

**RHODE ISLAND GLOBAL CONSUMER CHOICE COMPACT
1115 WAIVER TASKFORCE
EMPLOYMENT WORKGROUP RECOMMENDATIONS PAPER**

Overview:

On January 16, 2009, Rhode Island Global Consumer Choice Compact Waiver (Global Waiver) was approved by the Center for Medicare and Medicaid Services (CMS). The Global Waiver establishes a new federal/state compact that gives the state greater flexibility to provide services in a more cost-effective way that will better meet the needs of Rhode Islanders.¹ On May 12, 2009, Executive Office of Health & Human Services (EOHHS) held the first meeting of their 65 member Task Force. At this meeting, six workgroups, including the Employment Workgroup, were described to Task Force members who were then asked to join at least one of these workgroups. Any Rhode Islander could join any of the workgroups at the discretion of the respective Workgroup Chairperson.

Elaina Goldstein, Executive Director of Rhodes to Independence (RTI) was asked to Chair the Employment Workgroup. Upon approval of the RTI Advisory Board at their May 27, 2009 meeting, the two groups began working together to meet the charge of the Employment Workgroup, as the charge is also a primary RTI objective. Rather than meeting once a month it was agreed that the Advisory Board/Employment Workgroup would meet twice a month in order to present recommendations to EOHHS by September 2009.

This Paper is the culmination of the work performed and the recommendations of the committed group of individuals who are the Global Waiver Task Force Employment Workgroup. (See [Attachment A](#))

Task Force Charge to Employment Workgroup:

The Employment Workgroup will develop recommendations in the following focus areas:

- a) How to increase employment among Medicaid beneficiaries with disabilities.
- b) How to support Medicaid beneficiaries with disabilities who are working.²

Background:

The Employment Workgroup began by agreeing that our overarching goal was to make Rhode Island an “Employment First” state for all people with disabilities. Through

¹ <http://www.eohhs.ri.gov/Medicaid/index.php>

² Handout at the Global Waiver Taskforce meeting of May 12, 2009.

consensus, the following explanation of what this means for Rhode Islanders was developed:

Rhode Island Employment First Goal: “ To improve competitive employment outcomes of individuals with disabilities through demand-side business, strategies that ensure any individual with a disability who wants to work has the proper skills, tools and access to training and employment opportunities.”

Prior to the Global Waiver, Medicaid beneficiaries were often placed into various eligibility silos which permitted them to access different long term services and supports that did not always meet their individual needs. This led to both inconsistency and inflexibility in the delivery of employment services and supports for people with disabilities. The first issue the Workgroup needed to address was how we were going to transition from the old Medicaid system, consisting of various eligibility categories and various Home and Community Based Waivers (with a variety of long term services and supports), to the new Global Waiver. A key concern for individuals with disabilities who are working or who want to work has been delinking the old requirement that a person must meet a “nursing home level of care” in order to be eligible for Home and Community Based Waiver Services.

The Workgroup focused on developing a clearly defined benefits package of long-term services and supports for individuals with all types of disabilities. In particular, the Workgroup focused on the state’s Medicaid Buy-in (Sherlock Plan) because of the myriad of issues and concerns the plan has had since its passage in 2004. Our hope is to create a seamless Medicaid system for all people with disabilities, offering the right amount of employment services to each individual depending on their employment support needs.

Review of the Current Medicaid Policy

It became clear to the Workgroup in order to move forward, clear definitions and understanding of Medicaid services, supports as well as the various eligibility categories for people with disabilities was needed. Our first task was to develop a definition of what “supported employment” means for Rhode Islanders with disabilities, realizing that there exist multiple definitions of employment within federal and state laws. It was imperative that in defining supported employment we align it with our guiding principle that we intend Rhode Island to be an “Employment First” state and that there needs to be a shift from thinking and talking about employment as a service. It is not. Employment means having a job/career or running your own business. The supports that an individual might need to get a job and keep a job or to run his /her business are the service. After reviewing a variety of definitions from Medicaid programs across the country the Workgroup agreed on the following definition:

Supported Employment, “ Competitive work, including opportunity to earn competitive wages and benefits, in an integrated setting with ongoing appropriate and necessary support services for individuals for whom competitive employment has not traditionally occurred, been interrupted or intermittent as a result of a disability”.

(1) What are Employment Supports?

Although Medicaid services are primarily based upon medical interventions, a growing body of research indicates that health and wellness measures are reliant upon an individual’s quality of life, particularly in maintaining employment or a career. This research, coupled with the Olmstead ruling in favor of integrated settings in the community for people with disabilities and the notion of employment as a key component of recovery for an individual with mental illness, has led to a broader understanding of community supports for people with disabilities.

States have a large amount of flexibility to define the services available, and the eligibility requirements contained. States can also define provider qualifications for specific services, to ensure that the services are delivered in an appropriate manner.

The majority of long term services and supports in Medicaid cannot be used to directly support employment; however many of them can be used to treat a medical condition in such a manner that it improves an individual’s ability to be employed. [Attachment B](#) outlines key provisions in the Medicaid program, and how they have been used as “best practices” in a variety of states to directly or indirectly support the employment of individuals with disabilities.

The United States Department of Labor, Office of Disability Employment Policy (ODEP) defines employment supports “*as services, benefits, policies tools and equipment that make it possible for us to get to work and do our jobs. Some may not consider things like transportation, child care, access to health care, technology, and flexible work schedules as “supports,” but for many Americans they can mean the difference between working and not working.*”³

Rhode Island’s Global Waiver Terms and Condition definition states that employment supports are: “*activities needed to sustain paid work by individuals receiving waiver services, including supervision, transportation and training*”⁴

(2) Medicaid Eligibility vs. Support Services Needed

It was important for the Workgroup to understand the variety of ways individuals with disabilities can become eligible for Medicaid. Using the Global Waiver Terms and

³ http://www.dol.gov/odep/categories/employment_supports/

⁴ *RI Global Consumer Choice Compact Waiver - pages 12-21*

Conditions document, a chart was developed highlighting the different ways a person with a disability can become eligible for Medicaid as of November 2008. All eligibility categories were classified in one of four core groups: (1) Mandatory Categorically Needy, (2) Optional Categorically Needy, (3) Optional Medically Needy and (4) Expansion Groups.⁵ People with disabilities fit into each of these groups. (See [Attachment C](#))

As the Workgroup reviewed each of these eligibility categories we found that the type of disability a person has often determines their eligibility category and what services and supports that person receives. For example, individuals with developmental disabilities are eligible for a specific waiver and services if they meet one of the legislated listings of developmental disability. Individuals with severe mental illness are eligible under community Medicaid and are provided a different group of services. The Sherlock Plan participants are in the Optional Categorically Needy coverage group and eligible for a variety of waivers and services dependent upon meeting a nursing home level of care.

Compounding the complexity within the state Medicaid program is that each of these eligibility categories placed a person into a different system of long-term services and supports depending upon the person's disability, such as behavioral health, developmental disabilities, or physical disabilities. The critical questions for the Workgroup were: (1) What about the people who have multiple (co-occurring) disabilities and (2) How seamless is it for a person to move from one eligibility category to another, primarily because they have increased their income because of employment, without losing the services and supports that they need to continue working?

(3) Services Needed to Support Employment for People Working People with Disabilities

Responding to the specific charge we were given, “how to increase employment among Medicaid beneficiaries and how to support Medicaid beneficiaries who are working,” the Workgroup developed a comprehensive list of long-term services and supports necessary for working individuals with disabilities. We did this in the following manner: group brainstorming sessions, environmental scan of current Medicaid employment supports in the State Plan and the Core Home and Community Based Services,⁶ best practice review of what other states are providing in their Medicaid programs.⁷ A document was created to illustrate how the Workgroup's recommendations lined up with the current long-term services and supports provided in the current Rhode Island Medicaid program. (See [Attachment D](#)) [Attachment E](#) compares the Workgroups service and support recommendations with what other states are offering. With the exception of services such as financial literacy and childcare, the overwhelming majority of the Workgroups recommendations are long-term services and supports currently offered in Medicaid. Again, though, the Workgroup questions whether all of these services are now available

⁵ *Ibid* - pages 12-21

⁶ *Ibid*, [Attachment A](#), page 48

⁷ *Medicaid Funding Sources that Can Support Employment*, APHSA; *Services and Supports National Best Practices*, Rhodes to Independence

to any working disabled person on Medicaid or to any disabled person on Medicaid who wants to work and, if so, how?

Medicaid Buy-In (Sherlock Plan) Review:

In order to try to answer the questions posed by the Workgroup in the previous sections of this document we decided to use the Sherlock Plan eligibility group as our transition prototype from the “old” Medicaid system to our “new” Medicaid Global Waiver. Throughout the four years since passage and implementation of the Sherlock Plan, there have been a variety of documented problems with the Buy-In. As of July 2009, there were only 19 people on the Sherlock Plan while many states around the country have robust Buy-ins.

In order to best chronicle the issues the Workgroup reviewed the legislation as originally passed in 2004 and as amended in 2005. In addition, benefits counselors certified by the Social Security Administration (SSA) (whose principle job responsibility is to provide benefits planning to people with disabilities who want to go back to work) were invited to present the problems they have uncovered and review the documented system problems Rhodes to Independence research staff has had in evaluating the program.

1. Legislative Implementation Issues:
 - a. **State Plan Amendment:** Section 40-8.7-3 (4), which authorized the Department of Human Services to amend the Medicaid state plan for personal care services in the workplace was never implemented.
 - b. **Employer Health Insurance Coverage Coordination with Sherlock Plan Coverage:** Section 40-8.7-7 (b), language in the 2004 legislation was amended in 2005 (the original language would have given the choice of employer health insurance or the Sherlock Plan to the individual); the Department of Human Services remained authorized and directed to promulgate rules related to coordination of employer health coverage with the Sherlock Plan but this has never been implemented.
2. Eligibility Barriers presented by the SSA Certified Benefits Counselors:
 - a. **Process:** There is confusion as to the actual process of applying for the Sherlock Plan. Systemic change needs to occur from the top down. On occasion when a referral is made to DHS for a Sherlock Plan application the client will report that DHS personnel tell them that the program does not exist. Very few people, including beneficiaries, are aware of the program. Unfortunately, many clients have either refrained from working or held their hours to a bare minimum because of spend- down restraints. DHS personnel often advise people that they are not eligible for Medicaid due to excess earnings or resources; this determination does not appear to take the Sherlock Plan criteria into account.

- b. **Premium Structure:** The current design makes it cost-prohibitive for many people to enroll in the Sherlock Plan. One part is based on an individual's unearned income, such as SSDI, Unemployment, Veteran's benefits, etc. Currently, all of a person's unearned income, which is over the medically needy income limit (\$800 in 2009), is owed toward the premium. Many individuals with a solid work history have SSDI payments or other unearned income of \$1500 or more per month. In this example individuals may have to pay \$700 or more toward their Medicaid benefits each month. For many people this is a major work disincentive. A better design might entail a cap on the amount of unearned income an individual has to pay toward the Medicaid premium. Earned income is treated much more leniently. The premium structure is similar to that of the Rite Care program. Premiums range from \$0-\$100 per month.
- c. **Data Research Issues** – In the process of undertaking an analysis of the Sherlock Plan (2006 – present), a number of data issues were encountered. To understand enrollment trends in a Medicaid Buy-In program, at a minimum it is essential to know who is participating (demographics), the primary disabling conditions, prior and current participation in other public plans (e.g., SSDI, SSI, Medicare) including the number of months participants received benefits prior to the first Buy-In enrollment and thereafter. It is additionally important to have accurate data regarding the length of time an individual participates in the Buy-In, income prior to participation and during Buy-In enrollment and premium amounts paid. Analysis of MMIS and InRhodes databases (2006-2009) revealed multiple inconsistencies, data gaps and other errors that render any reliable and sound analysis very questionable.⁸ There are a few apparent inconsistencies with the MMIS data, but the major problems are with the InRhodes data. Data are meaningless unless accurate and complete. This problem needs to be addressed immediately.

Review of Other State Programs that Fund Supports and Services for Working People with Disabilities

An environmental scan was performed to compare the different funding sources within the state for employment services for people with disabilities. Individuals from the Office of Rehabilitation Services (ORS), netWORKri, and the Department of Mental Health, Retardation and Hospitals all provided overviews of the programs they oversee for the disability population. Each agency has different criteria established by their funding source to determine eligibility for their respective programs and also various assessment tools to determine the long-term services and supports they will provide. It became clear to members of the Workgroup that the current Medicaid long-term care assessment tool is based strictly on a medical model and benefits needed by individuals

⁸ Data for most participants, for example, lack a primary disabling condition. While the data indicates for multiple individuals that they are still on the Buy-In, it is clear from other data elements that they are off the Buy-In and did not re-enroll. There are numerous inconsistencies revealed in a longitudinal profile, by individual that bring all data into question. RTI researchers were told that "the feeling of people using InRhodes data is that it has a lot of errors in it....All in all, not conducive to getting a coherent batch of data..."

with disabilities who are working or want to work include a variety of independent living, social and vocational assessments in order to support employment. Our ultimate goal as we move forward is to braid all of these funding sources to maximize the services and supports provided the individual while at the same time eliminate duplication of services.

Workgroup Recommendations:

Responding to the charge by the Global Waiver Task Force the Employment Workgroup respectfully submits the following recommendations to the EOHHS. We strongly believe that investment in long term employment services and supports will not only lead to improved outcomes for individuals with disabilities but will also benefit the economy of Rhode Island. After all, *every working* Rhode Islander pays his or her fair share of taxes.

GENERAL RECOMMENDATIONS

- ❑ **RECOMMENDATION:** That the Employment First goal, the definition of Supported Employment and the outlined Employment Long Term Services and Supports be adopted as the state’s policy for people with disabilities.
- ❑ **RECOMMENDATION:** A new brochure should be developed that clearly documents how a person can earn more money, remain eligible for Medicaid and be provided the services and supports needed to work.

Rationale: In order to create a seamless Employment First system for people with disabilities eligible for Medicaid through various eligibility categories, who are working or want to work, it is imperative that a clear understanding of the earnings, resources, services, and supports allowable in each of these eligibility categories be shared with each individual when they first become eligible for Medicaid.

SHERLOCK PLAN RECOMMENDATIONS

- ❑ **RECOMMENDATION:** Replace the current Balanced Budget Act Medicaid Buy-in with the more generous earnings buy-in afforded in the Ticket to Work Act.

Rationale: In order to address the fact that some people on the Sherlock Plan (Medicaid Buy-in) have lost eligibility because they began earning more than the limit permitted under the current Balanced Budget Act Buy-in and to encourage individuals to achieve the maximum in employment status.

- ❑ **RECOMMENDATION:** Individuals with disabilities who apply for Medicaid eligibility under the Sherlock Plan should no longer be required to go through the long-term care eligibility portal in order to obtain the supports and services they need to work. Similar to individuals eligible for Medicaid under the behavioral health category and those eligible under 1619(a)(b), Sherlock Plan beneficiaries will be considered “community” Medicaid.

- **RECOMMENDATION:** In addition to the mandatory services all Medicaid beneficiaries receive Sherlock Plan beneficiaries should be eligible for a set of long term services and supports modeled after the Core Home and Community Based service and supports stipulated in the Global Waiver Terms and Conditions, as well as, services and supports the Rehabilitation Option affords to behavioral health beneficiaries.

Rationale: All Sherlock Plan individuals, prior to the Global Waiver, were eligible for any long-term supports or services available in each of the previous waivers. Therefore, in order to be held harmless, at a minimum Core Home and Community Based Services should be available to Sherlock Plan participants. (See [Attachment F](#)) Upon implementation, the Medicaid state plan amendment that was required under the 2004 Sherlock Act would be considered null and void.

- **RECOMMENDATION:** A new comprehensive long term support and service evaluation/assessment tool, with specific modules for medical, social and employment supports, should be developed. A team of individuals, including the Medicaid beneficiary and his or her family if appropriate, who are qualified to assess each of these modules also needs to be put in place and a team coordinator should be designated.
- **RECOMMENDATION:** The outcome of the tool would be an individual plan that enables the person with a disability to function as independently and productively as possible in the community. This plan should be reviewed annually unless a specific significant event occurs that requires the plan to be evaluated earlier. The employment module portion of this plan will stipulate employment expectations from providers and the individual. The plan should include outcome measures, similar to the new Ticket to Work regulations, so that providers are paid in accordance with employment outcomes achieved.
- **RECOMMENDATION:** That this Workgroup include members from the Workforce Investment Boards and the Chambers of Commerce to develop rules that permit businesses to (a) either provide employee health coverage with a wrap around Medicaid benefit package that should provide services and supports not generally offered in employee health plans or (b) pay Medicaid a premium equal to the premium the employer is paying for a single participant in their health plan.

Rationale: When amending the Sherlock Act of 2004, the original intent to encourage and support employers, especially small employers, to hire individuals with disabilities was never achieved. Furthermore, rules simply coordinating employer health insurance coverage with the Sherlock Plan were never developed.

- **RECOMMENDATION:** That a sub-committee of this Workgroup review the “best practices” of other Buy-ins in the country to develop a more rationale premium structure in accordance with the rules in the Ticket to Work Buy-in. We further

recommend developing a premium for a wrap around benefit to coordinate with employee benefit health plans.

Rationale: A review of the current Sherlock Plan premium structure is long overdue. Rhode Island currently has one of the most cost prohibitive premiums in the country.

- **RECOMMENDATION:** That each of these concerns addressed in [Attachment G](#), which identifies the data problems in the current system, be rectified as soon as possible so that policy makers can see the true outcomes and effectiveness of Rhode Island's Buy-in program.

Rationale: In order to evaluate the effectiveness of the Sherlock Plan and the recommended changes to the other disability eligibility categories in Medicaid it is imperative that accurate data be collected and made available to evaluators.

EMPLOYMENT SUPPORTS AND SERVICES RECOMMENDATIONS

- **RECOMMENDATION:** Every Medicaid beneficiary who is disabled and working or wants to work should have the opportunity to be evaluated by professionals qualified to perform the assessment afforded under the newly developed employment support and service module.⁹ If a comprehensive support and service evaluation is indicated and, has not been conducted, a referral should be made to the interdisciplinary team assigned this task.
- **RECOMMENDATION:** Based on the employment assessment, an employment plan stipulating employment expectations from providers and the individual should be generated and reviewed at least annually. The plan should include outcome measures, similar to the new Ticket to Work regulations, so that providers are paid in accordance with employment outcomes achieved.
- **RECOMMENDATION:** Employment long term services and supports should be available to each person with a disability on Medicaid in accordance with the employment plan to function as independently and productively as possible in the community. Employment long term services and supports should include but are not limited to job coaching, vocational evaluation, case management, job development, and job training.

RECOMMENDATIONS SUBMITTED: SEPTEMBER 30, 2009

⁹ See the Comprehensive Evaluation and Assessment Tool development in the Sherlock Plan Recommendations above.