



Policy Update – Employment, Health Care and Disability - July 2014 Newsletter

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The LEAD Center Policy Update – Employment, Health Care and Disability is a project of the LEAD Center in collaboration with the [Autistic Self Advocacy Network](#).

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CMS Releases New Medicaid Enrollment Data for May 2014

The Centers for Medicare and Medicaid Services (CMS) has released an updated report on enrollment in Medicaid and CHIP (Children’s Health Insurance Program) through May 2014. According to the report, recent enrollment data shows significant success at streamlining the Medicaid application process. Many states, including Alabama, Colorado, Kentucky, and New York, have established online applications processes that enable many individuals to receive Medicaid eligibility determinations and begin receiving coverage within one day of their application.

This “real-time” eligibility determination process is only available to those who qualify for Medicaid based on their income and not to those who qualify for Medicaid based on disability. Nevertheless, this streamlined process will benefit many workers with disabilities who also qualify for Medicaid based on their incomes. Because continuous access to health care is

necessary for many individuals with disabilities in order to enter and succeed in the workforce, increased availability of instantaneous or next-day coverage through Medicaid may improve employment outcomes for people with disabilities. Further data is necessary in order to measure the effect of Medicaid eligibility streamlining on access to health care and employment services among people with disabilities.

Download the full Medicaid and CHIP report:
www.nationaldisabilitynavigator.org/wp-content/uploads/news-items/CMS-Medicaid-May-2014-Enrollment-Report.pdf

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Kaiser Family Foundation Issue Brief on "Olmstead's" Role in Community Integration of People with Disabilities Receiving Medicaid

The Kaiser Family Foundation has released an issue brief on the role of *Olmstead v. L.C.*, a Supreme Court case holding that the Americans with Disabilities Act requires states to provide services in the most integrated setting appropriate to a person's needs, focusing on community integration of people with disabilities receiving Medicaid coverage. The brief, which marks the 15th anniversary of the Supreme Court's ruling in *Olmstead*, analyzes the crucial role that state Medicaid programs have played in *Olmstead* enforcement and implementation. Although Medicaid programs have historically been structurally biased toward institutional provision of long-term services and supports (LTSS), *Olmstead*-based litigation and advocacy in the past 15 years has played a key role in encouraging states to rebalance toward providing LTSS, including supports for employment, in community settings - often funded through Medicaid as home- and community-based services (HCBS). Today, although most Medicaid spending on LTSS still goes toward institutional care, the proportion of LTSS funding spent on HCBS has increased from 32 percent in 2002 to 45 percent in 2011.

As noted in the report, *Olmstead* enforcement and increased spending on HCBS have had a significant impact on workers with disabilities. Living in the community, with adequate support, is often a prerequisite to attainment of competitive integrated employment. People with disabilities may need personal care services, attendant services, habilitative services, or supported employment services in order to gain and maintain employment in the community. In addition, *Olmstead* enforcement efforts have increasingly acknowledged the importance of employment, and of services that facilitate employment, as a necessary element of comprehensive community-based services. For example, settlements of *Olmstead* lawsuits in New Hampshire and Rhode Island this year both required states to provide supported employment services.

Download the full *Olmstead* issue brief from the Kaiser Family Foundation:
http://kaiserfamilyfoundation.files.wordpress.com/2014/06/8602-Olmstead_s-role-in-community-integration-for-people-with-disabilities-under-medicaid.pdf

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AARP Releases Long-Term Services and Supports Scorecard3 www.dol.gov/whd/homecare

The AARP has released a state-by-state scorecard on long-term services and supports (LTSS). The scorecard rates state LTSS programs on 1) affordability and access, 2) choice of setting and provider, 3) quality of life and quality of care, 4) support for family caregivers and 5) effective transitions. LTSS includes employment-focused services, including supported employment.

Among other findings, AARP found that states needed to improve availability of employment services for people with disabilities who receive LTSS. It also noted that some states needed to increase the number of people in the personal care, home care, and home health workforce; improve transitions from institutional to community-based settings; and increase opportunities for consumer self-direction in order to enable more people to live and work in the community. The data presented in the LTSS scorecard is timely for informing state implementation of both the U.S. Department of Labor's Home Care Final Rule [www.dol.gov/whd/homecare](which goes into effect on January 1, 2015), as well as the final regulation on Medicaid state plan HCBS [www.federalregister.gov/articles/2014/01/16/2014-00487/medicaid-program-state-plan-home-and-community-based-services-5-year-period-for-waiversproviderscorecard] issued by CMS on January 16, 2014.

AARP's scorecard can serve as a starting point to identify states that have experienced particular success at providing community-based services, including employment services, and that can serve as models for programs in other states. For example, AARP noted that Minnesota had achieved particular success at developing and maintaining an adequate personal care, home care, and home health workforce and that Utah had excelled at transitioning people from nursing homes to community-based settings.

The scorecard is available via the AARP web site:
www.longtermscorecard.org/2014-scorecard#.U9INKsaWFMY

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Courts Disagree on Tax Credits for Health Insurance Premiums

On Tuesday, July 22, two United States Courts of Appeals issued contradictory rulings on consumers' ability to obtain subsidized health insurance through the Affordable Care Act (ACA). The ACA authorized states to create statewide health insurance marketplaces that allow people to buy health insurance for themselves and their families. If a state decides not to run its own marketplace, the federal government takes the lead in managing the state's marketplace instead. Under the ACA, people who buy insurance on statewide exchanges can receive tax credits to help cover the cost of insurance if they earn between 133 percent and 400 percent of the Federal Poverty Level (FPL) and who do not have access to affordable insurance through

some other source such as their employer.

Individuals who did not want to buy health insurance filed lawsuits in D.C. and Virginia, arguing that the federal government could give tax credits to people who buy health insurance in a state-operated marketplace, as opposed to one operated by the federal government. The plaintiffs in these lawsuits were people who lived in states that did not operate their own marketplaces and who did not want to purchase health insurance, but would be subject to a tax penalty under the ACA unless they could show that they lacked access to a health insurance plan that cost less than 8 percent of their yearly income. Because the health insurance tax credits reduced their out-of-pocket cost for insurance purchased on the marketplace, they would be subject to a tax penalty for not purchasing insurance unless the court struck down the credits.

In the D.C. lawsuit, [Halbig v. Burwell](#), the D.C. Circuit held that, under the ACA, the federal government could only give tax credits to people who bought insurance through state-operated marketplaces, and not federally-operated marketplaces. In the Virginia Lawsuit, [King v. Burwell](#), 7 the Fourth Circuit came to the opposite conclusion and held that tax subsidies were available to people in any state. The federal government plans on appealing the D.C. Circuit's ruling by asking for an en banc review, which would require all 11 judges of the D.C. Circuit to review the decision. In the meantime, the tax credits will continue to be available to eligible individuals regardless of where they live.

The ultimate outcome of these lawsuits, however, has the potential to affect access to health insurance in 36 states that decided not to operate their own health insurance marketplaces. Lack of access to tax credits may render health insurance out of reach to numerous workers with disabilities with incomes below 400 percent of FPL, and who do not have access to insurance through their employers or a Medicaid "buy-in" program. Faced with possible loss of coverage, individuals with disabilities – especially those with significant and ongoing health care needs – may be forced to reduce their hours to preserve their eligibility for Medicaid coverage or may forego work altogether.

Further coverage of the cases, as well as the text of the D.C. Circuit and Fourth Circuit opinions, is available via the Washington Post: www.washingtonpost.com/national/health-science/federal-appeals-court-panel-deals-major-blow-to-health-law/2014/07/22/c86dd2ce-06a5-11e4-bbf1-cc51275e7f8f_story.html

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CPSD Issues Brief on Cost-Effectiveness of Supported Employment for People with Disabilities

The Collaboration to Promote Self-Determination (CPSD) and the Ruderman Foundation released a brief on outcomes for people with disabilities working in the community versus those in sheltered workshops. This brief discusses research from several sources on the benefits and

drawbacks of competitive employment, including its effect on government benefits. It found that people working in competitive workplaces experienced a significant gain in wages for every dollar lost in government benefits— between \$4.07 and \$5.28 in wages for every dollar lost in the groups the research observed.

The brief also discusses research on the change in average wages in sheltered workshops over time, and found that wages in sheltered workshops dropped significantly. Between 1980 and 2009, wages for employees in sheltered workshops dropped 18¢ an hour—a total decline of \$2.65 an hour accounting for inflation. In contrast, people in supported, competitive, integrated employment have experienced an overall increase in wages, even when their wages are adjusted to account for benefits that they lost as a result of their income.

The brief’s findings highlight the importance of funding supported employment services for people with disabilities. These services are frequently funded through Medicaid home- and community-based services state plan amendments or waivers. [CMS has recently issued regulations](#) requiring states to provide HCBS in community-based, integrated settings that maximize opportunities for competitive integrated employment.⁹ CPD’s issue brief may help inform policymakers as states develop transition plans to come into compliance with these regulations. As the brief illustrates, shifting Medicaid LTSS funding toward supported employment services and away from workshop-based “training” programs not only increases access to competitive integrated employment but also improves workers’ overall economic well-being, even after accounting for reduction in benefits.

View the full CPD brief online:
<http://thecpsd.org/wp-content/uploads/2014/06/Should-People-With-Disabilities-Work-Competitively-Within-Their-Communities-FINAL.pdf>

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Disability Rights Ohio Finds Olmstead Violations After Investigation of Institutions, Sheltered Workshops and Day Programs

The Protection and Advocacy agency for the state of Ohio, Disability Rights Ohio (DRO), has sent a letter to state officials detailing its findings after an 18-month investigation of institutions and state-funded facilities serving people with disabilities, including large residential facilities, sheltered workshops, and day programs. DRO stated in its letter that Ohio was out of compliance with the ADA’s requirement that people with disabilities be served in the most integrated setting appropriate to their needs, as set forth by the Supreme Court in [Olmstead v. L.C.](#) The Center for Public Representation (CPR), a nationwide nonprofit advocating for the rights of disabilities, and Sam Bagenstos, a professor at the University of Michigan Law School and former Deputy Assistant Attorney General for the U.S. Department of Justice, joined in the letter. DRO, CPR, and Bagenstos cited instances in which people with disabilities living in institutions have waited up to 12 years to receive services that would allow them to live and work in the

community. While living in institutions, these individuals lack access to employment opportunities as well as opportunities to participate in other aspects of community life. The authors further reported that Ohio had not taken meaningful steps to implement its Employment First policy, and found that individuals with disabilities received day services primarily in sheltered workshops and other segregated day settings instead of receiving supported employment services. The authors recommended that Ohio remediate these issues through a variety of actions, including eliminating institutional bias in the state's Medicaid waiver funding system and helping providers of supported employment services to increase their capacity to serve more people.

Read the full DRO letter to Ohio state officials:

www.dispatch.com/content/downloads/2014/07/DRO_to_Governor_Kasich_et_al_re_ICFs-IID.pdf

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Florida Creates Managed Medicaid Plan Integrating Mental, Physical Health

This month Florida became the first state to offer a Medicaid plan exclusively to people with psychiatric disabilities. The plan is operated by Magellan—a Connecticut-based private insurance company—and focuses on integrating physical and mental health care through a managed care model. According to Karen Koch, Vice President of the Florida Council for Community Mental Health, this plan may reduce unnecessary hospitalizations by ensuring that people with significant mental health needs receive adequate outpatient treatment and rehabilitation. She also noted, however, that managed care can be difficult to work with for both providers and consumers.

If the new plan meets its goals of reducing unnecessary hospitalizations, employment outcomes for people with psychosocial disabilities may improve. Although members will also have access to psychosocial rehabilitation services, it is not yet clear whether Magellan intends to include supported employment as part of its psychosocial rehabilitation package. The plan is currently available only in Miami-Dade and Broward counties, but will expand to other regions in September.

Florida is one of four states working on a plan to include mental health in state-provided health care. Arizona is creating the option for mental health care, Tennessee is allowing subcontracts to include mental health care, and Minnesota is making providers accountable for mental health.

Further coverage of Florida's managed Medicaid plan is available through Kaiser Health News. www.kaiserhealthnews.org/Stories/2014/July/07/florida-program-for-mental-health-coverage.aspx

More detail about the new plan is available via the Magellan website: www.magellancompletecareoffl.com/fl-site/specialty-plan/welcome.aspx

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Georgia Delays Changes to Medicaid Program for Residents with Income Above Eligibility Thresholds

In response to concerns from consumers, Georgia has delayed approval for a change in Medicaid eligibility policy that would have disallowed individuals from using Qualified Income Trusts (QITs) to preserve their Medicaid eligibility if their incomes exceeded a certain threshold. After the proposed change took effect, these individuals would remain eligible for Medicaid only if they had sufficiently large medical expenses to qualify as “medically needy.”

Consumers voiced concern that the proposed change would create an imbalance in eligibility between those receiving community-based services and those receiving institutional care. Advocacy groups expressed concern that individuals with QITs who are currently served in HCBS waiver programs would not be eligible for Medicaid under the “medically needy” program. As a result, Department of Community Health officials have decided to delay the change in eligibility criteria in order to ensure that people enrolled in home- and community-based services waiver programs did not lose coverage.

Access to services through waivers can be crucial for workers with disabilities who rely on HCBS in order to maintain employment, but who earn income that exceeds the eligibility cutoff for traditional Medicaid. Even after the proposed change, however, many workers with disabilities with incomes above the cutoff may remain eligible for Medicaid coverage through Georgia’s Medicaid for Workers with Disabilities program.

Further coverage is available via Georgia Health News: www.georgiahealthnews.com/2014/07/medicaid-change-long-term-care-delayed/

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