibility workers to move the medically needy folks over, can you go into that again?

Larry Carlson: Yes. In our first month, we went from zero to 409 people in the first 30 days. That was primarily, because we sent out to our regional offices a listing of every person who had a Medicaid spend-down and had some earned income. So those people were automatically deemed to have met the requirements, and that goes back to our program design, which was intentionally set up this way. Unlike Oregon, where if your SSDI is over there Medicaid medically needed criteria all your unearned income over and above become part of a monthly payment, premium payment. In Connecticut, we treat earned income and unearned income the same. That's partially because of when we did this, and what we were allowed to do by CMS. What our eligibility workers have the ability to say to a person who doesn't like their Medicaid spend-down because of their SSDI income, what they are able to say is that, well, if you were working at all, and paying appropriate taxes on your earnings, you would eliminate that spend-down. So, working becomes the more attractive alternative to not working just from a purely eligibility standpoint. The idea is that once a person found that the state was encouraging employment, obviously some people can't work, or don't have the training, or experience to work, but anybody who can make even a minimal work effort, can kind-of access eligibly in that way. The hope is that once their out in the world of employment, that they will continue to raise their employment level

because our program, you know up to that \$75,000 doesn't really prevent increased earnings.

The other things that may throw the numbers off a little bit, when we were in the planning stages, one of the things I had to do was try to come up with numbers on the disability population in the various states. Since Oregon and Minnesota were our starting points back then, we were able to come up with numbers of roughly 69,000 disabled persons in Connecticut, 72,000 in Oregon, so our numbers are pretty close. We were also estimated at 88,000 people in Minnesota. So, they are about 25% higher than us, and that may have a little bit to do with their higher numbers. Of course that's not the only factor, but it might get them a little bit higher and that would justify this 4,000, just based on the higher population, as opposed to our 3200, so we will just throw that in as another factor.

Allen Jensen: One other thing on this last question, is that Connecticut does have a state administrator and state SSI supplementation which the maximum is about \$750, what is it now Larry?

Larry Carlson: Well, it's been \$747 for about ten years.

Allen Jensen: So there are number of people who can get on SSI and Medicaid in Connecticut, who in Minnesota, would have had a spend-down situation. That does deal with the issues of the starting point.

Are there other questions coming at this point? Jason?

Jason (Moderator) Once again, if you do have a question, please press one.

And our first question is from Jim Kreatschman

Allen Jensen: Where are you from Jim?

Mike Thibodeau I am not Jim, I am Mike Thibodeau, but we are from Alaska. Jim and I are both here. I had a question concerning the term that we don't use "Medicaid spend-down". Is this the term that you use in reference to have your resource limits within acceptable levels, or is this a monthly thing, or is it strictly something people have to use for medical expenses? I was just curious what the term means.

Allen Jensen: You don't have a medically needy program in Alaska. That is the term used. Others can jump in here if I don't say it right, is that one of the options that states have, is to provide that people who in effect use their medical expenses, in effect, to spend-down to a medically needy income level, protected income level, then at that point, they become eligible for Medicaid. That's an option that states have. Now Alaska of course, you have a, your Adult Public Assistance program, and also I think a Standard of Need program for eligibility. Which is quite frankly higher than many states

medically needy program. But here again, a number of states have a medically needy protected income level, which is less than the federal SSI standard. Mary Alice, you made some changes with that in Minnesota recently as far as that in concerned.

Mary Alice Mowry: Yes we did. We raised up the income that

Allen Jensen: Protected income level. Poverty level now isn't it?

Mary Alice Mowry: Right, to 100%.

Allen Jensen: Right. In Connecticut, it is less than SSI, isn't it Larry?

Larry Carlson: Well, the limit itself is less, but because of our unearned income disregards its actually, it's actually higher the effective limit. Basically just for the folks in Alaska, the way it would work is, our medically needy income limit after income exclusions is about \$650 per month. Let's say you have somebody with income of \$750 per month. They would be \$150 over the monthly income limit. We then set up a six-month spend-down period and their excess would be \$100 x 6 or \$600 for that six-month period. If at any time during that six month period there medical expenses got up to \$600 or above, we would start their Medicaid eligibility on the day they reach \$600 and cover them for the rest of that six-month period. They would be on the hook, so to speak, for that first \$600 of expenses. That's how Connecticut is. Most states do set up a six-month spend-down period, although I guess there are other options from state to state, but at least that is how the Connecticut program would work.

Allen Jensen: One of those issues that I've discussed with folks in Alaska is, Connecticut has a program where, I guess you would call it your Adult Public Assistance, APA program. People who are eligible for that and eligible for the SSDI, in Connecticut, either they just have SSDI, and have that state supplement, which you call Adult Public Assistance, and they lose that because of earnings. They can continue on Medicaid, under an equivalence of 1619, but that's a provision, that's an option that Alaska has not chosen to date. But I know there have been discussions with the Medicaid folks, and with Nellie Ryan, and others there on that issue.

Scott Lay: Yes, we actually go straight to the working disabled if they get on the SSDI folks. We can go, they still can purchase that, they just kind of skip over the 1619.

Allen Jensen: 1619 okay. Any other, more questions from other places, at this point, Jason?

Moderator (Jason): I am showing no further questions at this time.

Mary Alice Mowry: Allen, I wanted to pick up a little more about the discussion that we are just having. From the point of not being in the Medicaid agency, one of the

things, when Larry has talked about the ways in which their system is set up so that an eligibility worker could really see what all the options are, that's a great automation tool.

Allen Jensen: Yes, I was thinking that too.

Mary Alice Mowry: There are lots of states that as they are moving forward now or even if they already have a Buy-In in place, they do not have the money to make that kind of automation happen right now. So, be aware that in a number of states, really fax machines and pieces of paper, are what are being used so that people can get this option, can go on a Buy-In.

Now Minnesota, we have just done the first big stage of automation. Later on this year, we will be able to have the same kind of array that we have an automatic premium calculator that the workers use. We are actually going to be developing, a consumer in Wisconsin is developing a premium calculator that we are going to put out in the world for the consumers, so that they and family members and service providers so that they can see what premiums are. But there is a lot of issues regarding automation that make sure that when you are talking to the state agencies, you kind of understand how all that works. You need to have somebody be your friend, that is going to say, yes, we have a whole separate little, like three, live human bodies from July of '99, until April of this year, have literally just taken faxes and manually plugged in what a premium is.

Larry Carlson: If I could just jump in on that. We, I have developed an Excel Spreadsheet that will compute a person's premium based on the basic information that is sent in along with the family size. It is used by our Voc-Rehab outreach people, through our Connect the Work project. It is part of the infrastructure grant under Ticket to Work. Having our automated system now compute eligibility and premiums, it is kind of a double-edge sword. What happens is, because the system is doing it and the workers are not constantly doing these computations manually, or at least using a spreadsheet, if there is something wrong, or they have forgotten to enter in some data, such as private health insurance premiums, which are a deduction under our program, if they don't enter those things, sometimes the computer, since it is only as good as what you put in, will make an incorrect determination and overcharge a premium, etc. But, it is true as far as not throwing people into spend-downs inappropriately. It keeps people out of spend-downs. So I guess that a premium that is done incorrectly once in a while is a fair trade off, because eventually if we catch up to it we do refund people their money.

One of the other things in advantage we have here in Connecticut is, we are a state run Medicaid program. We are not farming this out to the individual counties, which does happen in a lot of states. So we have one automated eligibility system, which is used in our fifteen regional offices because it all centrally run here in Hartford. In that respect, I was talking to folks in Virginia who were trying to come up with something, come up with a similar program, but they have, I think they told me they had a 150 different county systems, of varying degrees of automation, that they had to deal with, which made a state-wide operation much more difficult.

Allen Jensen: Scott do you have any more? We are about out of our time here. Any more comments you would like to make at this time.

Scott Lay: Actually I have got three other topics, but I will be really quick with them.

The first is when states are looking at trying to cost out the expense of this. It has been Oregon's experience, and I think that the majority of others, is majority of your consumers that will be on this program, are already on your system. So, it is not going to be new people on this system. Mary Alice and Larry, same thing?

Larry Carlson: Yes, I would agree with that.

Scott Lay: Yes, so you are not going to get lots of new people.

Mary Alice Mowry: Just a caution on that. I think we have far more than we projected that we were going to have.

Scott Lay: That's true. We got about 20%. I don't know what your running.

Mary Alice Mowry: Right. And we are running a little above 25%, so you are going to have to negotiate with folks around that part.

Scott Lay: States have a lot of leeway on how to develop their own system, which is really nice because each state is different as Allen said in the beginning. So, did I hear another comment there? There is one thing about states can chose whether it is going to be a household of the one individual or the family, the wife, the kids, that is open to the states.

The last thing I want to say is benefits planning, benefits planning, benefits planning. The consumer needs accurate information to make the decisions about what they are gong to do with their life. So that's my soap box. Thank you Allen, and thank you all for listening.

Allen Jensen: I will also say, those of you who are on the audio now and have been listening, and if you have questions, or comments, or just additional information, you've got our e-mails and also we will be providing this information up there. The information that Larry was talking about in Connecticut, will be on the Connecticut page on my website within the next 24 hours. The material from Minnesota is already up on the Minnesota page. Here again, as you have questions and comments keep our e-mail addresses. If you send to the other folks, I would appreciate getting a cc here also, so that we know as we proceed here in our technical systems from state to state, and as we do it on a National basis, that we know what your

questions are and what your need are. I'll just ask is there any one more on last question from anyone at this point?

If not, we thank you very much for listening and we look forward to hearing form you.

Scott Lay: Thank you all.

Mary Alice Mowry: Thank you.