

# PERSPECTIVES

*Serving the Nation's DD Community for More Than 30 Years...*

*May 2007  
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## Senate Passes 2008 Budget Resolution

The Senate has approved its FY 2008 Budget Resolution, rejecting many of the steep cuts to domestic programs such as Medicare and Medicaid that were requested in the President's budget. The resolution calls for a \$2.96 trillion budget blueprint that would set FY 2008 discretionary spending at \$948.8 billion, plus an additional \$2 billion in "advanced appropriations." This is \$18 billion above the discretionary spending level requested by President Bush.

The budget resolution allows up to \$50 billion over 5 years in increases to the SCHIP program, \$15 billion of which come from unspecified Medicare cuts. The other \$35 billion could be established in the form of a reserve fund and would require finding offsets. The \$15 billion in Medicare cuts stands in stark contrast to the \$65 billion proposed by the President in his FY 2008 budget request. The resolution also includes \$383 million to fight fraud and abuse in the Medicaid program.

Senators defeated, 44-55, an amendment offered by Chuck Grassley (R-IA) and Jim Bunning (R-KY) that would have undermined Medicaid's guarantee of EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) for children. The House budget, also \$2.9 trillion, was passed on March 29 by a vote of 216-210. The House resolution, drafted by John Spratt (D-SC), exceeds the amount President Bush requested for discretionary spending by more than \$24 billion and exceeds the amount of the Senate FY 2008 budget resolution by about \$7 billion. The House budget resolution does not include a proposal from Bush to reduce funds for Medicare and Medicaid. Next, the House and Senate budget resolutions will go to a conference committee to reconcile their differences.

**FMI:** To read the Senate budget or track its progress through conference, go to <http://thomas.loc.gov> and search for S.CON.RES.21. ■

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# CMS Releases 2008 Part D Call Letter

The Centers for Medicare and Medicaid Services (CMS) has released its Final 2008 Call Letter for the Medicare Advantage (MA) program and Medicare Part D drug benefit. The letter outlines changes



in Prescription Drug Plan (PDP) requirements for 2008 and includes alterations to rules about benefit and formulary design, marketing, and compliance. Plans must submit their 2008 bids to CMS by June 4.

Noteworthy provisions in the Call Letter include:

- CMS will no longer require that plans cover at least one drug in each of the U.S. Pharmacopoeia’s Formulary Key Drug Types, but plans will be required to cover all or substantially all drugs in certain protected classes, including those used to treat HIV/ AIDS, cancer, and mental illnesses.
- Plan providers will be limited to two bid submissions. The call letter allows an exception if one of the proposed plans includes gap coverage. Plans can submit a fourth bid if the fourth plan covers all generics and preferred brands in the coverage gap.
- CMS plans to introduce “report cards” in 2008 to allow beneficiaries to more easily compare plan quality.

**FMI:** The 2008 Call Letter for the Medicare Advantage program and Medicare Part D drug benefit is available at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/CallLetter.pdf>. #

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## Durbin Amendment Would Halt Proposed Medicaid Provider Rule

An amendment to the supplemental appropriations bill sponsored by Senator Richard Durbin (D-IL) would put a 2-year moratorium on a proposed Medicaid provider rule under which state Medicaid reimbursements to health care providers operated by local governments could not exceed actual costs. If enacted, the amendment would delay the rule proposed January 18th by the Centers for Medicare & Medicaid Services (CMS) for 2 years. The amendment would be paid for by boosting the rebate that brand-name drug makers must pay to the federal government for drugs sold through the Medicaid program, from 15% to 20%. This increase is expected to generate \$1.35 billion over 5 years, Durbin said in a statement.

The amendment came after a bipartisan group of senators, led by Senator Jay Rockefeller (D-WV) and Senator Gordon Smith (R-OR), sent a letter to CMS expressing “strong opposition” to the proposed rule. The letter attracted 56 signatures, including 16 Republicans.

The letter expresses particular concern with the proposed rule’s new definition of a “unit of government,” arguing that it is “at odds” with the definition in Section 1903(w)(7)(G) of Title IX. According to the Senators, the new, narrow definition would lead to “substantial cuts for public providers” and “limit access to... vital health care services” by restricting states from incorporating university hospitals, public nursing homes, and the like into the governmental health care infrastructure.

The Senators also object to “the restrictions [the rule places] on states’ ability to fund their share of Medicaid costs.” Under the proposed rule, only funding derived from state and local taxes could be used to fund the state’s share of Medicaid services, an attempt to eliminate inappropriate federal matching arrangements. However, the Senators point out that CMS reports largely eliminating

such arrangements over the last 3 years through oversight activities, and question why new restrictions are necessary. Further, the letter suggests that this new restriction

contradicts federal law. Section 1902(a)(2) of the Social Security Act allows states to rely on “local sources” for up to 60% of the non-federal share of program expenditures, and the letter argues that current law does not allow CMS to limit the types of local sources that may be used.

The letter also takes issue with the cost limit imposed on Medicaid provider payments. The Senators point out that current regulations allow states to provide

Medicaid reimbursement up to the amount that would be payable using Medicare policies, and question why this limit should be reduced for governmental providers only, given that public providers disproportionately serve the uninsured.

The amendment was added during a Senate Appropriations Committee markup and accepted by a vote of 18-11. Subsequently, the Senate approved the bill, providing emergency supplemental appropriations, by a vote of 51-47. After conference with the House, the bill was vetoed by the President due to provisions related to the war in Iraq. Legislators are currently negotiating with the executive branch a mutually acceptable approach to funding the Iraq war. Any new supplemental is likely to include the Durbin amendment.

**FMI:** To read the bill or track its progress, go to <http://thomas.loc.gov> and search for HR 1591. The letter is online at <http://www.familiesusa.org/assets/pdfs/medicaid-coalition-stuff/bipartisan-senate-letter-cms.pdf>. The rule is available in the online *Federal Register* at <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-195.htm>. #



*Senator Richard Durbin*

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## CMS Will Not Enforce Claims Deadline for Part D State Costs

The Centers for Medicare and Medicaid Services has announced that it will not enforce the March 31, 2007 deadline for receipt and payment for claims related to the State-to-Plan Demonstration Project, and direct Coordination of Benefits (COB) processes with State Medicaid Programs, State Pharmaceutical Assistance Programs (SPAPs) and other third party payers that should not have paid primary to the Part D plan (PDP). These claims may be submitted for payment and considered under the CMS payment reconciliation process provided the PDP's claims processor has received them in time to submit the prescription drug event data by the cut-off date for payment reconciliation.

The announcement comes in response to the concerns over the timing of payments involving 2006 claims initially paid by States that should have been paid primary by PDP. The concerns centered on regulations at 42 CFR 423.308, which defines the Part D coverage year as including payment by PDPs on claims for covered Part D drugs made no later than 3 months following the end of the calendar year. Although CMS will not be enforcing this deadline for certain payments, the agency stresses that it does not intend this policy to supersede the contractual terms in PDPs' trading partner agreements regarding the timely filing of claims. Rather, CMS seeks to facilitate COB that involves third party claims based on extraordinary technical issues. The decision is limited to the 2006 coverage year.

**FMI:** For more information, please contact CMS official Alissa DeBoy at (410) 786-6041.

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## CMS Proposes to Revise Provider Tax Rules

The Centers for Medicare and Medicaid Services (CMS) has published a notice of proposed rule-making (NPRM) revising the threshold allowable amount that can be collected from health care-related provider taxes to reflect the provisions of the Tax Relief and Health Care Act of 2006 (P.L. 109-432). The provisions take effect beginning January 1, 2008 through September 30, 2011. The rule also clarifies the standards for determining provider contributions and the arrangements when a state collects taxes from providers to increase the amount of federal matching funds it receives and then returns the taxes either directly or indirectly to providers.

The proposed rule would revise the allowable amount that can be collected from a health care-related tax from 6% to 5.5% of net patient revenues received by the taxpayers. The rule also proposes to modify the three broad tests to determine if there is a hold harmless arrangement with respect to a health care-related tax. The

first, known as the positive correlation test, examines whether a state or other unit of government has imposed a health care-related tax and also provided for a direct or indirect non-Medicaid payment that is positively correlated to the tax amount or to the difference between the Medicaid payment and tax amount. The proposed rule explains that both direct and indirect payments to providers, or others paying a health care-related tax, will be analyzed in determining compliance with this test, and CMS proposes to interpret the phrase "direct and indirect non-Medicaid payment" broadly, to include many forms, including grants or tax credits. CMS recognizes that this test injects some degree of subjectivity into the hold harmless analysis, but argues that some subjectivity is necessary to effectively prohibit hold harmless arrangements that directly or indirectly pay a taxpayer for the costs of a tax.

*(Provider Tax Rules continued on page 5)*

## Harkin Sponsors Community Choice Act

Senator Tom Harkin (D-IA) has introduced the Community Choice Act of 2007, a bill that would allow individuals eligible for Nursing Facility Services or Intermediate Care Facility Services for the Mentally Retarded (ICF/MR) the opportunity to choose instead a new alternative, “Community-based Attendant Services and Supports (CASS).” In addition, the bill offers an enhanced match and grants for CASS services provided before October 2011 when the benefit would become permanent and mandatory. The bill is an updated version of the Medicaid Community Attendant Services and Supports Act (MiCASSA), legislation Harkin has introduced repeatedly over the last several years.

The bill would require states to offer CASS as part of the state plan. CASS services include assistance with:

- activities of daily living (ADLs—eating, toileting, grooming, dressing, bathing, transferring),
- instrumental activities of daily living (IADLs—meal planning and preparation, managing finances, shopping, household chores, phoning, participating in the community),
- and health-related functions.

*(Provider Tax Rules continued from page 4)*

Under the Medicaid payment test, a hold harmless arrangement exists if all or any portion of the Medicaid payment varies based only on the amount of the total tax payment. CMS is proposing to revise this rule to use the standardized terminology “tax amount,” and to add a clarification that a Medicaid payment will be considered to vary based on the tax amount when the payment is conditional on the tax payment. In that circumstance, the variation between a payment of zero and a positive payment would be based only on the payment of the tax amount.

Under the current third hold harmless test, the guarantee test, a hold harmless arrangement exists if there is a direct or indirect guarantee that holds taxpayers harmless for any portion of their tax cost. The rule would clarify this test to specify that a state can provide a direct or indirect guarantee through a direct or indirect payment. A direct guarantee will be found when a state payment is made available to a taxpayer or a party related to the taxpayer in the reasonable expectation that the payment would result in the taxpayer being held harmless for any part of the tax, and does not need to be an explicit promise or assurance of payment.

The regulations contain tests for hold harmless arrangements with respect to provider-related donations that are similar to those with respect to provider taxes. The rule proposes parallel revisions to these tests.

**FMI:** The NPRM is available in the Federal Register at <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/07-1331.htm>. 

“Assistance” can include hands-on assistance, supervision and/or cueing, as well as support in learning, maintaining and enhancing skills to accomplish the above activities. The legislation requires that the services be provided in the most integrated setting appropriate to the needs of the individual. CASS services would be:

- based on functional need, rather than diagnosis or age;
- provided in home or community settings like – school, work, recreation or religious facility;
- selected, managed and controlled by the consumer of the services;
- supplemented with backup and emergency attendant services;
- furnished according to a service plan agreed to by the consumer;
- and would include voluntary training on selecting, managing, and dismissing attendants.

The legislation allows consumers to choose among various service delivery models including vouchers, direct cash payments, fiscal agents, and agency providers. All models

*(Community Choice Act continued on page 6)*

## Public Citizen Report Finds State Medicaid Programs Deficient

Public Citizen has released a report finding that state Medicaid programs have severe deficiencies and suffer from a great disparity of coverage and eligibility from state to state. The report concludes that the federal Medicaid program is failing to deliver adequate services to millions of people because of differing state eligibility requirements, benefits, and performance. The report, “Unsettling Scores,” ranks the state-operated Medicaid programs and points out where each state is performing well or lagging with respect to the rest of the nation and accepted benchmarks for care. Along with the report, Public Citizen has released an online database that allows users to compare states for each of the categories studied.

The 10 state programs Public Citizen found most deficient have overall scores between 317.8 and 379.1 of the possible total of 1,000 points. The report’s worst, in order from 50 to 41, are: Mississippi, Idaho, Texas, Oklahoma, South Dakota, Indiana, South Carolina, Colorado,

(*Community Choice Act* continued from page 5)

Alabama, and Missouri. Five of the top-ranking states are in the Northeast, with three in the Midwest and two in the Northwest. The top 10 states, from 1 to 10, are: Massachusetts, Nebraska, Vermont, Alaska, Wisconsin, Rhode Island, Minnesota, New York, Washington, and New Hampshire.

Public Citizen ranked the states on the extent to which they surpass the already low federal mandates and divided the scores into four categories: eligibility, scope of services, quality of care, and provider reimbursement. The organization, working with independent Medicaid experts in academia and the private sector, assigned numerical values to score the states’ performance in the categories and weights to yield their overall score. The report updates a previous analysis conducted by Public Citizen in 1987, and uses 2004 and 2005 Medicaid data compiled by the Kaiser Commission on Medicaid and the Uninsured

(*Public Citizen* continued on page 7)

are required to be consumer controlled. For consumers who are not able to direct their own care independently, the Community Choice Act allows for an “individual’s representative” to be authorized by the consumer to assist them. A representative might be a friend, family member, guardian, or advocate. The act would also allow health-related functions or tasks to be assigned to, delegated to, or performed by unlicensed personal attendants, according to state laws.

The proposed law would provide funding to cover costs associated with transitioning individuals from a nursing facility or ICF-MR to a home setting, such as rent and utility deposits, bedding, basic kitchen supplies and other necessities. The bill would also provide an enhanced match (up to 90% Federal funding) for individuals whose costs exceed 150% of the average cost for an individual in a nursing home. Furthermore, between 2007 and 2011, after which the services become mandatory, the bill offers enhanced matches (10% more federal funds each) for states which:

- begin planning activities for changing their long term care systems, and/or
- include Community-based Attendant Services and Supports in their Medicaid State Plan.

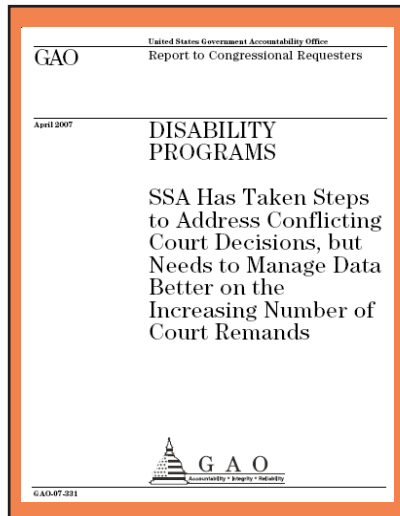
The bill also provides grants for Systems Change Initiatives to help states transition to a more strongly community-based system of services and supports, and calls for a national 5 -10 year demonstration project, in 5 states, to enhance coordination of services for individuals dually eligible for Medicaid and Medicare.

Thanks to the high price tag associated with the bill’s provisions, many observers feel that chances of passage are slim, with the Democrat-controlled Congress having adopted pay-go rules and focusing on balancing the budget.

**FMI:** To read the bill or track its progress, go to <http://thomas.loc.gov> and search for bill number S 799. ■

# GAO Examines SSA's Handling of Disability Determination Remands

The Government Accountability Office (GAO) has released a report assessing the Social Security Administration's (SSA's) handling of court decisions overturning the agency's disability determinations. GAO was asked by Congress to examine: (1) trends over the past decade in the number of appeals reviewed by the courts and their decisions, (2) reasons for court remands and factors contributing to them, and (3) SSA's process for responding to court decisions that conflict with agency policy. GAO reviewed SSA data and documents on court decisions, remands and SSA's processes and interviewed agency officials and stakeholders on data trends, reasons for remands, and SSA processes.



The report cites SSA officials and outside observers as asserting that a range of errors prompted by heavy workloads is responsible for court remands of SSA's disability determinations, but GAO discovered that SSA has only recently begun collecting data on remands, and not enough has yet been collected to establish the cause of most remands. GAO also points out that the information is collected by two different offices using different categories for the data, making some of the information inconsistent and possibly redundant.

GAO indicates that SSA has acknowledged the need to reduce remands and introduced new decision-writing templates to improve efficiency and reduce errors. The report also describes SSA's process for determining whether appellate court decisions conflict with the agency's interpretation of disability statutes or regulations, and the steps the agency has taken to align its national policies with appellate court decisions. In cases where the agency acceded to conflicting appellate court decisions by issuing acquiescence rulings within the related circuits, GAO found that about half of the rulings issued were eventually replaced with national policy. Moreover, GAO found that the timeliness of acquiescence rulings had improved since 1998, when SSA established a timeliness goal of 120 days.

**FMI:** The report is available online at <http://www.gao.gov/new.items/d07331.pdf>. ■

GAO found that between fiscal years 1995 and 2005, the number of disability appeals reviewed by the federal district courts increased, as did the proportion of decisions that were remanded to SSA for re-determination. According to the report, more disability claims were remanded than affirmed, reversed, or dismissed over the period, and the proportion of total decisions that were remands ranged from 36% to 62%, with an average of 50%. Remanded cases often require SSA to re-adjudicate the claim, and, GAO found, the majority of remanded cases result in allowances.

*(Public Citizen continued from page 6)*

(KCMU), as well as independent data gathered by Public Citizen, to determine state-by-state rankings.

States earned the lowest scores in the category measuring quality of care, which the report suggests is because they have not been required to measure quality in their Medicaid programs. Public Citizen compensated for this lack of information by looking at indicators that suggest quality care is being delivered to Medicaid patients, such as nursing home data about the number of nurses per resident on duty and childhood immunization rates for children.

**FMI:** The report is available at <http://www2.citizen.org/hrg/medicaid/>. ■

## Brief Examines Options for Covering Case Management in MFP Demonstrations

A new issue brief prepared by Robert L. Mollica of the National Academy for State Health Policy (NASHP) examines funding mechanisms states with Money Follows the Person (MFP) grants may use to cover case management as a part of supporting individuals in institutions to move to the community. The paper identifies five options states may use to cover case management under Medicaid:

- Targeted case management services;
- 1915 (c) home- and community-based waivers;
- Administrative activity;
- A component of another Medicaid service (e.g., home health); and
- 1915 (b) freedom of choice waivers.

and identifies the first three options as relevant to MFP Demonstration programs, describing each of the three and addressing their relative merits.

The first mechanism the paper delves into is targeted case management (TCM). Mollica points out that states may define nursing home residents as a target population for TCM, and that TCM activities may be paid by the state to the provider prior to the date the individual becomes a waiver participant. In fact, states may claim FFP for TCM activities prior to the individual leaving the nursing home and becoming a waiver participant, and the individual need not ever be enrolled in a waiver for the state to claim FFP, as long as they are placed outside of the institution.

On the other hand, Mollica writes, The Centers for Medicare and Medicaid Services (CMS) is preparing regulations that will implement clarifications to TCM in the Deficit Reduction Act (DRA), and “some states report being cautioned that TCM state plan amendments will receive greater scrutiny than in previous years and other options may be approved more quickly.” Until the regulations are issued, Mollica suggests, states might consider covering case management as an administrative activity and submitting a state plan amendment at a later date. Mollica also points out that states may not limit access to providers of TCM services, except with regard to target

groups that consist entirely of persons with developmental disabilities or individuals with chronic mental illness, in which case the state may limit the providers of TCM to ensure that case managers are capable of ensuring that needed services are actually delivered to these vulnerable populations.

Mollica then addresses funding case management under 1915 (c) home- and community-based services (HCBS) waivers. He indicates that case management services provided under a waiver are reimbursed at the state’s Federal Medicaid Assistance Percentage (FMAP) rather than the administrative rate which may be lower than the FMAP. According to the brief, waiver case management activities can include arranging, and coordinating access to services that are not covered by Medicaid such as housing and food stamps. Case management activities may be provided under the waiver up to 180 days prior to the date the person becomes a waiver participant, Mollica writes, and unlike TCM, states may establish qualifications for providers of case management services to people in nursing homes that includes prior experience serving this population.

Unfortunately, under HCBS waivers, states may not limit providers of case management to a single individual or entity, and reimbursement may be claimed only when the person becomes a recipient of waiver services. Case management services provided to nursing home residents who do not leave the nursing home cannot be reimbursed. Mollica also indicates that states that have a waiting list for waiver services would not be able to claim Federal Financial Participation (FFP) for waiver case management services provided to a person who was able to move because other supports were available but did not use Medicaid waiver services.

The brief then examines the advantages and disadvantages of claiming case management as an administrative activity. Under this option, Mollica suggests, states may limit providers of case management activities which may be

*(Issue Brief continued on page 9)*

## Clinton and Allard Introduce Autism Services Bill

Senators Wayne Allard (R-CO) and Hilary Clinton (D-NY) have introduced the Expanding the Promise for Individuals with Autism Act of 2007. This legislation, if passed, would provide approximately \$350 million to improve access to comprehensive treatments, interventions, and services for individuals with autism and their families.

The proposed legislation aims to:

- convene a task force to evaluate and report on evidence-based biomedical and behavioral treatments and services
- provide \$80 million over 4 years to establish a State based demonstration grant program to provide evidence-based autism treatments, interventions, and services, as identified by the Task Force.
- Provide \$40 million to protection and advocacy (P&A) systems to address the needs of individuals with autism and other emerging populations of individuals with disabilities.
- provide \$60 million to expand access to treatments, interventions, and services to children with autism, with the goal of providing and coordinating multi-agency, intensive, and comprehensive, evidence-based treatments, interventions and services.
- provides \$77 million in supplemental grants to University Centers of Excellence for Developmental Disabilities to provide training, technical assistance, dissemination, and services.
- provide \$85 million to establish a grant program that includes a one-time, single year planning grant and a multiyear service provision demonstration grant program to increase access to appropriate services for adults living with autism.
- require the Comptroller General of the United States to release a report that examines financing for autism services, current policies for public and private health insurance coverage, disparities in provision of services, and ways in which to improve financing of autism treatments, interventions, and services.
- provide \$10 million to establish and maintain a national technical assistance center to gather and disseminate information about autism treatments, interventions, and services, provide technical assistance, and establish and maintain a website.

**FMI:** A summary of the bill is available at [http://asa.convio.net/site/DocServer/2007\\_IWA\\_Act.pdf?docID=5521](http://asa.convio.net/site/DocServer/2007_IWA_Act.pdf?docID=5521). ■

*(Issue Brief continued from page 5)*

important in states that use single entry point agencies to facilitate access to services. As with the other options, services may be claimed prior to the individual leaving a nursing home and becoming a waiver participant, but unlike the waiver option, they may also be reimbursed prior to the individual entering the waiver program. Furthermore, case management furnished as an administrative expense may be eligible for FFP even if the person is not eventually served in the community because the service is performed in support of the proper and efficient administration of the State plan.

However, Mollica points out, only case management activities related to assisting an individual to gain access to services covered by the Medicaid state plan or HCBS waiver may be reimbursed as an administrative activity. Furthermore, services are reimbursed at the administrative rate (50% of case managers, or 75% for services provided by registered nurses) which may be lower than the FMAP for non-administrative services.

**FMI:** The issue brief is available online at [http://www.hcbs.org/files/107/5335/TCM\\_update\\_2007.pdf](http://www.hcbs.org/files/107/5335/TCM_update_2007.pdf). ■

# KFF Examines Challenges of Aging Out of EPSDT

The Kaiser Family Foundation (KFF) has released an issue brief discussing the challenges and implications for young people with disabilities when they become adults and lose their Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage. The brief focuses on those children with severe disabilities who, if they maintain Medicaid coverage as adults, will do so on the basis of their disability.

Among the challenges KFF identifies for adults aging out of EPSDT coverage is more limited access to services. While EPSDT mandates comprehensive coverage of medical and long-term care services for children, the brief emphasizes that the terms of Medicaid coverage change markedly once children reach adulthood, providing much more limited access to services. The brief points out that enrollment caps and other state restrictions associated with home- and community-based services (HCBS) waivers limit the access of adult Medicaid beneficiaries with disabilities to services that are critical to maintaining function and maximizing independence.

KFF suggests that the greatest threat facing young adults with disabilities as they lose EPSDT coverage is “the threat of institutionalization, or of having basic health and daily

living needs go unmet if they remain in the community without [sufficient] services and supports.” Although the authors acknowledge that recent policy changes have improved the availability of support in the home- and in community-based settings, they argue that access to these services remains limited, and, without such services, many young adults have no other choice but to

move into an institution or have some of their most basic needs go unmet while living in the community. Waiting lists, the brief indicates, are “a particular problem for programs targeting younger adults because turnover is minimal.” According to the brief, some states have addressed this problem by placing children who will likely need HCBS as adults on waiting lists at ages as young as 14 so that by the time they become adults they will have risen to the top of the waiting lists and will become eligible for the services.

**FMI:** The report is available at <http://www.kff.org/medicaid/upload/7491.pdf>. #



# GAO Strategic Plan Includes Evaluation of Long-Term Care

The Government Accountability Office has released a Strategic Plan that includes, as one of seven health-related goals, evaluating federal and state program strategies for financing and overseeing long-term health care. While the strategic plan’s discussion of long-term care focuses on the elderly population, several planned nursing home and community-based care audits may have an impact on service systems for individuals with developmental disabilities.

GAO plans to examine nursing homes’ compliance with federal and state quality standards, including the “adequacy of federal and state oversight and resources.” The watchdog agency also plans a review of federal requirements and standards and their use to ensure quality care in community-based, long-term care settings, such as home health arrangements, assisted living facilities, and adult day care. A third audit will analyze public and private payment sources and strategies that finance the continuum of long-term care, including integrated programs for elderly or disabled beneficiaries who are dually eligible for Medicare and Medicaid.

**FMI:** The strategic plan is available online at <http://www.gao.gov/new.items/d071sp.pdf>. #

## Study Examines Reasons for Low Medicaid Enrollment Among Low-Income Children with Special Health Needs

The Urban Institute Health Policy Center in Washington, DC has released a study examining potential barriers to enrollment in public programs among low-income children with special health care needs who are uninsured. The center considered such barriers as



lack of knowledge among parents about the Medicaid and State Children’s Health Insurance programs (SCHIP), possible belief among parents that their child is not eligible for public coverage, perception that the enrollment process is difficult, and hesitance to enroll their child in a public program.



The study found that many low-income parents with uninsured children with special health care needs do not have full information about Medicaid and SCHIP or do not have positive perceptions of the application processes. Although 93.5% had heard of at least one of the two programs, only 54.6% believed that their child was eligible for public coverage, and just 48.1% believed that the application processes were easy. Almost all said that they

would enroll their child if told he or she was eligible for public coverage.

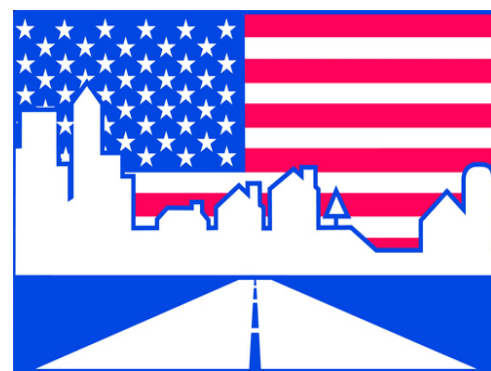
The study obtained data from the 2001 National Survey of Children with Special Health Care Needs. A series of five questions about the child’s health needs, known as the Children with Special Health Care Needs Screener, was used to identify children with special health care needs. Uninsurance is defined as having no insurance coverage at the time of the survey, and low-income families are defined as those with household incomes below 200% of the federal poverty level. The analytic sample consists of 968 low-income uninsured children with special health care needs. The study authors examined the socioeconomic and demographic characteristics of the sample, the reasons the children lack coverage, and the awareness and perception measures, both individually and combined as a summary measure.

**FMI:** The study is available online (for a fee) at <http://pediatrics.aappublications.org/cgi/content/full/119/1/60>. #

## NFI Conference Presentations Available Online

Presentations from the 7th Centers for Medicare and Medicaid Services (CMS) New Freedom Initiative (NFI) Conference, held March 5-7 in Baltimore, are now available online in both PDF and text formats. The 2007 conference was titled “Access to Community Living: Promoting Independence and Choice” and focused on the policies, programs, and tools -including opportunities authorized by the Deficit Reduction Act– available to shape and carry out a vision of “Choice and Independence” as a key pillar of a person-centered long term services and supports system for the future.

**FMI:** The presentations are available at [http://www.nashp.org/\\_catdisp\\_page.cfm?LID=EF15BBC8-AF14-4F12-9534B1F025AD7AB1&CFID=775705&CFTOKEN=93802691](http://www.nashp.org/_catdisp_page.cfm?LID=EF15BBC8-AF14-4F12-9534B1F025AD7AB1&CFID=775705&CFTOKEN=93802691). #



NEW FREEDOM INITIATIVE CONFERENCE

## KFF Issues Primers on Medicare and Medicaid

The Kaiser Family Foundation (KFF) has issued a new primer on the Medicare program and updated its primer on the Medicaid program. Prepared by Foundation staff, the primers provide an overview of the programs, who they serve, how the programs work, and how they are financed.

*Medicare: A Primer* explains key elements of the Medicare program, examining the characteristics of the Medicare population, what benefits are covered, how much people with Medicare pay for their benefits and the program's overall costs and future financing challenges. It also provides information about the Medicare Advantage program and the Medicare Part D drug benefit, and includes detailed tables showing the number of Medicare beneficiaries in each state, broken out by age, income

level, source of drug coverage, and by enrollment in Medicare Advantage plans.

*Medicaid: A Primer* provides an overview of the basic components of Medicaid, exploring the structure of the program, who it covers, what services it provides, and spending. Tables examining the state-to-state variation in eligibility, enrollment, and spending for Medicaid enrollees are included in the primer.

**FMI:** The Medicare primer is available at <http://www.kff.org/medicare/7615.cfm>. The Medicaid primer is available at <http://www.kff.org/medicaid/7334-02.cfm>. For additional information, please Craig Palosky at (202) 347-5270 ([cpalosky@kff.org](mailto:cpalosky@kff.org)) or Rakesh Singh at (202) 347-5270 ([rsingh@kff.org](mailto:rsingh@kff.org)). ■

### Mark Your Calendars...

## NA\$DDDS 2007-2008 Meetings Schedule



2007  
National Policy Forum  
September  
Baltimore, Maryland

2007 Annual Meeting  
November 7-9  
Raddison Hotel-Old Town  
Alexandria, Virginia



2008  
Mid-Year Meeting  
May  
Nashville, Tennessee

2008  
Reinventing Quality Conference  
August  
Denver, Colorado



Additional Information Will Be Posted on the NA\$DDDS Website as it Becomes Available