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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

MEMO

To: Diana Fortuna
From: Nancy-Ann Min DeParle NMD
Subject: Disability Issues
Date: December 15, 1997

Over the past year, the Clinton Administration has made some incremental steps forward in public policy as it relates to people with disabilities. With the help of the disability community, in particular ADAPT, this Administration has focused the attention of the country and the Congress on these important issues. During a September 10 meeting with the President, ADAPT raised a number of issues important to the disability community. We want to continue working with ADAPT and others in the disability community to move this important agenda forward.

This paper highlights the issues ADAPT identified and some of the steps we have been able to achieve, as well as some of the efforts that we are planning for the future. These activities are being coordinated by the Department of Health and Human Services' Home-and Community-Based Services Workgroup, jointly led by the Health Care Financing Administration (HCFA) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). Activities for which HCFA has the primary responsibility are indicated below with an asterisk.

*1. **Study of institutional bias within Medicaid** * (Projected completion: November 1998)*

HCFA has contracted for a study to identify federal policy barriers and incentives which impede and/or promote consumer directed home- and community-based (HCB) services. The study involves a systematic analysis of Medicaid statutes, regulations, and manual transmittals. Using this analysis, the contractor will identify and describe both barriers and opportunities for shifting the emphasis in Medicaid long-term care services from institutions to community-based supports, and from an emphasis on a medical model to a social model. The study will also review policies that are the same in Medicare and Medicaid. To encourage use of home- and community-based services, the study will identify policies that may have been linked inappropriately. The project will develop recommendations for policy changes and potential research and demonstration projects.

The study is being funded by HCFA and conducted by a team of researchers from the University of California at San Francisco (UCSF), led by Charlene Harrington. An interim report will be

submitted in February, and a final report in November. An HHS home- and community-based services workgroup has been involved in framing its scope, but will not necessarily endorse the final product. The workgroup will disseminate the contractor's report as an independent product.

2. Development of an Administration initiative to expand home- and community-based supports and consumer-directed personal assistance services (PAS) through the leadership and advocacy of states and the sharing of model practices. *(Projected completion: ongoing)*

In the meeting with ADAPT, other disability advocacy leaders, and federal officials, President Clinton expressed support for states with successful practices to become leaders and teachers in helping other states move nursing home residents to community- based settings and expanding consumer-directed PAS. The federal government can play a significant role in supporting and promoting this effort. We believe that the first step is to articulate principles that can be supported and disseminated by the Secretary and the President to the States, perhaps in an upcoming National Governors' Association meeting.

A number of other activities also could be undertaken to further this goal. For example, we plan to identify states which have been successful in expanding the use of home- and community-based services. We will compile and disseminate information about their successful practices through a variety of mechanisms which may include written documents, conference workshops, and Internet postings.

Another key component of this initiative may involve a new project to identify barriers perceived by states as preventing them from expanding home- and community-based services. The UCSF study mentioned previously will be one source of background information on this subject. The Long-Term Care Mentoring Project, initiated by the Administration on Aging, will also contribute useful information for this part of the initiative. In addition, discussions with state Medicaid and long-term care officials, providers, and consumers will inform our work.

3. Analysis of provisions, implications, and costs of CASA and the Feingold bill, and formulation of a set of recommended changes to the bills that may enable the Administration to support them. *(Projected completion: February 1998)*

A workgroup is conducting a thorough analysis of the provisions of both the Community Attendant Services Act of 1997 (H.R. 2020, as introduced by Representative Gingrich) and the Feingold bill. This workgroup will also develop cost estimates for the CASA bill, and identify basic principles in the bills which the Administration can support. This information will be shared with the Domestic Policy Council and White House health policy staff.

*4. **Feasibility study and design of a "date certain" pilot or demonstration** * (Projected completion: June 1998)*

The CASA legislation includes a specific date by which all nursing home and intermediate care facilities for the mentally retarded residents who choose to move into community-based services would be guaranteed those services. At the White House meeting, Administration officials expressed strong interest in pursuing a pilot project to more fully describe and test the "date certain" concept.

This effort will begin with a process to define the "date certain" concept and identify clearly what will be tested in a pilot or demonstration. Early in the process, a subgroup of federal officials will meet with state Medicaid and long-term care officials to explore interest, motivation, and incentives. A feasibility analysis will be completed. If there is sufficient interest among the states, the framework for the demonstration or pilot will be filled in and an implementation plan developed. The group will explore problems to be resolved and potential solutions and develop a work plan and time line. The group may engage in a process of interviewing nursing home residents about barriers to moving to the community. As necessary, additional public and/or private financing will be sought.

*5. **Review of programs to date, and options for increasing supply of personal attendants through employment of TANF recipients** (Projected completion: March 1998)*

In his meeting with advocates, the President noted his interest in the idea of encouraging the development of programs for individuals leaving the welfare rolls to become employed as personal assistants to people with disabilities. A number of research studies have already been conducted demonstrating how this can be accomplished and the benefits of doing so. A paper will be developed that reviews these programs to date, and proposes options to increase the supply of PAS workers.

*6. **Conduct and complete the "Homebound Study" required in the Balanced Budget Act** * (Projected completion: due to Congress October 1, 1998)*

The Balanced Budget Act included a requirement that the Secretary conduct a study of the definition of "homebound" as a criteria for receiving Medicare Home Health services. The research will be factored into our future deliberations. HCFA and ASPE staff have agreed that analyses of the National Long-Term Care Surveys and the Disability Supplement to the National Health Interview Survey may be useful in determining the "homebound" status of current home health users. In collaboration with the HCFA, ASPE will pursue framing and funding this research.

*7. **Provide Technical Assistance Regarding Potential Legislative Proposals** (Projected completion: Ongoing)*

HCFA and ASPE staff will provide technical assistance to committee staff as they develop legislative proposals regarding employment incentives for persons with disabilities. Staff will also examine other opportunities for expanding employment possibilities for persons with disabilities, focusing on younger people.

*8. **Cash and Counseling Demonstration** * (Projected completion: demonstration proposal under review at OMB)*

With funding from the Robert Wood Johnson Foundation, four States (Arkansas, Florida, New Jersey, and New York) have developed and submitted to HCFA a waiver application to explore alternative ways to provide consumer-directed personal care services. This waiver application has been approved by HCFA and is currently under review at the Office of Management and Budget. The purpose of this major DHHS research demonstration would be to provide greater autonomy to consumers of long-term care services by empowering them to purchase the assistance they require to perform their activities of daily living. In order to accomplish this objective, cash allowances (coupled with information services) would be provided directly to persons with disabilities -- enabling them to choose and purchase the services they feel would best meet their needs. This proposed demonstration is frequently referred to as the "Cash and Counseling Demonstration."

Attachment A highlights additional achievements for persons with disabilities. We believe the steps which either have been completed or are in progress represent a full response to the President's commitment to the disability community made during his September 10 meeting.

Attachment

cc: Chris Jennings
Jeanne Lanbrew

ATTACHMENT A
Other Recent Achievements for People with Disabilities

The Balanced Budget Act of 1997(BBA)

The BBA that was enacted in August of this year has a series of important Medicaid and Medicare that will address the concerns of people with disabilities.

- States are permitted to allow certain Supplemental Security Income (SSI) beneficiaries who are disabled and would lose eligibility because of their earnings to purchase Medicaid coverage. Medicaid eligibility is extended to SSI beneficiaries whose income is less than 250 percent of the Federal poverty level for the applicable family size. Currently, 250 percent of the poverty level for one person is a little over $2,210 per month. States will set premiums based on an income-related sliding scale.

- The availability of prevocational and supported employment services under a home and community-based services waiver was expanded. Prior to the BBA, in order for a person to receive prevocational and supported employment services as a component of habilitation services, the person had to have a prior institutional stay in a nursing facility or in an intermediate care facility for the mentally retarded. This BBA provision removed the prior institutional stay requirement.

- The BBA exempts certain children with disabilities including SSI beneficiaries, and children in foster care from being required to receive care through a managed care entity under freedom of choice waivers.

- The BBA reinstates Medicaid eligibility for certain legal immigrants who receive SSI, but have subsequently been terminated from SSI because of the 1996 Personal Responsibility and Work Opportunities Reconciliation Act's (PRWORA) tighter definition of childhood disability.

- Similarly, the BBA restores Medicaid eligibility to disabled children who were receiving SSI at the time of enactment of the PRWORA of 1996.

- The BBA establishes the Program of All inclusive Care for the Elderly (PACE) as a State plan option under Medicaid to provide comprehensive community-based health and long-term care to eligible individuals over age 55 who would otherwise require nursing care.

- Finally, BBA will now let Medicare pay at least part of the cost of renting upgraded durable medical equipment (DME). The BBA allows DME suppliers to receive Medicare payment for upgraded DME as if it were equipment. Beneficiaries may be billed the difference between the standard rate and the cost for the upgraded equipment.

Personal Care Services Regulation

HCFA recently published a new final regulation addressing the Medicaid program benefit for personal care services. The Personal Care Services Regulation will gives the States the option to expand the availability of personal care services under States' Medicaid programs. It was signed by the Secretary of Health and Human Services and published in the *Federal Register* on September 11.

- The regulation implements statutory changes which allow personal care services to be provided outside the home at State option if personal care services are also provided in the home under the State plan.

- Personal care services are services to assist a person with activities of daily living such as assistance with eating, meal preparation, bathing, dressing, personal hygiene, and taking medications. Services may also include activities which are essential to the health and welfare of the beneficiary, such as house keeping chores like bed making, dusting, and vacuuming.

- The regulation also removes the requirement that a registered nurse must supervise personal care services, thus reducing the cost, and making the service more flexible to meet the beneficiary's needs.

Home- and Community-Based Care Services

The Health Care Financing Administration continues to support and promote community- based long-term care for the elderly and people with developmental or physical disabilities through the home and community-based waiver program authorized under section 1915(c) of the Social Security Act. Currently over 250,000 individuals with disabilities receive a wide array of services from personal assistance to home modifications and assistive devices (to name only a few) under 226 of these programs in 49 States and the District of Columbia. Similar services are provided in Arizona under their 1115 waiver. Through the use of this Medicaid waiver provision, four States have entirely eliminated their large publicly-funded institutions for people with developmental disabilities and replaced them with integrated community services. Most others have significantly phased down reliance on inappropriate institutional care for people with disabilities as a result of the waiver program.

Under the Clinton Administration numerous changes have been implemented to simplify the home and community-based waiver application and approval process.

- One of the most lasting and meaningful changes to promote home- and community-based care and "level the playing field" with institutional care was the elimination of the so-called "cold bed test," a rule that required States to show that without the waiver an equal number of beds would have to exist in institutions or nursing homes to accommodate those receiving waiver services.

- In an effort to further simplify the process for receiving certain waivers, HCFA has provided States with a prototype waiver application for individuals with AIDS, individuals with traumatic brain injury, and medically fragile children to expedite approval of these waivers. States may now establish a 1915(c) waiver program for these individuals by attaching State-specific information, signing, and submitting the prototype waiver application. Waivers submitted without alteration are expeditiously approved by HCFA.

- On June 27, HCFA released a letter to State Medicaid Directors to encourage them to reduce the size of large providers of residential services under the home and community-based waiver program. To allow maximum flexibility to States in establishing home and community-based waiver programs, HCFA has not established a formal Federal policy on the number of people who can reside in a group home. However, the Department is concerned that homes serving large populations may not be able to provide an authentic community experience.

- In an additional letter, dated July 25, HCFA urged all State Medicaid Directors to make available appropriate home and community-based waiver options to all persons who are institutionalized, or at risk of institutionalization. HCFA also firmly stated its belief that, "... an individual has the right to assume risk, commensurate with that person's ability and willingness to assume responsibility for the consequences of that risk."

Research and Demonstration Activities

HCFA is using its research and demonstration program to assist in the development of appropriate services to people with disabilities.

- HCFA recently approved an 1115 waiver for Colorado which will permit greater flexibility in defining where Medicaid home health services may be provided. Instead of limiting visits to a beneficiary's place of residence, the demonstration would permit the same types of services to be provided in other settings (e.g., schools, work sites, or day treatment centers). However, the State would not permit reimbursement for any visits which occur in hospitals, nursing homes, or intermediate care facilities for the mentally retarded.

  - The State estimates that between 100 and 200 clients will participate. Demonstration clients will meet Medicaid eligibility requirements. The primary purpose of this demonstration project is to develop and refine the independent care model, and to assist individuals who are capable of directing their own care.

  - Services will be provided under a fee-for-service delivery model for this demonstration project. Demonstration participants will be permitted to choose among participating providers (agencies) within a geographic area. Participation by home health agencies, nurses, and aides will be voluntary. Approximately 10 agencies will be selected to participate in the program. These agencies will be stratified by size and location (rural and urban).

- HCFA recently released a program announcement to Centers for Independent Living (CILs) intended to test a model of consumer-directed durable medical equipment (CD-DME) that covers a range of activities such as assessment and purchasing related to wheelchairs and accessory items. CD-DME sponsors will provide assistive technology information and facilitate consumers' access to expert assessment and care coordination. In partnership with consumers with physical disabilities, sponsors will also more efficiently acquire Medicare-financed DME products and services through a process of prior authorization. Savings accrued from more efficient purchasing will be used to establish beneficiary credit accounts that may be used by beneficiaries to acquire enhanced equipment and/or services not covered by Medicare. Up to four sites are expected to be awarded pre-waiver development grants of approximately $150,000 each.

- In their fiscal year 1998 research agenda, HCFA is funding a grants program to foster a more integrated and flexible service delivery system for Medicaid and Medicare dually-eligible beneficiaries by working collaboratively with States and providers to develop more effective systems of care to meet the diverse and complex needs of these beneficiaries.

  - One illustrative model included in the May 1997 grants announcement was an ***Independent Living Model Integrated with Medical Services***, with emphasis on increased consumer direction and control, innovative case management models built around current resource systems for those with disabilities (e.g., CILs), and new payment approaches that provide increased consumer control and flexibility around key long term care services such as personal assistance services. Discussions with States preparing proposals indicate that several plan to submit proposals targeted to non-elderly beneficiaries with disabilities, with some features of HCFA's illustrative model.

  - Twelve proposals were received by the August 29 deadline. Proposals are under review, and HCFA plans to award approximately six grants of $150,000.

- The State of Wisconsin submitted an application for Medicare and Medicaid demonstration waivers to establish a partnership model of care delivery for under age 65 beneficiaries with physical disabilities and frail elderly beneficiaries who are eligible for Medicare and Medicaid and meet nursing home level of care criteria. The model is similar to the PACE model in the use of multi-disciplinary care teams, prepaid capitation and the sponsorship by a community-based service provider. The partnership model for people with disabilities would use Centers for Independent Living as the community-based provider. Waiver approval is anticipated this Winter, with implementation targeted for late Spring 1998. The model is a voluntary enrollment model, and Wisconsin expects to enroll up to 300 individuals at each of three sites. The Wisconsin Partnership model is the first known comprehensive capitated model of service delivery specifically designed for Medicare and Medicaid beneficiaries with physical disabilities.

- The State of Rhode Island was awarded a HCFA planning grant to design an integrated approach to health/medical care and for life-long community supports for adults with developmental disabilities. Staff from Rhode Island Division of Developmental Disabilities along with Department of Human Services, people with disabilities, service providers, and advocates worked for over 2 years to design this waiver proposal. The planning was completed in July 1996. HCFA is currently reviewing the implementation proposal submitted by the State in May 1997 which will consolidate the current Medicaid and other Federal funding streams into a single coherent funding resource. This will help enable the restructuring and transition of the service system to promote more personally directed supports and services. The program will serve 3,500 beneficiaries statewide.

HCFA - 2nd letter on menu

Cover Plus 3 pages

TO: Kathy King
Bob Williams
Ruth Katz

FROM: Diana Fortuna DF

CC: Bill White
Jeanne Lambrew
Anne Tumlinson

SUBJECT: One-pagers on Home and Community-based Services for Meetings with Disability Groups

I decided to take a shot myself at doing a one-pager for disability groups on the home and community-based issue, so that you can see what kind of document we need. All the information in the attached is based on the memo Nancy-Ann sent me in December, but it is much simplified, so you can see if I got the translation right.

So you can either work off of my version, or finish your version with whatever insight mine adds.

I ended up with 3 one-pagers: one on our current process to address this issue, one on past accomplishments, and then a very short sheet on non-HCBS accomplishments that were kind of left over when I was done. I am not sure that 3 one-pagers is the way to go, so see what you think. And if you have more non-HCBS accomplishments to add, you should do so. There are questions from me sprinkled throughout, particularly over timelines. But regardless of the edits, this has to stay quite short and in simple language.

Overall, I think my main one-pager is still weak in terms of specifics, particularly on the 4th bullet on supporting state practices. I think this is one of our most fruitful possibilities, so please think how to make it more specific.

I'm not sure when we or you might be meeting with disability groups, but Bill White believes it will be next week. So we need something from you Friday or Monday. And we may want to sit down before then to talk this through.

DRAFT

HHS Current Agenda on Home and Community Based Services (HCBS) for People with Disabilities

- Formed a workgroup to focus on this issue and supervise the work described below, with representatives from across HHS and from other key agencies. (Ongoing.)

- HHS contractor is studying institutional biases of Medicaid program, with interim report due to HHS next month. Will help HHS identify steps it can take, although HHS will not necessarily endorse report. (Interim report due in February.)

- Developing demonstration to test "date certain" concept. Now defining what such a demonstration would look like. Next step is to explore state interest. (Feasibility study of demo to be completed in June.)

- [This item is important but very vague in HCFA's write-up.] Support states with successful practices and help them inform other states about encouraging HCBS. Options:

    - Articulate principles that President/Secretary can support and disseminate to states, perhaps at NGA.

    - Compile and disseminate successful state practices through written documents, conference workshops, and Internet postings.

- Analyzing CASA and Feingold bills, including cost estimates. Will also identify basic principles in the bills that we can support. May also recommend changes to these bills that would allow us to support them. (To be completed in February.)

- Paper by workgroup will look at options to employ those leaving the welfare rolls as PAS workers. (March 1998)

- Cash and counseling demonstration. Four states want demonstrations to give consumers of long-term care services greater autonomy by letting them purchase PAS (Arkansas, Florida, New Jersey, and New York). (Demo approved by HHS and under review at OMB.)

Drop -- Not Worth Highlighting

- Study of definition of homebound in Medicare home health that is required by Balanced Budget Act.

- Ongoing technical assistance to Hill staff on HCBS.

HHS Past Accomplishments on HCBS

Balanced Budget Act

- Removed requirement that a person must have been in a nursing home to qualify for certain employment services under an HCBS waiver. (Whose idea?)

- Makes PACE a state option under Medicaid. (PACE is a demonstration that provides HCBS to those over 55 who would otherwise require nursing home care).

- Lets Medicare pay for upgraded durable medical equipment.

Personal Care Regulation

- Regulation issued last September allows personal care services to be provided outside the home and drops requirement that personal care services be supervised by an RN. (Did this reg do anything beyond the statutory requirement? Did we support change in law?)

HCBS Provided through Waivers

- HHS continues to support state use of HCBS waivers. Using waivers, four states have closed all their institutions for the developmentally disabled and now serve all clients in the community. (But I understand we can't say that nursing home census is down or that the number of people receiving HCBS is up since 1/93 -- how to answer this?)

- In a letter to states last July, HHS urged state Medicaid directors to make HCBS available to persons who are institutionalized or at risk of institutionalization. In a June letter, HHS encouraged states to reduce the size of group homes (ICF-MRs) since homes with large populations may not provide an authentic community experience.

- In 1993, HHS took a major step to encourage HCBS waivers by eliminating the "cold bed test."

Demonstrations

- Recently approved Colorado waiver will foster independent living by allowing home health services to be provided in schools and work sites, in addition to the home.

- HCFA has asked Centers for Independent Living to help test a model that will allow consumers to become more involved in selecting and purchasing durable medical equipment. Consumers may use the savings from more efficient purchasing to purchase equipment not covered by Medicare. (when?)

- In May 1997, HCFA asked states for grant proposals that stress an independent living model with consumer direction and control for Medicare/Medicaid beneficiaries. States proposals are now under review. (Outcome?)

- HCFA expects to approve soon a Wisconsin waiver that would use independent living centers as providers of HCBS on a capitated basis.

- HCFA is working with Rhode Island to integrate medical and community supports and consolidate funding streams for adults with developmental disabilities. (Planning for years.)

Recent HCFA Disability Accomplishments Not Related to HCBS

- Balanced Budget Act included our plan to give states the option of a Medicaid buy-in for SSI recipients who go to work (although with income cap that makes it less effective).

- BBA exempted certain children with disabilities from being required to enroll in managed care under freedom of choice waivers. (Whose idea?)

- BBA restores Medicaid for disabled children who lose SSI due to the tighter definition of childhood disability in welfare reform.

DRAFT, ~~CONFIDENTIAL~~, CLOSE HOLD

December 7, 1997

MEMORANDUM FOR THE PRESIDENT

FROM: BRUCE REED
GENE SPERLING

SUBJECT: Health Insurance Coverage Initiatives in the FY 1999 Budget

Overview

Throughout your Administration, you have worked to enact legislation to expand access to affordable health insurance. Your signing of the Balanced Budget Act included an unprecedented $24 billion investment for state-based children's health insurance programs. This historic initiative will clearly reduce the number of uninsured. However, there are other deserving populations whom we could target in our step-by-step reforms. These include the pre-65 year olds (referenced in the Medicare memo), workers between jobs, and workers in small businesses. In addition, we are working on proposals to expand Medicaid coverage to people with AIDS and disabilities through demonstration programs. The policy development of these proposals is still underway, but we reference them in this memo because we believe that they are sound and inexpensive enough to justify being considered for your FY 1999 budget.

Taken together, these are not large initiatives, summing to around $10 billion over 5 years, which is less than half of investments in this year's budget and less than a fraction of the premium assistance in the Health Security Act. Having said this, none of your advisors believe that it will be possible to find $10 billion in available resources for these investments. Most Medicare and Medicaid savings were included in last year's deficit reduction effort. There may be $0.5 to 1 billion over 5 years in Medicaid savings, but those savings will be difficult to achieve and there may be other claims on them (e.g., child care). It could also be argued that, given the link between tobacco and health care, any residual revenue from the tobacco settlement or a tax could be considered for coverage initiatives, particularly those related to children.

Your advisors uniformly agree that we need to take all actions possible to achieve if not exceed your goal of increasing insurance coverage for 5 million children. A series of proposals are described to accomplish that goal. There is less agreement on whether we address a new group of uninsured people in this budget. Labor strongly supports the workers between jobs demonstration; of all health initiatives in the budget, it is their highest priority. OMB also supports that demonstration if sufficient funds are available. While HHS believes that this proposal has merit, they are skeptical that it will achieve significant support since it has not in the past three years of trying. The same holds true for the small group purchasing cooperatives.

A. CHILDREN'S HEALTH OUTREACH

The Children's Health Insurance Program (CHIP) provides funds for coverage of millions of working families' children, a population that previously had trouble affording coverage. It also builds upon a strong Medicaid program that this Administration has worked so hard to protect. However, important work remains to be done. In particular, we need to work with states to enroll the millions of uninsured children in these programs.

Medicaid eligible children are especially at risk of remaining uninsured. Over three million uninsured children are eligible for Medicaid. Educating and enrolling families about their options has always been a problem, but recently has become more challenging. The growth in the number of children covered by Medicaid leveled off in 1995 and, according to the Census, dropped by 6 percent in 1996. While some of this may be due to the lower number of children in poverty, some may also result from families' misunderstanding of their children's continued eligibility for Medicaid regardless of the changes in welfare.

Options to Increase Outreach for Medicaid and the Children's Health Insurance Program

To address the need for children's health outreach, we propose a series of policy options. First, we could offer states enhanced match for enrolling new, uninsured children, giving them an incentive to find these children. Second, we could build upon a new option in the Balanced Budget Act called "presumptive eligibility", that essentially allows children to be given temporary Medicaid coverage while they are formally enrolled in CHIP or Medicaid. Third, we could clarify the law so that states may use their TANF allotments for outreach at 90 percent matching for all children, not just those transitioning from welfare. Finally, we could work on a series of policies to simplify the application and enrollment process, making it easier to access the system. Together, these initiatives could cost $0.5 to 1.5 billion over five years. Preliminary discussions with NGA and some children's advocates suggest they strongly support these efforts.

Enhanced match for outreach. One option for improving state outreach is to provide enhanced match to enroll new, uninsured children in Medicaid. At the end of the year, if a state can document that it has increased its enrollment over baseline, it receives a increased matching amount per newly covered child. This policy rewards states only if they succeed in outreach, rather than just matching activities that may or may not work. Its costs depend on the amount of the enhanced match, but estimates range from $0.5 to 1 billion over five years.

Moving outreach to schools and child care sites. We could build upon the presumptive eligibility provision in the Balanced Budget Act to make it easier to enroll children in Medicaid and CHIP. This could be done by changing the law to allow schools and appropriate child care sites, at the states' option, to determine "presumptive eligibility". This means that certified people may, using a simple test, give a child up to two months of Medicaid coverage on the spot as the application is processed. Additionally, under the Balanced Budget, states that use presumptive eligibility must pay for its costs out of the CHIP allotment, reducing the amount

available for other coverage. States have advised us that this is a disincentive to take this option. HCFA actuaries preliminarily estimate that this would cost $400 million over 5 years.

Accessing 90 percent funds for outreach. A third way to increase financing for children's health outreach is to clarify the uses of a special fund set aside in TANF for outreach for children losing welfare. This $500 million fund is allocated to states with a 90 percent matching rate for outreach activities. We would expand its use to all children, not just welfare children. HCFA Actuaries preliminarily estimate that this would cost $0.2 billion over 5 years (the cost of the new coverage generated by these efforts). NGA supports this change.

Simplifying enrollment. A simple, accessible enrollment process from beginning to end could encourage more families to enroll their children in Medicaid or CHIP. To help create such a process, we propose several actions, all of which are low cost initiatives. First, we could streamline the application process by simplifying Medicaid eligibility and by encouraging the use of simple, mail-in applications. HCFA has already developed a model, single application form for both Medicaid and CHIP. We could condition some of the financial incentives, described above, on using a single or simple application. Second, we are reviewing the feasibility and costs of a nationwide 1-800 number that will link families with their state or local offices. Such a number could be placed in public service announcements, on the bottom of school lunch program applications, and on children's goods like diaper boxes, for example, allowing families easy access to information.

Departmental Positions

There is unanimous support across agencies for focusing on children's health outreach. For HHS and Treasury, it is their first priority in all health initiatives. NEC/DPC believe that aggressive outreach will be needed to meet or exceed the Administration's goal of covering 5 million uninsured children. Although we believe this policy will receive validation by policy experts, children's advocates, and Governors alike, this package of outreach initiatives may be a communications challenge so soon after the enactment of the $24 billion base children's health program. Given its importance, we should also consider how outreach could be done in the context of the tobacco settlement. Since one of the stated uses of the $368 billion settlement was children's health, it is possible that we should fund this initiative in that way. We also could consider allowing states to keep some of the Federal funds if they use them for children's outreach.

B. WORKERS BETWEEN JOBS DEMONSTRATION

Families who lose health insurance while they are between jobs are a small but important group of uninsured Americans. These families pay for health insurance for most of their lives, but go through brief periods without coverage when they are temporarily unemployed. If they experience a catastrophic illness during this transition, the benefit of their years' worth of premium payments is lost. Worse, for families with an ill child or a worker with a chronic condition, the loss of health insurance while between jobs can make it financially impossible to regain coverage.

Limited Demonstration

This policy option is a modification of the program that we have carried in our last three budgets. It would award grants to several states to provide temporary premium assistance to eligible families. States would use this money to partially subsidize families' premium payments for up to 6 months. To truly test how best to address this population's needs, we would select states using a range of approaches like COBRA, Medicaid, or covering the parents of children covered by CHIP. Since it is a grant program, the costs are a policy choice. To give a sense of the coverage for the options, last year's $10 billion proposal covered about 3.3 million people. If we assume the same set of policy parameters, a demonstration of $1 billion over 5 years would coverage about 300,000, of $2.5 billion would cover about 700,000, and it would take about $3.5 billion to cover about 1 million people.

Departmental Positions

On policy grounds, all of the agencies support this policy. It has been in our last three budgets because of its merits. This policy remains Labor's first priority. They view the unemployed uninsured as a particularly vulnerable and important group to target. They also believe that this is a particularly important policy in the context of the trade debate and worker insecurity issues. OMB would support this initiative if there are sufficient funds. HHS has always been supportive of this policy but feels as though circumstances have not changed to make this policy viable this year when it has not been in the past. They would focus the funds on the children's outreach option. DPC/NEC are concerned about dropping this policy altogether and do support a demonstration. However, if resources are limited, we would advocate for the children's outreach initiative before this proposal.

C. VOLUNTARY PURCHASING COOPERATIVES

Workers in small firms are most likely to be uninsured. About one-third of workers in firms with fewer than 10 employees lack health insurance — more than twice the nationwide average. While 88 percent of workers in firms with 250 or more workers are offered health insurance, only 41 percent of workers in firms with less than 10 workers are offered coverage. This results in large part from the fact that the small group health insurance market does not function as well as the large group market. Studies have shown that administrative costs are higher and that small businesses pay more for the same benefits as larger firms.

Grants to States

Given the disadvantages faced by small firms, the question is: are there policies that can make insurance more affordable for small businesses and their employees? In the last three budgets, we have included a policy to provide seed money for states to establish voluntary purchasing cooperatives. These cooperatives would allow small employers to pool their purchasing power to try to negotiate better rates for their employees. This year, we propose both the original policy and a variation: a competitive grant approach so that fewer states could apply for a smaller amount of money. The total costs would be $50 to 100 million over 5 years.

Departmental Positions

All agencies remain supportive of this policy and believe it should be included in this year's budget. It is important that we have some initiative that illustrates our understanding that a major problem of lack of insurance continues to exist in the small employer community. In the past, we have been unable to get this policy passed into law primarily because it has been viewed as an alternative to an initiative proposed by Congressman Fawell. His approach would allow virtually all small businesses to self-insure and in so doing escape all state regulation. Governors and consumer groups have consistently opposed the Fawell approach, mostly because of their concerns that it would make the small business insurance market for those who elected not to self insure even more unstable than it already is. We have raised similar concerns and have also pointed out that a Fawell-type approach would eliminate all of the consumer protections state insurance regulation currently provides. Based on our preliminary conversations with Congressman Fawell, it may be that our impasse is resolvable since this is his last year as a Member of Congress and there are some compromises that seem within reach.

D. AIDS DEMONSTRATION

As described in the memo on AIDS initiatives, the Health Care Financing Administration is looking into options to see if there is a feasible demonstration for providing Medicaid coverage for certain therapies earlier than when people have full-blown AIDS. This demonstration would allow a few states or cities to have a capped amount of funds to provide Medicaid coverage to people with AIDS earlier in the progression of the disease. The details and merits of such a policy are still in development, but we think that we could limit this funding to $40 to 50 million over five years.

E. DEMONSTRATION FOR PEOPLE WITH DISABILITIES

A similar demonstration is being considered for people with disabilities. As you know from your meeting with the disability community, there is a strong desire to experiment with ways to encourage states to de-institutionalize people with disabilities. Often, these people could live in the community if they has Medicaid support. However, states have been reluctant to move extensively in this direction because for every one person that they move out of a nursing home due to this benefit, several who are already in the community but being cared for by their families would turn to Medicaid for help. For this same reason, HCFA is still trying to determine whether a limited demonstration is possible. The ideas being considered would both test options for encouraging de-institutionalization and develop an information strategy to encourage states to use models that work. If possible, we would limit funding to $50 million over five years.

THE WHITE HOUSE

WASHINGTON

Arlen's pet
approp 6.77
conf rpt for Comm
$2m — PAS demo

ORD & subst reduced

fax Min - HHS - HCFA

fax Bob W - call 690-6443 for fax

in-house mail Gotbaum, Miller, Tumlinson - all OMB

~~Fenning~~, Lambrew

DPC

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*** TX REPORT ***
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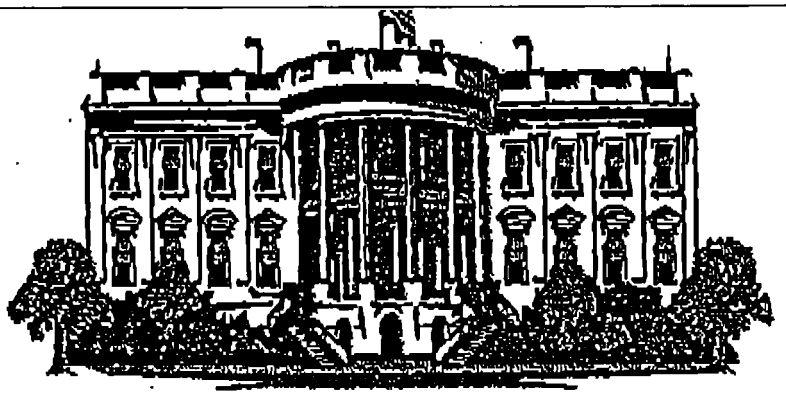


THE WHITE HOUSE

Domestic Policy Council

DATE: January 12, 1998

FACSIMILE FOR: Bob W.

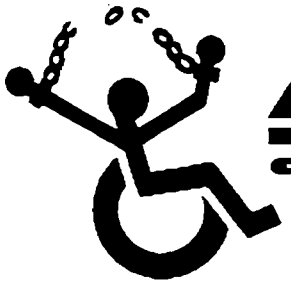
FAX: 202-401-7733
PHONE: 690-6443

FACSIMILE FROM: Diana Fortuna

FAX: 6-7431
PHONE:

NUMBER OF PAGES (INCLUDING COVER): 4

COMMENTS:



ADAPT
action news bulletin

FYI - Nancy-Ann Min
Bob Williams
Josh Gotbaum
Chris Jennings
Jeanne Lambrew
Mark Miller
Anne Tumlinson

To: Disability Rights Advocates

From: ADAPT

Pls distribute and ask folks to monitor the President's State of the Union address to see if Long term services are included as a priority for the Clinton/Gore Administration

"There is no place like Home"

To: DIANA FORTUNA pm 2/2

fr: Bill WHITE

A D A P T
FREE OUR PEOPLE

The Honorable Bill Clinton
The President of the United States
White House
Washington, D.C. 20500

January 5, 1998

Dear President Clinton:

The year of 1997 has come to a close and 1998 begun with millions of disabled Americans, old and young, still in need of community-based long term support services that will enable their independence in the community. There is a lot of rhetoric about keeping disabled Americans as independent as possible but the funding realities contrast strikingly with this rhetoric. The latest numbers we have are from 1996 when $51.5 billion Medicaid dollars were spent on long term care services with almost $41 billion spent on institutional services. That is one dollar for community services for each five dollars going to institutional services. That is roughly the same 80% for institutions as when you took office.

From these same 1996 figures we find fully 33% of all Medicaid dollars was spent on long term care services. Long term services is an issue that your Administration needs to confront directly, as an issue in its own right, not just as part of health care. The concern over Social Security and Medicare solvency is to a large degree due to the aging of the US population. The growing need for long term services is also partly due to the aging of America but partly to the number of children and younger adults who are now living to a "normal" age. The growing need for long term services must first be addressed politically by recognizing it as a separate need of the US population.

With all due respect, though many in the disability community have supported your Administration in the fight for health care reform your Administration's public commitment to changing long term care policies and funding appears low. There was hope that the September 10th meeting with the disability community, in which long term services took a major part of the discussion, would have been a jumping off point for your Administration's commitment to this issue as we moved into 1998. In fact, at that meeting you promised to give community based long term care services higher attention. However, in all public reports of Administration priorities for 1998 long term services is never mentioned. Your lack luster support for long term care has meant the workgroup that was created within HHS after the September 10th meeting has, as of this date, not been given the status in your Administration to fostered innovative proposals. It appears long term services does not have a political life within your Administration.

As long as long term services is ONLY discussed in the context of health care services it will be a political stepchild to the needs of physicians, hospital, insurance companies and other health care providers It will always be dominated by the "medical model" and discussion on how to move it towards an "independent/community living model" will not

occur. Though there is an obvious link between acute and long term services, the political discussion must begin to focus on long term services as a separate category of services to meet the need of a growing population in this country. Your State of the Union address needs to identify long term services as an issue to be addressed by Congress and the American people. Here is a real opportunity to keep your promise and send a message to the country that long term services must be addressed by Congress.

Long term services needs to be discussed in the same way we are discussing the need for child care. The similarities between the issue are striking: the needs of the people who use the services, the effects on families and the people who are the caregivers, the economic impact on business which must give time off for people to provide "informal care".

Even more than childcare, long term care effects women disproportionately. Families have and continue to provide the bulk of long term services. The majority of people needing services are women. The majority of people, both paid and unpaid, providing services are women. As the need and desire of women to participate in the workforce continues to grow, the number of people able to provide "free" long term services dwindles. The need for a national long term care policy outside the health care debate is critical. Planning for the future service and funding demands for long term services must be a priority for your Administration in 1998.

The passage of the Americans with Disabilities Act reflects the changing nature of our population. The long term service needs of our population is a logical extension of the growth of the disability population. The changing nature of our population is not only in the ethnic mix but it also is in the mental and physical characteristics of the population. Disability has always been a normal part of the life experience. With medical and rehabilitative advances the numbers of people with disabilities is a growing and significant percentage of the American population. These individuals will need long term ongoing services.

ADAPT represents a growing number in the disability community who are fed up with the inability of Congress and this Administration to address the long term support issues. These are life and death issues. Your leadership is required for these issues to be brought before Congress and addressed.

ADAPT hopes your State of the Union address begins the political discussions on long term support issues throughout 1998 and as we head towards the year 2000.

"There is No Place Like Home"

Michael Auberger
Organizer

Bob Kafka
Organizer

Mike Oxford
Organizer

Stephanie Thomas
Organizer

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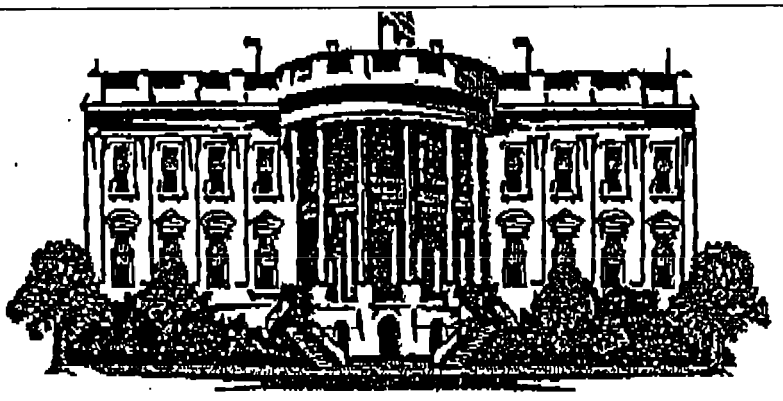

THE WHITE HOUSE

Domestic Policy Council

DATE: January 12, 1998

FACSIMILE FOR: HHS - HCFA Min, Nancy-Ann

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NUMBER OF PAGES (INCLUDING COVER): 4

COMMENTS:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

DEPARTMENT OF HEALTH & HUMAN SERVICES·USA

1) higher match a prob? 2) if so, what on disc side

Need a carrot grad CHIP match?

Bob W – running into problems – Callahan + NAM most $ from higher MA match

Secy: int'd in mkg perf. bonus pymts to states w/ ⇒

~~CONFIDENTIAL~~

PHONE: (202) 690-6870 FAX: (202) 401-7321

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2018-0525-S

Date:

From: Gary Claxton

To: Chris Jennings

Phone: (202) 690- 6870
(202) 690-6870

FAX: (202) 401-7321

Phone: Diana

Fax:

Number of Pages (Including Cover): 8

Entitlement capped cap is on enhanced match

Comments:

FY 99 Special Funding Request:

STOPPING UNNECESSARY NURSING HOME PLACEMENTS AND PROMOTING CONSUMER RESPONSIVE HOME AND COMMUNITY BASED SERVICES FOR DISABLED PEOPLE

Purpose: The Secretary and the President have endorsed the implementation of an HHS led special initiative to work with states and the aging and disability communities to reduce nursing home placements for persons who would prefer and are able to live in home and community settings. The President noted in a meeting with HHS policy officials and members of the disability community that some states are far more successful than others in offering people with disabilities the choice of home and community based consumer directed services . He directed HHS to work with the states to develop a range of strategies that enable people who choose community living to make the transition from nursing homes and to ensure that state long-term care systems are not inappropriately biased toward institutional care and are based on consumer directed, consumer responsive service principles.

In response to this charge an HHS work group has developed an action plan that includes two major components -- (i) the design and implementation of "date certain" pilot projects in up to five states and the completion of the Cash and Counseling Demonstration , for a total of $45 million dollars from Medicaid and $7 million dollars in discretionary funds over four years; and (II) the development and implementation of a best practices/information dissemination/technical assistance center, for a total of $5 million in discretionary dollars over three years. See attached chart for proposed funding plan.

I. Design and Implementation of "Date Certain" pilot projects in up to five states.

These projects are intended to support selected states in a major effort to reduce unnecessary institutionalization including: identifying potential candidates for community living, arranging for alternative home and community based services for persons who choose to be relocated from nursing homes, organizing and purchasing short term transitional services to assure that people who choose to leave a nursing home have appropriate supports and developing new structures in the community to assure that people who are considering nursing home placements are also informed of consumer directed community living options.

The planning and implementation of the "Date Certain" pilots in three to five states would be paid for through a combination of discretionary funds and by increasing the federal match for approved Medicaid expenditures to 100% up to a ceiling based on the state's nursing home population. This will require new statutory authority. The total discretionary allotment for planning and evaluation is estimated to be $7 million, $2 million of which is already in the HCFA base budget for 1998; the other $5 million is allocated in the following way: $2 million in 1999 for planning, $1.5 million in 2000 for evaluation, $1 million in 2001 for evaluation, and $.5 million in 2002 for evaluation.

The total Medicaid allotment for the three to five states over the three year implementation

period is estimated to be $45 million, broken out in this way: $10 million in 2000, $20 million in 2001, and $15 million in 2002.

The planning and implementation of the "Date Certain" pilots in five states would be paid for through a combination of discretionary funds and by increasing the federal match for approved Medicaid expenditures up to 100%. Each state would have an overall ceiling on new Medicaid expenditures for the pilot project.

The planning and implementation of these date certain pilot projects will include:

1. **Case Studies**

Conducting case studies of individuals who are currently in nursing homes who want to live in the community and others who previously lived in nursing home but made a successful transition to community living. These studies will help to identify specific barriers that have prevented people from leaving nursing homes and to identify successful strategies for mobilizing existing resources and removing barriers.

2. **Analyzing Successful Strategies**

Analyzing successful state strategies for reducing unnecessary nursing home use and increasing the proportion of expenditures allocated to home and community based services (e.g., approaches used in Oregon and Washington).

3. **Competitive Grant Program**

Designing a grant program, to be offered on a competitive basis, to provide states with planning resources to design and implement the demonstration and to support payments for transitional services. The grant could be used to: develop the infrastructure needed in the community to support relocation of nursing home residents and to assure that people seeking nursing home placement are informed of their options; the deployment of new case management mechanisms to identify candidates for relocation, and the purchase of short term transitional services for people leaving institutions for home and community based settings e.g., locating a new living arrangement, placing a security deposit on an apartment until SSI income is available, purchasing special furnishings or clothing, or other necessities to make a transition possible.

4. **Targeted Studies and Technical Assistance**

Conducting targeted studies and providing technical assistance to the states to support date certain implementation plans.

5. **Evaluation of Impact**

Conducting an evaluation of the 5 selected pilots and their impact on maintaining people in the community and reducing reliance on unnecessary nursing home use.

II. Establishing and Implementing an Information/Best Practices/Technical Assistance Strategy

Outlined below are the key elements of a coordinated "Best Practices/Technical Assistance" strategy which could be undertaken by HHS in response to the President's suggestion that the Administration should work with states (and encourage states to help each other) to expand and promote consumer directed home and community based personal assistance services. The strategy would address promoting and expanding all forms of home and community based services, with emphasis on consumer centered and consumer directed PAS, but other types of personal support would also be included within its scope.

The strategy outlined here would be implemented over a three year period, at a cost of $5 million ($1 million in 1999, and $2 million for each subsequent year, 2000 and 2001). (It might be extended for longer, perhaps for a total of five years.) We anticipate that the funds would be used to support a national consumer directed PAS center that would work closely with HHS project officers. The center would conduct research, TA, and information dissemination activities directly, as well as fund other subcontractors for specific activities, such as data analysis, running focus groups, planning and hosting conferences, or conducting training and TA in states. This center would be similar to other centers and clearinghouses supported by HHS, through the Administration on Developmental Disabilities and the Administration on Aging. It would be a private nonprofit organization.

1. Strategy Design

This first step involves developing a strategic plan for the three year project, operated through a National Consumer Directed PAS Center. The plan will address all aspects of the Center's work, including funding studies and analyses; creating, supporting and disseminating a public relations component, including conferences, meetings, a website, and a range of informational and promotional materials; and, developing and supporting a solid technical assistance program.

A. **Consult with Stakeholders.** The first phase of developing the coordinated information campaign and technical assistance strategy is to identify and consult with the key stakeholders -- state Medicaid, Aging, MR/DD officials; independent living centers; other service providers; consumers and consumer organizations, etc. We should solicit their input in an organized manner to: (1) help us identify best practices in states and programs; (2) identify state, provider, and consumer TA needs; and, (3) identify experts and consultants who can assist in developing and implementing the coordinated strategy. This process will help the Center and HHS to frame the overall TA strategy.

The consultation process should be accomplished initially over a period of two months, and encompass individual conversations with experts, focus groups, meetings, and conference calls. In addition, we anticipate that the consultation links established through this process would be maintained throughout the

implementation of the strategy, for guidance and assistance. The Center will call on selected individuals who participate in this initial process to participate in an Advisory Board to oversee operations throughout the implementation period.

The outcome of the process will be a summary that highlights a few examples of best practices, problems, and TA needs; the document will be used to develop the overall plan of the Center's coordinated strategy. More detailed needs assessments, barriers, and best practice documents will be developed later in the process; this general survey of stakeholders is designed to support the development of the entire coordinated strategy.

B. **Map Current Activities in Promoting HCBS and Consumer Directed PAS.** As part of the planning process, HHS and the Center will have to develop a detailed understanding of current projects to study and promote home and community based services models and programs, particularly those that emphasize consumer centered and consumer directed PAS. For example, one such project is the National Association of State Units on Aging project on consumer directed PAS, funded by the Robert Wood Johnson Foundation.

C. **Develop Plan for Coordinated Strategy.** In collaboration with HHS and other Federal partners, as well as the Advisory Board, the Center will develop a plan to provide information and technical assistance to the states. An element of this plan will address the involvement of other federal agencies (e.g., NIDRR, SSA) and specific roles for foundations and other private sector organizations.

2. **Announce and Promote Coordinated Strategy: Meetings, Speeches, Promotional Materials**

A. **President to Speak to NGA in January on HCBS/PAS Efforts.** In January, when the President meets with NGA, he could include in his speech/discussion, his thoughts on the need to move in the direction of reducing needless nursing home placements and developing cost effective models of consumer directed PAS. He could also announce the Administration's interest in talking to states to develop the "date certain" demonstration and giving them incentives to participate in it.

B. **White House to Host National Kickoff Conference.** This conference could be scheduled in July to coincide with the anniversary of the ADA. It would be used to demonstrate the President's interest in helping states address the institutional bias in Medicaid and finding ways to help them develop, improve, and expand consumer directed PAS. Conferees would include consumers, state and federal officials, providers, researchers and others. Sessions would be used to identify barriers and solutions. The Center staff would use input from attendees to develop a publication that promotes the Administration's principles and plan for promoting the expansion of consumer directed PAS services and decreasing

inappropriate reliance on institutional placements.

C. **Develop Promotional Materials and Plan to Disseminate Them.** The Center would develop a plan to develop and disseminate information products. Products might include a regular newsletter, "how to" articles about specific activities related to consumer directed PAS programs, an Internet website, brochures about TA services available, descriptions of model programs, etc.

D. **Host a Series of Regional and/or Subject Specific Conferences to Promote the Administration's Interest in Forward Momentum on These Issues.** These conferences could showcase promising practices and models, as well as disseminate practical information learned from current demonstration projects such as Cash and Counseling, Independent Choices, and the Mentoring Project. One or more of the conferences could feature panels of experts from states talking about how they overcame barriers.

3. **Provide Technical Assistance to States**

A. **Assess State TA Needs to Enable them to Promote and Expand Consumer Directed PAS.** Assess needs through a two pronged process of gathering input from states, providers, and consumers, AND studying available research findings from the Kane's Mentoring Project and UCSF's 1992 study of each state's percentage of HCB waiver expenditures compared to nursing home expenditures. The Center would select a sample of states with low spending and conduct in-depth interviews about the barriers to expanding and promoting consumer directed PAS. Interviewees would be asked to identify the factors that have limited development of PAS services, the barriers to further development, and the changes needed in policy or the incentives that would address the barriers and limitations. The Center might also conduct or support research in all states to identify specific TA needs. Finally, the Center will also assess the ability of each state to provide training or expert consultation to other states for focused topics of interest.

B. **Convene Consumer Focus Groups and Conduct Individual Interviews to Obtain Views on State TA Needs.** Consumers in each state will have clear views on what TA their state needs and who should be targeted to receive it. The Center should use interviews and focus groups to give consumers a voice in identifying the TA needs and solutions in states, and nationally. The interviews and focus groups could be conducted in collaboration with independent living centers and other community based organizations.

C. **Develop Plan to Respond to TA Needs.** The Center will develop a comprehensive plan to respond to the TA needs identified. The plan will include specific outcomes, activities to achieve them, and an evaluation plan.

D. **Provide Support to Expand the State TA Projects that Include an Emphasis on Consumer Directed PAS for Consumers of all Ages.** Robert and Rosalie Kane's Mentoring Project aims to develop and strengthen HCB services and overcome barriers by enabling selected states to sustain relationships with experts from other states and academia. These mentoring relationships are individually tailored to address unique problems faced by the state receiving the help. Similarly, the World Institute on Disability is funded by the National Institute on Disability and Rehabilitation Research to disseminate information and provide TA to programs that promote PAS. The National Association of State Units on Aging is developing a small TA and information center and the National Association of State Directors of DD Services offers consultation to state DD agencies. The PAS Center would coordinate with (and possibly add on to) these and similar projects, but it would include a specific emphasis on HCB services that have a strong consumer responsive, consumer direction component.

E. **Work with States to Develop Performance Indicators.** The Center would facilitate a process that takes into account the views of states, consumers, and others, in establishing a consensus set of performance indicators to measure each state's progress in developing consumer directed PAS and expanding HCB services.

F. **Develop and Present Training Modules to Address Specific State Needs.** It is anticipated that states will express specific concerns and needs for training, to support their efforts to promote consumer directed PAS. For instance, a training module on setting up and operating a fiscal intermediary system may be needed, with information on the legal issues, oversight needed, tax issues, etc. Another module on quality assurance and monitoring might be appropriate. The training could be tailored to state specific needs and requests and conducted only in that state; other training sessions could be targeted to groups of states with similar needs. The Center could also maintain videotapes of training sessions and make them available for states and others interested in obtaining the information.

G. **Provide Scholarships for a Limited Number of State Teams to Visit Other States to Study Model Programs.** The Center could support state teams of individuals (Medicaid or other state staff, consumer advocates, independent living center staff, etc.) to travel for a two week study period to another state to learn how to establish and implement specific program models. Visiting teams would meet with financing, program, planning, legislative, and other staff, as well as consumers and providers when they visit another state.

Proposed Budget for "Date Certain" Demo and Best Practice/TA Center (In Millions)

YEAR	DATE CERTAIN DEMO		BEST PRACTICES CENTER	ANNUAL TOTAL	
	Discre-tionary	Medicaid	Discretionary	Discre-tionary	Medicaid
1998	2*+	0	0	2	0
1999	2+	0	1	3	0
2000	1.5**	10	2	3.5	10
2001	1**	20	2	3	20
2002	.5**	15	0	.5	15
TOTALS	7	45	5	12	45

NOTES

* - We believe the $2 million in discretionary dollars in FY 1998 is already in the HCFA budget.

+ - The $2 million discretionary dollars each in FY 1998 and FY 1999 are for planning and evaluation

** The discretionary allotments in 2000, 2001, and 2002 are for evaluation

Anne 12/5/97

5,000 (1 million)

option to leave

1/3

50K ea cost (~~woodwk~~ → backfill 1/2)

No carrot to states - reg matching

$3/5 m

Proves what?

CTC Ins for Elderly - what for dis?

FAX TRAN-MISSION

CENTER ON BUDGET AND POLICY PRIORITIES
820 FIRST STREET, NE, SUITE 510
WASHINGTON, DC 20002
(202) 408-1080
FAX: (202) 408-1056

To: Cynthia Rice **Date:** December 12, 1997

Fax #: 456-7431 **Pages:** 03, including this cover sheet.

From: Cindy Mann

Subject: Summary of Kaiser/Commonwealth Fund Report

COMMENTS:

Earlier this week, we sent you a paper suggesting that the President's budget allow states new options for covering low-income working parents under Medicaid. On December 8th, the Kaiser Family Foundation along with the Commonwealth Fund released a new report entitled *Many Working Families Struggle to Get Needed Care and Pay Medical Bills* that presents data underscoring the need for the option we have suggested. The findings prompted Drew Altman, President of the Kaiser Family Foundation, to say in the press release issued along with the report: "The low-wage working uninsured deserve special attention when the country considers the next incremental step in expanding health insurance coverage.

Since you might not have had time to review the full Kaiser/Commonwealth Fund report, we have prepared the attached summary of the report's key findings relating to low-income working families.

CENTER ON BUDGET AND POLICY PRIORITIES

December 10, 1997

NEW REPORT HIGHLIGHTS NEED FOR AN INITIATIVE TO EXPAND MEDICAID COVERAGE FOR ADULTS IN LOW-INCOME WORKING FAMILIES

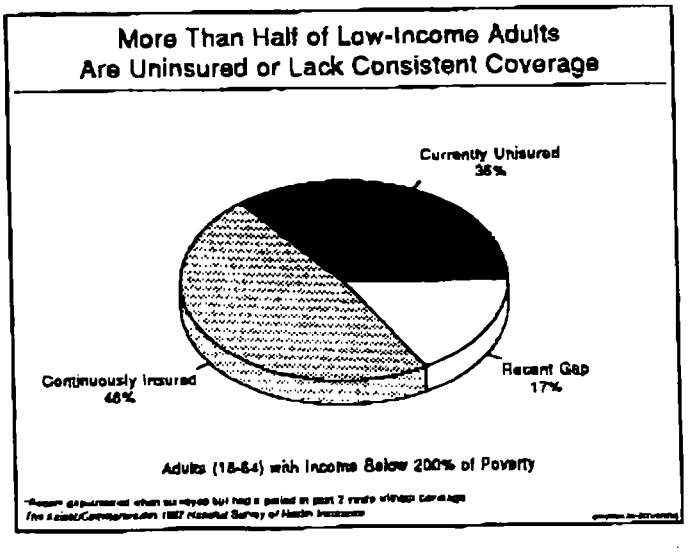
On December 8, 1997, the Kaiser Family Foundation and the Commonwealth Fund released a report entitled *Working Families at Risk: Coverage, Access, Costs, and Worries* that examines the health insurance status of adults in the United States. The report found that three out of four American adults who lack health insurance or who have experienced a recent gap in coverage are part of working families, and that low-income working families are particularly likely to lack consistent health insurance coverage over a significant period of time.

Among the key findings of the new report are the following:

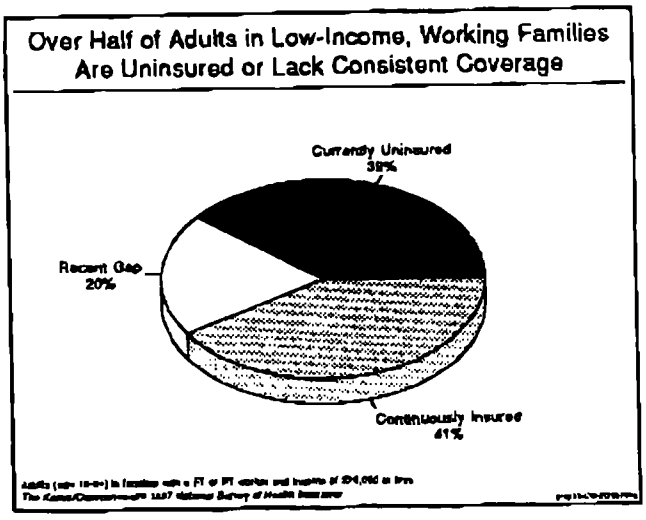
A large number of low-income adults are uninsured or lack consistent health insurance coverage, including low-income adults in *working* families

- *More than half of low-income adults are uninsured or have experienced a recent gap in coverage.* Thirty-six percent of adults with income below 200 percent of poverty lack health insurance coverage, and an additional 17 percent of such adults have experienced a recent gap in coverage. This means that more than 52 percent of low-income adults lack consistent health insurance coverage, compared to the 19 percent of adults with income at or above 200 percent of poverty who lack consistent health insurance coverage.

- *Working does not protect low-income adults from being uninsured.* Thirty-nine percent of adults in *working* families earning $20,000 or less per year are currently uninsured and an additional 20 percent of such adults have experienced a recent gap in coverage. Only 41 percent had consistent health insurance coverage.

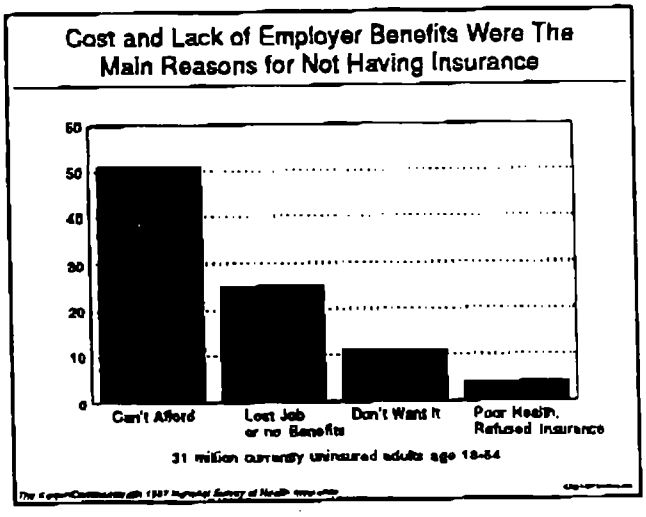


- *Adults in low-income working families are uninsured for long periods of time.* Among adults in working families who are currently uninsured or who have experienced a recent gap in coverage and who have income below 200 percent of the poverty line, 72 percent were without health insurance for a year or more.



The vast majority of adults lack health insurance coverage because they cannot afford it or because it is not available through an employer

- Fifty-one percent of all adults who are currently uninsured say that they cannot afford coverage, while an additional 25 percent cite a lost job or an employer that does not offer coverage as the reason why they do not have coverage.



The consequences of being without health insurance are more severe for low-income, uninsured adults in working families

- Forty-one percent of currently uninsured adults in working families with income of $20,000 or less report not getting needed medical care or prescriptions and/or experiencing problems paying medical bills in the past year. For uninsured adults in working families with income between $20,000 and $35,000, the comparable rate is 24 percent, while for those with income above $60,000 it is a more modest 12 percent.

The Kaiser/Commonwealth survey provides powerful support for the need for initiatives that will provide coverage to low-income working parents. Giving states the option to extend Medicaid to low-income parents whose children are already covered under the program and to simplify and expand TMA and would create important new opportunities for addressing the significant problems documented by this report.