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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. list	Clearance information re Foster Care Emancipation [event] (partial) (3 pages)	11/16/1998	P6/b(6)
002. list	Clearance information re Foster Care Emancipation [event] (partial) (2 pages)	11/16/1998	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Domestic Policy Council (Nicole Rabner)
OA/Box Number: 15410

FOLDER TITLE:
Emancipation-Interagency Issue [1]

2012-1035-S
kc998

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

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Foster children over 18 need our support, too

I met the most extraordinary young woman last week. Joy Warren had just begun her first week at Yale Law School. But what's remarkable is that Joy grew up in foster care, and like more than 20,000 foster-care children each year, she "aged out" of the system when she turned 18.

This means Joy has been entirely on her own, without the traditional support system so many families provide, for the past seven years — years in which she managed to receive a college degree, work as an advocate to improve foster care and begin law school.

Children who grow up in foster care face many of the same challenges as other children and have many of the same needs. But they also have special challenges that demand special attention — and too often they just don't get it.

One 13-year-old foster child told me what she wants most: "I want a place that I can call home; a room that I can call my room; a family that I can love and would love me back." Is this too much to ask?

Although my own mother was never in formal foster care, her teen parents were unable to care for her when she was born. They sent her to live with her grandparents, but when that didn't work out, she went to live in the home of a family where she helped take care of the children for room and board.

My mother has often told me how grateful she is to the woman with whom she lived because she got to see what a real family was like. She watched what happens inside a home where parents and children go through all they should go through as a family. And she wanted to pass that opportunity on.

When I was growing up, she invited young women from a group home to come and work for us, spending time with our family, much as my mother had done so many years before.

I'm proud that this administration has cared enough to improve and reform our nation's foster-care system, including passing the Family and Medical Leave Act, which gives time off for parents to adopt a child. Tax credits are now available for families who adopt, and foster care and adoption have been freed from discrimination and delays based on race, culture and ethnicity.

I was especially proud when, last year, the president signed the Adoption and Safe Families Act of 1997, a historic step toward improving the lives of children in foster care. The aim of this bill is to place this country's 500,000 foster-care children in safe, stable, loving and permanent homes. And it will help us meet our national goal of doubling the nation's annual adoption rate.

But, as important as this bill is, it doesn't address all the needs of the children who "age out" of the system each year and who, like Joy Warren, have to make the tough transition to living on their own.

Last year, at a roundtable in Berkeley, Calif., I spent an afternoon listening to young people describe the challenges of leaving the foster-care system. A disproportionate number are homeless and have trouble finishing school, finding jobs and receiving adequate health care. And, often, they don't get the life skills they need to survive in today's world.

There are many programs that work, several of which exist as a result of the advocacy and leadership of former foster kids like Joy. One national conference, Destination Future, where I met Joy last week, brings together older foster children and homeless young people to teach them life skills and advocacy techniques. Programs in Texas and Florida provide college-tuition assistance for young people in foster care. In Los Angeles County, set-aside entry-level jobs are available for young people aging out of foster care. Massachusetts has a teen parent transitional living program. And the California Youth Connection has become a national model of how to bring young foster teens together to form a network of support and advocacy.

One of the most critical challenges remaining is to make sure that children who age out of foster care gain access to health care. It is outrageous that these young people should find themselves among the uninsured. Some states are addressing this issue, but there is still far to go.

We must also strengthen the Federal Independent Living Program, which provides 85,000 young people critical assistance in their transition to independent living, helps them earn their high school diplomas and offers access to vocational training.

Federal legislation and state programs have put us on the right track. But we must do better. Now is the time to make sure that the 20,000 young people who each year become too old to remain in foster care receive the help they need to become independent and productive members of society.

• *To find out more about Hillary Rodham Clinton and read her past columns, visit the Creators Syndicate Web page at www.creators.com.*

The Washington Times
THURSDAY, SEPTEMBER 24, 1998

U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT
WASHINGTON, D.C. 20410-7000

OFFICE OF THE ASSISTANT SECRETARY FOR
COMMUNITY PLANNING AND DEVELOPMENT

DATE: December 8

MEMORANDUM TO: Nicole Rabner, Associate Director for Domestic Policy

FROM: Fred Karnas, Deputy Assistant Secretary, Department of Housing and Urban Development

SUBJECT: HUD's Initial Response to the Issue of Youth Aging Out of Foster Care.

Attached is our initial effort to respond to your request for ideas regarding how the Department of Housing and Urban Development could help in the effort to better respond to youth aging out of the Foster Care system. We will continue to review HUD's programs to determine if additional mechanisms exist for assisting this population.

Please do not hesitate to contact me at 202/708-1506 (x-4621) if you have questions.

12/8/98

Children Aging Out of Foster Care

Response from the Department of Housing and Urban Development

Each year, approximately 17,000 youth in the Foster Care system reach the age of 18 and are no longer eligible for system benefits. Among the nearly 60,000 youth between the ages of 18 and 21 who fall in this category are many who, because they lack the basic support system, fall victim to homelessness and/or a variety of other health and social problems.

Mrs. Clinton has requested ideas from across the Federal government for addressing this problem. Below, are some ideas for actions the Department of Housing and Urban Development can take to respond to this issue.

1. The Department will consider adding language to Consolidated Planning guidance (which will be updated in 1999) encouraging communities to plan for youth aging out of Foster Care as they develop their Consolidated Plan for housing and community development. Since this plan is key to obtaining billions of dollars in Community Development Block Grant and HOME affordable housing funding, communities should respond positively.

2. The Department will issue a Directive to HUD Field Offices across the nation highlighting the need to respond to this problem, and encourage Field Offices to work with local communities to consider ways of increasing housing resources for this population. It should be noted that at least one HUD Community Builder, in New Jersey, is already involved in convening a diverse community planning group to address this issue.

3. HUD will seek to identify "best practices" among its state and local partners (state and local governments and non-profits) who may be providing important services to this population, so that information can be shared with partners across the nation and replicated.

4. For those youth aging out of the Foster Care system who find themselves homeless, the Department has included language in the 1999 Notice of Funding Availability (NOFA) encouraging communities to include "persons knowledgeable on this issue in the planning process and ensure that your Continuum of Care system adequately addresses this need." Among other criteria, each Continuum of Care is scored based

on the extent of their inclusion of identified sub-populations in local planning. This requirement will be an incentive for inclusion of persons who can provide education and guidance regarding this problem to the local homelessness assistance planning process.

HUD will continue to review its programs to determine other possible ways that the tools and resources of the Department can be brought to bear on the issue of youth aging out of Foster Care.

Deborah Baker
11/30/98 11:36:28 AM

Record Type: Record

To: Nicole R. Rabner/WHO/EOP

cc:
Subject: Agency Responses

Nicole, I thought you might like to know where we were in trying to obtain a response from the various agencies. I provided email addresses where I could.

debbie

Monday, November 16th, 1998 4:00PM - 5:30 PM
Foster Care Emancipation Agency Responses

Carol Williams
Department of Health and Human Services
Phone: 205.8618
Fax: 260.9345
EMAIL:

--left message with assistant, Francis

Pamela Johnson
Department of Health and Human Services
Phone: 205.8086
Fax: 260.9333
EMAIL: pjohnson@asc.dhhs.gov

-- Carol and Pamela are both working on putting something together as soon as possible (11/25)

Sheldon C. Bilchik
Shay Bilchik
Department of Justice
Phone: 307.5911
Fax: 307.2093
EMAIL: bilchik@ojp.usdoj.gov

--left message with secretary (11/25)

Sarah Ingersoll
Department of Justice
Phone: 616.3650
Fax: 307.2093
EMAIL: ingersol@ojp.usdoj.gov

--left message (11/25)

Gina Wood
Department of Justice
Phone: 307.5911
Fax: 307.2093
EMAIL: woodg@ojp.usdoj.gov

--left message with secretary (11/30)

Maureen McLaughlin
Department of Education
Phone: 205.2987
Fax: 401.5749
EMAIL:

--left a message on voice mail (11/30).

Lynn Jennings
Department of Labor
Phone: 219.6197
Fax: 219.9216
EMAIL:

--Will be back on Tuesday; left message (11/30)

Fred Karnas
Department of Housing and Urban Development
Phone: 708.1506
Fax: 401.8939
EMAIL: fred_karnas@hud.gov

--Will try and send information as soon as possible (11/25)

Deborah Jospin
Corporation for National Service/AmeriCorps
Phone: 606.5000 ext 287
Fax: 565-2787
EMAIL: djospin@cns.gov

--left message with assistant (11/30)

John Gomperts
Corporation for National Service/AmeriCorps
Phone: 606.5000 ext 121
Fax: 565-2784

--left message on voice mail (11/30)

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[001]

Clearance Information for Monday, November 16th, 1998 4:00PM - 5:30 PM
Staff member: Nicole Rabner
RE: Foster Care Emancipation

Carol Williams
Department of Health and Human Services
DOB:
SS#: P6/(b)(6)

Phone: 205.8618
Fax: 260.9345

Gilda Lambert
Department of Health and Human Services
DOB:
SS#: P6/(b)(6)

Phone: 205.8085
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Sheldon C. Bilchik
Shay Bilchik
Department of Justice
DOB:
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Phone: 307.5911
Fax: 307.2093

Sarah Ingersoll
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Lynn Jennings
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SS#: P6/(b)(6)

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Fred Karnas
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[001]

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Phone: 606.5000 ext 287
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John Gomperts
Corporation for National Service/AmeriCorps
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SS#: P6/(b)(6)

Phone: 606.5000 ext 121
Fax: 565-2784

Draft Discussion Paper
Transitional/Independent Living Programs

Background

There is a growing number of adolescents aging out of the foster care system who are presenting communities with significant challenges. These challenges are similar to those presented by other, older teens at greatest risk, including youth offenders. Adolescents in foster care are a troubled population, particularly at risk. Without intervention, many of these troubled youth end up in the juvenile or criminal justice system. The following statistics describe a stratified sample of foster care youth at age 18 and are from a study (Westat, 1991) completed for the Department of Health and Human Services (HHS).

Sample of Foster Care Youth at Age 18

— 2/3 of 18 year olds did not complete high school or obtain a GED
— 61 % had no job experience
— 17% had drug abuse problems
— 17% of the females were pregnant

Two and ½ to four years later, the status of these young adults had not improved:

Sample of Foster Care Youth 2 ½ to 4 Years Later

— 46% still had not completed high school
— 51 % were unemployed
— 40 % were a cost to communities (they were either dependent upon the welfare system or involved with the justice system)
— 60% of the women had one child
— only 17 % were completely self-sufficient

Not surprisingly, the same study indicated that providing these youth a combination of services, supports and opportunities in three core areas --employment, education and consumer and fiscal skills management --greatly increased their positive outcomes and the likelihood for self-sufficiency and satisfaction with their lives. By way of example, a typical young woman who ages out of foster care has a 22% likelihood of holding a steady job for three years. Providing services in one of the core areas increases that probability to 40%; providing services in all three core areas increases the probability to ***95%!***

Easing the transition to self-sufficiency for older teens in the child welfare system is an area with implications for the juvenile justice system --and an area to which the juvenile justice field can contribute ideas and examples of promising practices.

Delinquency Prevention

Youth development is one of a number of critical prevention strategies and is an essential

component of what must be done to prepare *all* young people for adulthood. Youth must be provided opportunities to engage in positive activities and to develop constructive skills. In addition, adequately educating youth and providing employment and job training opportunities are critical to delinquency prevention and to transitioning youth alike.

School-to-Work programs make use of alternative schools or develop ties to the business community to provide academic and job training that addresses youths' needs and interests.

Mentoring --programs that seek to ensure that children and youth have caring adults in their lives --is another delinquency prevention strategy which has application to transitioning foster care youth. Practitioners who work with these older teens agree that adult involvement in the lives of these children makes all the difference in the world. Some of the statistics from a Public/Private Ventures evaluation of Big Brothers/Big Sisters mentoring indicate:

Youth with Big Brothers or Big Sisters were:
46% less likely to start using illegal drugs
27% less likely to start drinking alcohol
32% less likely to hit someone
52% less likely to skip a day of school

Also, through the Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Juvenile Mentoring Program, more than 6,000 at risk youth in 25 states --youth who are Hispanic, incarcerated, on probation, in foster care, among others --are receiving the one-to-one mentoring from people in all walks of life to keep them in school and off the streets.

Another intersection between delinquency prevention and transitioning older foster care youth is aftercare. Providing continuing support for youth is a strategy that is needed whether the youth are leaving a juvenile facility, day treatment program or foster care. To expect that a young person has been adequately prepared by our educational, juvenile or foster care systems to be completely self-sufficient at the age of majority is an unreasonable expectation. Transitioning youth will need follow up support services for months --perhaps years --after they leave foster care.

Coordination with OJJDP Activities

OJJDP is currently funding a pilot aftercare project and evaluation in four sites --the Intensive Aftercare Program for High Risk Youth --which is designed to reintegrate youthful offenders back into their communities. What is different about this aftercare program from many others is its emphasis on integrated case management, pre-release planning for the transition back to the community, and the intensive monitoring and support provided the young person. All of these components make this program well suited for use with foster care youth. OJJDP is supporting programs of this type through the state formula grant program and through several other demonstrations and community-based programs including SafeFutures, Serious, Violent and Chronic Juvenile Offender programs and the

Comprehensive Strategies sites.
These OJJDP efforts are some of those that carry out the strategies suggested by the HHS research on outcomes related to transitioning to independent living. Preparing older teens in the foster care system for self sufficiency requires providing the same type of supports and opportunities that all youth need to become competent, productive adults. Working with this population, however, requires more intensive efforts than for youth not at risk, and increased coordination among the various public and private institutions that touch or affect youth in foster care.

Selected Program Strategies

Key program strategies to ensure success include education and job training programs, mentoring and aftercare or follow-up support services. Those are specific programs or initiatives. There is another level of effort also needed to ensure success with these youth, and that is to foster connections among agencies. One linkage that is critical is the one between dependency courts and human or social services agencies. Three of the model courts associated with the National Council of Juvenile and Family Court Judges' dependency court reform project are courts in Hamilton County, OH, Alexandria, VA and Chicago, IL with the primary goal to implement innovative and effective approaches in handling child abuse and neglect cases. Also to develop and strengthen their relationships with social services. Specifically, the Chicago dependency court model is developing a Transitional Living Program component for foster care children as one of their three primary goals this year.

Also, the Court Appointed Special Advocates volunteers often play a fundamental role. They facilitate cross-agency linkages though the work they do in obtaining services for the children they represent from multiple agencies.

Linkages need to be made at all levels to improve employment opportunities for high risk youth and juvenile offenders. OJJDP has partnered with the Employment and Training Administration of the Department of Labor to link employment/training and juvenile justice systems at the local, state and federal levels. In connection with this effort, both agencies are funding the Home Builders Institute, a recognized leader in vocational training for youth. Home Builders Institute operates nationwide training programs in residential construction for youth and adult offenders, similar to the Job Corps program. In addition, the Home Builders Institute's training for juvenile offenders boasts a ninety-four percent placement rate of graduates. Such successes can also be anticipated where this training is made available to transitioning foster care youth.

Possible Next Step

Facilitate a discussion among the appropriate federal agencies to further explore opportunities to coordinate efforts to enhance support to older youth in transition from foster care. Also, clearly identify the population of youth in transitional and independent living programs. Often these young people are identified as runaway and homeless youth, however

their specific needs and support services are slightly different.

Independent Living
Memo for Inter-Departmental Meeting

Each year approximately 17,000 18 year olds "age out" of the public child welfare system and are expected to function as adults. These young adults entered foster care due to abuse and neglect. They were unable to return to their birth families and did not find permanency with an adoptive family. Federal financial support to them ends just at the time they are making the critical transition to adulthood.

A proportion of these children are supported by two HHS programs:

The Independent Living Program (ILP) provides funds to the States that may be used to provide services to foster children who are 16 year of age or older to help them make the transition to independent living by supporting them as they earn a high school diploma; receive vocational training and education; and learn daily living skills such as budgeting, career planning and securing housing and employment. The types of services vary from State to State and may not be used for room or board.

The Transitional Living Program (TLP) provides funds to local community based organizations for residential care, life skills training, and other support services to homeless adolescents, ages 16-21. These programs help these youth achieve self-sufficiency, avoid long-term dependency on social welfare, and become independent, productive members of society.

Both ILP and TLP service providers are encouraged to support young people through a youth development approach which suggests that the best way to prevent young people's involvement in risky behavior is to help them achieve their full developmental potential. Youth development strategies, therefore, focus on giving young people the chance to exercise leadership, build skills, and become involved in their communities.

Like all young adults those leaving the foster care system need support to achieve an effective passage to adulthood. Unlike most, their lives have been chaotic and unpredictable. Maltreatment, lack of connection to families, multiple placements, and the resulting mental health and educational consequences, make the transition to self sufficiency and adult-functioning very difficult. Research documenting the experiences of these youngsters in the years immediately following foster care identifies unstable housing and homelessness, depression, poor health, violence and incarceration as part of their experience.

The support these youngsters need to achieve self-sufficiency, stable living arrangements and mature relationships includes:

Medical services, including mental health;
Education and/or vocational training;
Employment preparation and opportunities, including internships;
Transitional and/or supported housing; and
Psycho-social support via mentorship, counseling and/or or support groups.

- **Nationwide Housing Discrimination Audit:** On November 16, HUD announced the most comprehensive and sophisticated nationwide audit ever conducted to root out housing discrimination in urban, suburban, and rural communities around the nation. The audit will include 3,000-5,000 tests for housing discrimination. It will use African Americans, Hispanics, Asia-Pacific Islanders, and Native Americans to examine and evaluate patterns and trends in housing sales, rentals, and mortgage lending to minorities.

- **Youthbuild:** HUD is awarding $33.1 million this month to local governments, housing authorities and non-profit groups to train high school drop-outs in the Youthbuild program. Youthbuild helps young people get general equivalency high school diplomas and provides social services and training in leadership skills, in addition to training as construction workers. By building and renovating low-income housing, the participants simultaneously earn a solid wage as construction workers and provide housing for people in need. More than 850 affordable houses and apartments will be built or renovated this year. Over $170 million in grants have been made under Youthbuild since it began in 1993, enabling over 7,800 young people to take part in building or rehabilitating more than 3,650 affordable housing units in their communities.

Set aside Special grant to kids aging out? →

DEPARTMENT OF TRANSPORTATION

- **Possible Federal Express Pilot Action:** On November 13, in response to the ongoing Federal Express pilot labor discussions, the FAA increased safety oversight of Federal Express, in accordance with established inspection procedures for carriers involved in labor discussions. There was no evidence of safety-related concerns during the FAA inspection and surveillance process. Both parties continue talks with the National Mediation Board (NMB). On November 16, discussions began with Federal Express and the NMB. A strike vote is expected on December 3.

- **Central America Relief Efforts:** On November 10, Coast Guard Cutter SENECA delivered more than one ton of food and clothing for victims of Hurricane Mitch in Honduras, donated by personnel stationed at Naval Station Guantanamo Bay, Cuba. On November 12-15, three Coast Guard C-130s delivered more than 36 tons of plastic sheeting, water, and food to Tegucigalpa and La Masa, Honduras. The Coast Guard also provided search and rescue assistance to Belize in connection with a missing sailing vessel. The Federal Highway Administration identified a technical team to assess highway and bridge damage and pinpoint the most critical links for repair or reconstruction.

- **Millennium Trails Initiative:** On November 13, Secretary Slater announced nearly $4 million in projects for the National Millennium Trails Initiative. Through the Federal Highway Administration's Federal Lands Highways discretionary program, nine states received funds, including AZ, CA, ID, WA, NY, MA, RI, SC, and WY.

November 10, 1998

MEMORANDUM FOR DISTRIBUTION

FROM: **NICOLE RABNER**
DOMESTIC POLICY COUNCIL

SUBJECT: **Meeting on Foster Care Emancipation Issues**

Please join a discussion on Monday, November 16th, about emancipation from foster care. As many of you know, when young people in foster care turn 18, federal foster care assistance ends and they begin an often difficult transition to independence. While there are some federal assistance programs run by the Department of Health and Human Services that target this population, they are small in scale.

The purpose of this meeting is to explore better targeting of existing resources to serve this vulnerable population. As I have mentioned to many of you on the phone, we hope to develop an interagency initiative in this area.

To the extent possible, please come to the meeting prepared to discuss the programs administered by your agency that affect these young people and your agency's possible contributions to an initiative that targets new and ongoing resources to serve them. Attached is a background piece on this issue prepared by the Department of Health and Human Services and a recent column by the First Lady.

The meeting will take place on Monday, November 16th, at 4:00pm in Room 100 of the Old Executive Office Building. Please call Deborah Baker at 456-5582 to confirm your attendance and provide clearance information (date of birth and SSN). I look forward to seeing you next Monday. Thanks very much.

DISTRIBUTION:

Carol Williams, Department of Health and Human Services
Gilda Lambert, Department of Health and Human Services
Shay Bilchik, Department of Justice
Sarah Ingersoll, Department of Justice
Maureen McLaughlin, Department of Education
Lynn Jennings, Department of Labor
Fred Karnis, Department of Housing and Urban Development
John Gomperts, Corporation for National Service
Tess Scannel, Corporation for National Service
Jennifer Klein, White House Domestic Policy Council
Trooper Sanders, Mrs. Gore's Office

Recommendations to Improve Transition Process of Foster Care Youth to Independence

Increased Focus on and Expansion of Independent Living Programs

- Mandatory Independent Living programs for foster youth-- programs should be mandated and monitored closely by social workers
- Minimum standards should be set at the federal level for these programs instead of leaving the entire design to state and local agencies
- Facilitate information sharing among states
- Send kids to IL programs at an earlier age and extend service to a later age (i.e 14-21)
- Integrate IL programs with school to work programs
- Employ full-time independent living coordinators in all states
- Provide technical assistance for states advocates, and legislatures to improve utilization of IL resources and to make them aware of other possible resources
- Train all foster parents, care givers, and service providers in independent living skills
- Develop curriculum and make available to states who do not have their own

Housing

- Guarantee to find safe, affordable housing
- Create supervised transitional housing for older foster youth

Educational Advocacy

- Financial assistance for post secondary education (i.e. create national scholarship fund)
- Help with college applications and college visits
- School stability
- Testing for developmental disabilities
- State university/community college tuition waivers
- Target outreach for foster youth at colleges and universities

Develop Mentor Program (to provide youth with positive role models, tutoring, community connections, etc.)

Employment

- Provide more work experience opportunities at an earlier age
- Organize and provide job resource center/job fairs/job coaches

- Form partnerships with business community/private industry-- encourage companies, private sector businesses, etc. to provide meaningful employment for foster youth
- Provide workshops on interview skills, role-playing interviews, designing resume, etc.
- Encourage job programs to give priority to foster youth

Foster Care Youth Involvement

- State and local child welfare agencies should develop low-cost means for youth to meet one another at conferences, picnics, etc.-- reduce stigma and isolation associated with being a foster child
- Post-care alumni mentoring-- have former foster youth teach the system to current youth so that they can take advantage of everything being offered
- Toll-free hot line for youth-- peer support/encouragement/advice
- Involve current and former foster youth in all decisions and policy making
- Create long term support program-- monthly support groups, etc.

Raise Age of Emancipation/Extend Services

- Extend emancipation to age 21 so that foster youth can continue to receive financial support
- Provide low or no interest loans to those who need additional assistance upon leaving foster care during their initial2 years of independence
- Coordinate network of services to youth after leaving care including health care, transportation, and child care

Funding

- Identify states not using full allotment of money
- Allow more flexibility with IL funds including allowing private agencies to have access
- Allocate more funds to housing
- Earmark federal job-training funds specifically to help foster children develop job skills

Evaluation of all Independent Living Programs

- Develop performance and outcome measures
- Gather research on effective programs

BRIEF SUMMARIES of MEDICARE & MEDICAID

Title XVIII and Title XIX of The Social Security Act

as of June 25, 1998

(incorporating the impacts from the Balanced Budget Act of 1997)

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NOTE:

The following are very brief summaries of complex subjects. They should be used only as overviews and general guides to the Medicare and Medicaid programs. The views expressed herein are those of the author, and do not necessarily reflect the policies or legal positions of the Health Care Financing Administration or DHHS. These are not legal documents, nor are they intended to fully explain all of the provisions or exclusions of the relevant laws, regulations and rulings of the Medicare and Medicaid programs, nor of the relationship between these programs. These summaries do not render any legal, accounting or other professional advice, and should not be relied on in making specific decisions. Only original sources should be utilized.

BACKGROUND

Since early in this century, health care issues have continued to escalate in importance for our Nation. Beginning in 1915, various efforts to establish government health insurance programs have been initiated every few years. From the 1930s on, there was agreement on the real need for some form of health insurance to alleviate the unpredictable and uneven incidence of medical costs. The main health care issue at that time was whether health insurance should be privately or publicly financed.

Private health insurance coverage expanded rapidly during World War II, when fringe benefits were

increased to compensate for government limits on direct wage increases. This trend continued after the war, in part due to the favorable tax treatment of providing compensation in the form of fringe benefits. Private health insurance (mostly group insurance financed through the employment relationship) was especially needed and wanted by middle-income people. Yet not everyone could obtain or afford private health insurance. Government involvement was sought. Various national health insurance plans, financed by payroll taxes, were proposed in Congress starting in the 1940s; however, none was ever brought to a vote.

In 1950, Congress acted to improve access to medical care for needy persons who were receivingpublic assistance. This permitted, for the first time, Federal participation in the financing of State payments to the providers of medical care for costs incurred by public assistance recipients. In 1960, the Kerr-Mills bill provided medical assistance for aged persons who were not so poor, yet still needed assistance with medical expenses. But a more comprehensive improvement in the provision of medical care, especially for the elderly, became a major congressional priority.

After consideration of various approaches, and after lengthy national debate, Congress passed legislation in 1965 establishing the Medicare and the Medicaid programs as Title XVIII and Title XIX of the Social Security Act. Medicare was established in response to the specific medical care needs of the elderly (and in 1973, the severely disabled and certain persons with kidney disease). Medicaid was established in response to the widely perceived inadequacy of "welfare medical care" under public assistance. In 1977, the Health Care Financing Administration (HCFA) was established under the Department of Health and Human Services to administer the Medicare and Medicaid programs.

NATIONAL HEALTH CARE OVERVIEW

As a share of the gross domestic product (GDP), health care spending stabilized in 1993-96 at 13.6 percent. The GDP is the total value of goods and services produced in the United States. And although 1996 showed the slowest growth in more than 37 years of measuring health care spending, our nation's total spending for health care broke the $1.0 trillion mark in 1996. For the 275 million persons residing in the United States, the average expenditure for health care in 1996 was $3,759 per person.

Health care is funded through a variety of private payers and public programs. Private funds include individuals' out-of-pocket expenditures, private health insurance, philanthropy and non-patient revenues (e.g., gift shops, parking lots, etc.), as well as health services that are provided in industrial settings. For the years 1974 through 1991, these private funds paid for 58 to 60 percent of all health care expenditures. But by 1996, the *private* share of health expenditures had dropped to 53.3 percent of our Nation's total health care expenditures, while the share of health care provided by *public* spending increased correspondingly over this period.

Public spending represents expenditures by Federal, State, and local governments. Of the publicly funded health care expenditures for our Nation, each of the following account for a small percentage of the total: the Department of Defense health care programs for military personnel; the Department of Veterans Affairs health programs; non-commercial medical research; payments for health care under Workers Compensation programs; health programs under State-only general assistance programs; and the construction of public medical facilities. Other activities which are also publicly funded include: maternal and child health services; school health programs; public health clinics; Indian health care services; migrant health care services; substance abuse and mental health activities; and medically-related vocational rehabilitation services. The largest shares of public health expenditures, however, are for the Medicare and Medicaid programs.

Together, Medicare and Medicaid financed $351 billion in health care services in 1996 -- more than one-third of the nation's total health care bill and almost three-quarters of all public spending on health care. Since their enactment, both Medicare and Medicaid have been subject to numerous legislative and administrative changes designed to make improvements, with financial considerations, in the provision of health care services to our nation's aged, disabled and poor persons.

Historical information was extracted from the *Social Security Bulletin*, Volume 56, Number 4, Winter, 1993. National health expenditures data and estimates are from the Office of National Health Statistics in the Office of the Actuary (OACT) in HCFA. Medicare data are from the national claims history data base in the Office of Information Systems (OIS) also in HCFA, with estimates by OACT. Medicaid data are taken from the reports sent by the States to OIS, with estimates by OACT.

(For more information, data details, and an explanation of the various aspects of health care spending, see the Office of National Health Statistics, OACT/HCFA, report entitled "National Health Expenditures, 1996", by Katharine Levit, et. al., in *Health Care Financing Review*, Fall 1997; and in "National Health Spending Trends In 1996", by K. Levit, et. al, in *Health Affairs*, January/February, 1998, Vol. 17, No. 1, pages 35-51.)

For detailed statistical data:

- **on National Health Expenditures, phone 410-786-7933;**
- **on Medicare, phone 410-786-3689;**
- **on Medicaid, phone 410-786-0165;**
- **or visit: www.hcfa.gov/stats and data**

MEDICARE: A BRIEF SUMMARY

NOTE: The following is a very brief summary of a complex subject. It should be used only as an overview and general guide to the Medicare program . The views expressed herein are those of the author, and do not necessarily reflect the policies or legal positions of the Health Care Financing Administration or DHHS. This is not a legal document, nor is it intended to fully explain all of the provisions or exclusions of the relevant laws, regulations and rulings of the Medicare program. This summary does not render any legal, accounting or other professional advice; original sources of authority should be researched and utilized.

OVERVIEW

Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled," is commonly known as "Medicare." As part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons to complement the retirement, survivors and disability insurance benefits under Title II of the Social Security Act.

When first implemented in 1966, Medicare covered only most persons age 65 and over. By the end of 1966, 3.7 million persons had received at least some health care services covered by Medicare. In 1973, other groups became eligible for Medicare benefits: persons who are entitled to Social Security or

Railroad Retirement disability benefits for at least 24 months; persons with end-stage renal disease (ESRD) requiring continuing dialysis or kidney transplant; and certain otherwise non-covered aged persons who elect to *buy into* Medicare.

Medicare consists of two primary parts: Hospital Insurance (HI), also known as "Part A," and Supplementary Medical insurance (SMI), also known as "Part B. When Medicare began on July 1, 1966, there were 19.1 million persons enrolled in the program. A third part of Medicare, sometimes known as "Part C", is the Medicare+Choice program-- which was established by the Balanced Budget Act of 1997 (Public Law. 105-33) and began to provide services on January 1, 1998. Beneficiaries must, however, have Medicare Part A and Part B in order to enroll in a Part C plan. In 1997, about 38 million persons were enrolled in one or both of parts A and B of the Medicare program. About 87 percent of all Medicare "enrollees" *used* some HI and/or SMI service in 1997.

MEDICARE COVERAGE

Hospital Insurance (HI) is generally provided automatically to persons age 65 and over who are entitled to Social Security or Railroad Retirement Board benefits. Similarly, individuals who have received such benefits based on their disability, for a period of at least 24 months, are also entitled to HI benefits. In 1997, the HI program provided protection against the costs of hospital and specific other medical care to about 38 million people (33 million aged and five million disabled enrollees). Approximately 22 percent of these individuals received services covered by HI during the year. The HI benefits totaled $137.8 billion in 1997, -- an increase of 7.1 percent over the prior year, with an average expenditure per HI enrollee of $3,600, -- an increase of 6 percent over 1996.

The following lists the health care services covered under Medicare's Hospital Insurance:

- *Inpatient hospital* care coverage includes costs of a semi-private room, meals, regular nursing services, operating and recovery room, intensive care, inpatient prescription drugs, laboratory tests, X-rays, psychiatric hospital, inpatient rehabilitation, and long-term care hospitalization when medically necessary, as well as all other medically necessary services and supplies provided in the hospital. An initial deductible payment is required, plus co-payments for all hospital days following day 60 within a benefit period.

- *Skilled nursing facility* (SNF) care is covered by HI only if it follows within 30 days (generally) of a hospitalization of three or more days, and is certified as medically necessary. Covered services are similar to those for inpatient hospital, but also include rehabilitation services and appliances. The number of SNF days provided under Medicare is limited to 100 days per benefit period (defined below), with a co-payment required for days 21 through 100. Medicare HI does not cover nursing facility care at all if the patient does not require *skilled* nursing or *skilled* rehabilitation services.

- *Home Health Agency* (HHA) care, including care provided by a home health aide, may be furnished part-time by a home health agency in the residence of a home-bound beneficiary *if* intermittent or part-time skilled nursing and/or certain other therapy or rehabilitation care is necessary. Certain medical supplies and durable medical equipment may also be provided. There must be a plan of treatment and periodical review by a physician. Home health care under HI has no duration limitations, no co-payment, and no deductible. For durable medical equipment, beneficiaries must pay a 20 percent coinsurance, as required under SMI of Medicare. Full-time nursing care, food, blood, and drugs are *not* provided as HHA services.

- *Hospice* care, is a service provided to those terminally ill persons with a life expectancy of six months or less who elect to forgo the standard Medicare benefits for treatment of a traditional medical treatment, and receive only hospice care. Such care includes pain relief, supportive medical and social services, physical therapy, nursing services and symptom management for a terminal illness. However, if a hospice patient requires treatment for a condition that is not related to the terminal illness, Medicare will pay for all covered services necessary for that condition. For the hospice program, the Medicare beneficiary pays no deductibles, but does pay a very small

coinsurance amount for drugs and the cost of inpatient respite care.

An important coverage limitation of HI is the "benefit period" which starts when the beneficiary firstenters a hospital and ends when there has been a break of at least 60 consecutive days since inpatient hospital or skilled nursing care was provided. There is no limit to the number of benefit periods covered by HI during a beneficiary's lifetime; however, inpatient hospital care is normally limited to 90 days during a benefit period, and co-payment requirements (detailed later) apply for days 61 through 90. If a beneficiary exhausts the 90 days of inpatient hospital care available in a benefit period, he or she can elect to use days of Medicare coverage from a nonrenewable "lifetime reserve" of up to 60 (total) additional days of inpatient hospital care.

Supplementary Medical Insurance (SMI) benefits are available to: almost all resident citizens age 65 and over; certain aliens age 65 or over -- even to those who are not entitled (based on eligibility for Social Security or Railroad Retirement benefits) to HI Medicare services; and disabled beneficiaries who are entitled to Medicare's HI. SMI coverage is optional and requires payment of a monthly premium. Almost all persons entitled to HI also choose to enroll in SMI. In 1997, the SMI program provided protection against the costs of physician and other medical services to about 36 million people. Approximately 87 percent of these individuals received medical services covered by SMI during 1997, with SMI benefits of $72.8 billion paid on their behalf.

Part B (SMI) is often thought of primarily as coverage for physician services (in both hospital and non-hospital settings). However, SMI also covers certain other non-physician services, including: clinical laboratory tests, durable medical equipment, most supplies, diagnostic tests, ambulance services, flu vaccinations, prescription drugs which cannot be self-administered, certain self-administered anticancer drugs, some other therapy services, certain other health services, and blood which was not supplied by HI.

The expenditures for institutional services in hospital outpatient departments, ambulatory surgical centers and certain other centers are also covered. Home Health Agency services are also covered. To be covered, all services must either be medically necessary or be one of the prescribed preventives benefits. Certain medical services and related care are subject to special payment rules, including: deductibles (for blood); maximum approved amounts (for independently practicing, Medicare-approved physical or occupational therapists); or higher cost-sharing requirements (such as that for outpatient treatments for mental illness).

Medicare+Choice (Part C) is another option provided by the Balanced Budget Act of 1997 (BBA). Under the BBA, Medicare beneficiaries who have both Part A and Part B can choose to get their benefits through a variety of risk-based plans known as Part C of Medicare. To participate in this Part C, the beneficiaries *must* be entitled to HI *and* be enrolled in SMI (except for ESRD patients, who must be enrolled in Part C *before* they get ESRD; they cannot switch to Part C *after* they are diagnosed with ESRD). As is the case for risk plans, organizations that are seeking to contract as Medicare+Choice plans will have to meet specific organizational, financial, and other requirements. The primary Medicare+Choice plans are:

- Coordinated care plans, which includes Health Maintenance Organizations, Provider-Sponsored Organizations and Preferred Provider Organizations, and other certified public or private coordinated care plans and entities that meet the approved required standards as set forth in the law.

- The private, unrestricted fee-for-service plans, which allows beneficiaries to select certain private providers. For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk, nor vary payment rates based upon utilization.

- The Medical Savings Account (MSA) plan allows beneficiaries (only a limited number for the first five years) to enroll in a plan with a high-deductible (maximum for 1999 = $6,000). The Federal government pays a prescribed portion of the capitation amount into an insurance fund for each enrollee. The difference between the Medicare capitation rate and the plan premium is deposited into the MSA account. Deposits for the entire year are made at the start of the year.

After the deductible is paid, the MSA plan pays providers the lesser of 100% of specified expenses or 100% of amounts that would have been payable under the original fee-for-service Medicare program. If extra money remains in the MSA, it can be used to pay for future medical needs (including some not covered by Medicare -- e.g., dentures). Or, subject to certain requirements, the extra money can be used for non-medical purchases.

Except for MSA-plans, all Medicare+Choice plans are required to provide the current Medicare benefit package, excluding hospice services, and any additional health services required under the adjusted community rate process. There are some restrictions as to *who* may elect an MSA-plan, even when enrollment is no longer limited in number of participants.

OTHER MEDICARE CONSIDERATIONS

The Balanced Budget Act of 1997 included another provision for eligible persons known as PACE (Programs of All-inclusive Care for the Elderly). PACE provides an *alternative* to institutional care for persons aged 55 and over who require a *nursing facility level* of care and who meet the eligibility requirements for the program within each State. PACE functions within the Medicaid program as well as under Medicare, and is described more extensively on page 17 (in the Medicaid section below.) The individuals enrolled in PACE receive benefits solely through the PACE program. In addition to the new options and changes that were provided through the Balanced Budget Act of 1997, the BBA also enhanced Medicare prevention initiatives and rural health initiatives.

It should be noted that some health care services are *not* provided under any part of Title XVIII. *Non*-covered services under Medicare include long term nursing care or custodial care, and certain other health care needs -- such as dentures and dental care, eyeglasses, hearing aids, most prescription drugs, etc. These are not a part of the Medicare program unless they are a part of a managed care plan, or--after January 1, 1999--are selected as a part of the Medicare+Choice program.

MANAGED CARE PLANS

Prepaid health care plans known as managed care plans, such as *competitive medical plans* (CMPs) and *health maintenance organizations* (HMOs), are options for Medicare beneficiaries. Managed care plans function on a basis different from regular fee-for-service covered under Medicare. Under managed care plans, the Medicare beneficiary selects a specific HMO, CMP, or other approved plans within a service area for comprehensive health care services. It is central to the managed care conceptthat this selected plan coordinate all of the health care services for that person. Managed care plans function on a financial basis that is different from the traditional fee-for-service reimbursements to health care providers. Managed care plans receive a per-person payment from Medicare that is *pre*determined, based on a formula that is established by law and the demographic characteristics of the Medicare beneficiaries enrolled in their plan.

In addition to the regular services covered under Medicare, the managed care plans often cover services such as preventive care, prescription drugs, eyeglasses, dental care, or hearing aids. Electing to participate in a managed care plan may also serve as an alternative to purchasing "medigap insurance" (described later) which is often wanted if the beneficiary has traditional fee-for-service coverage. Although there are certain restrictions, limitations and differences from the fee-for-service plans, the managed care plan's fixed monthly premiums and cost-sharing structure helps to provide more predictability for out-of-pocket costs for the beneficiaries who do not have medigap insurance.

PROGRAM FINANCING, BENEFICIARY LIABILITIES, & VENDOR PAYMENTS

All financial operations for Medicare are handled through two trust funds, one for the Hospital Insurance and one for Supplementary Medical Insurance. These trust funds--which are special accounts in the U. S. Treasury-- are credited with all income receipts and charged with all Medicare expenditures for benefits and administration costs. Assets not needed for the payment of costs are invested in special Treasury

Securities. The following sections describe Medicare's financing provisions, beneficiary cost-sharing requirements, and the basis for determining Medicare reimbursements to health care providers.

Program financing:

The *Medicare Part A* program (HI) financing is primarily through a mandatory payroll deduction ("FICA tax"). Almost all employees and self-employed workers in the U.S. work in employment covered by the Medicare HI program and pay taxes to support the cost of benefits for aged and disabled beneficiaries. The FICA tax is 1.45 percent of earnings (paid by each employee and by the employer for each), as well as 2.90 percent for self-employed persons. For 1994 and later, this tax is paid on all covered wages and self-employment income without limit. (Prior to 1994, the tax applied only up to a specified maximum amount of earnings.) The trust fund for the HI program also receives income from: (*i*) a portion of the income taxes levied on Social Security benefits paid to high-income beneficiaries, (*ii*) premiums from certain persons who are not otherwise eligible and choose to enroll voluntary, (*iii*) general funds reimbursements for the cost of certain other uninsured individuals, and (*iv*) interest earnings on the invested assets of the trust fund. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Income not needed to pay current benefits and related expense is invested in U. S. Treasury securities. The hospital insurance trust fund money is used only for the HI program, and the SMI trust funds cannot be transferred for HI use.

The *Medicare Part B* program (SMI) is financed through: (*1*) premium payments ($43.80 per month in 1998) which are usually deducted from the monthly Social Security benefit checks of those who are enrolled in the SMI program, and (*ii*) through contributions from general revenue of the U.S. Treasury. SMI benefits may also be "bought" for persons by a third party directly paying the monthly premium on behalf of the enrollee. Beneficiary premiums are currently set at a level that covers 25 percent of the average expenditures for aged beneficiaries. Except for a small amount of interest income, general revenues provide the balance of the financing for SMI.

The *Medicare Part C* program (Medicare+Choice) has rather complex financing, depending upon which plan is chosen. Basically, the funding for the Medicare+Choice program comes from the HI and SMI trust funds in proportion to the relative weights of HI and SMI benefits to the total benefits paid by the Medicare program.

Beneficiary payment liabilities:

For Parts A and B, beneficiaries are responsible for charges not covered by the Medicare program, and for various cost-sharing aspects of both HI and SMI. These liabilities may be paid: (1) by the Medicare beneficiary, (2) by a third party such as private "medigap" insurance purchased by the Medicare beneficiary, or (3) by Medicaid, if the person is eligible. The term "medigap" is used to mean private health insurance which, within limits, pays most of the health care service charges not covered by Parts A or B of Medicare. These policies-- which must meet Federally-imposed standards-- are offered by Blue Cross and Blue Shield, and various commercial health insurance companies.

For hospital care covered under HI, the beneficiary's payment share includes a one-time deductible amount at the beginning of each benefit period ($764 in 1998). This covers the beneficiary's part of the first 60 days of each spell of inpatient hospital care. If continued inpatient care is needed beyond the 60 days, additional coinsurance payments ($191 per day in 1998) are required through the 90th day of a benefit period. Medicare pays nothing after day 90, unless the beneficiary elects to use "lifetime reserve" days, for which a co-payment ($382 per day in 1998) is required from the beneficiary.

For skilled nursing care covered under HI, the first 20 days of SNF care are fully covered by Medicare. But for days 21 through 100, a co-payment ($95.50 per day in 1998) is required from the beneficiary. After 100 days of SNF care per benefit period, Medicare pays nothing for SNF care. Home health care has no deductible or co-insurance payment by the beneficiary. In any HI service, the beneficiary is responsible for fees to cover the first three pints or units of non-replaced blood per calendar year. The beneficiary has the option of paying the fee or of having the blood replaced.

There are no premiums for the HI portion of Medicare for most people aged 65 and over. Eligibility for HI is generally earned through the work experience of the beneficiary or that of a spouse. However, some persons who are otherwise unqualified for Medicare may *purchase* HI coverage *if* they *also* buy the SMI coverage. The cost is determined by a formula: if they have 30 to 39 quarters of coverage as defined by the Social Security Administration, the 1998 cost of HI is reduced to $170 per month; if not, the HI cost is $309 per month.

For SMI, the beneficiary's payment share includes: one annual deductible (currently $100); the monthly premiums; the co-insurance payments for SMI services (usually 20 percent of the medically-allowed charges); a deductible for blood; and payment for any services which are not covered by Medicare. These "cost-sharing" contributions are required of the beneficiaries for SMI services. For ESRD patients, Medicare SMI covers kidney dialysis and physician charges incurred by the patient and donor during the transplant and follow-up care. Regular SMI cost-sharing also applies for ESRD services.

For Part C, the beneficiary's payment share is based upon the cost-sharing structure of the specific Medicare+Choice plan selected by the beneficiary (see descriptions on page 6 & 7), as each plan has its own requirements.

Vendor payments:

For HI, prior to 1983, payment to vendors was made on a "reasonable *cost*" basis. Medicare payments for most inpatient hospital care are now paid under a plan known as the Prospective Payment System (PPS). Under the PPS, a hospital is paid a predetermined amount, based upon the patient's diagnosis within a "diagnosis related group" (DRG), for providing whatever medical care is required during that person's inpatient hospital stay. In some cases the payment received is less than the hospital's actual costs; in other cases it is more. The hospital absorbs the loss or makes a profit. Certain payment adjustments exist for extraordinarily costly cases. The BBA made some reductions in the amounts paid to hospitals, and to other payments for traditional fee-for-service programs. Payments for inpatient rehabilitation, psychiatric, home health, hospice and for skilled nursing care coverage continue to be paid under the reasonable cost methodology, with each service having some restrictions and limitations -- although payment methods will be restructured as required by the BBA .

For SMI, prior to 1992, physicians were paid on the basis of "reasonable *charge*." This was initially defined as the lowest of (1) the physician's actual charge, (2) the physician's customary charge, or (3) the prevailing charge for similar services in that locality. Starting January, 1992, allowed charges were defined as the lesser of: the submitted charges, or a fee schedule based on a relative value scale (RVS). Payments for durable medical equipment and clinical laboratory services are also based on a fee schedule. Hospital outpatient services and HHAs are currently reimbursed on a reasonable *cost* basis. The BBA provided for implementation of a Prospective Payment System for these services in the future. If a doctor or supplier agrees to accept the approved rate as payment in full ("takes assignment"), then payments provided must be considered as payments in full for that service. No added payments (beyond the initial annual deductible and co-insurance) may be sought from the beneficiary or insurer. If the provider does *not* take assignment, the beneficiary will be charged for the excess (which may be paid by medigap insurance). Limits now exist on the excess which doctors or suppliers can charge. Physicians are "participating" physicians if they agree before the beginning of the year to accept assignment for all Medicare services they furnish during the year. Since Medicare beneficiaries may select their doctors, they have the option to choose those who *do* participate.

For Part C, payments to the Medicare+Choice plans are based on a blend of local and national capitated rates, generally determined by the capitation payment methodology described in Section 1853 of the Social Security Act. Actual payments to plans vary based on characteristics of the enrolled population. New risk adjusters are scheduled to be implemented in January 2000.

MEDICARE CLAIMS PROCESSING

The BBA included provisions for anti-fraud and for countering abuse, as well as improvements in protecting the Medicare programs' integrity. Other aspects of the BBA provisions are quite extensive and

have significant impacts on both the HI and SMI part of Medicare. However, since this is only an overview and brief summary of the total Medicare program, additional details will not be included herein.

Medicare claims are processed by non-government organizations or agencies that contract to serve as the fiscal agent between providers and the Federal government to locally process Medicare's HI and SMI claims. These claims processors are known as "intermediaries" and "carriers." They apply the Medicare coverage rules to determine the appropriateness of claims.

Medicare "intermediaries" process HI claims for institutional services, including inpatient hospital claims, skilled nursing facilities, home health agencies, and hospice services. They also process hospital outpatient claims for SMI. Examples of intermediaries are the Blue Cross and Blue Shield Association (which utilize their plans in various States), and other commercial insurance companies.

Intermediaries' responsibilities include:

- determining costs and reimbursement amounts;
- maintaining records;
- establishing controls;
- safeguarding against fraud and abuse or excess use;
- conducting reviews and audits;
- making the payments to providers for services; and
- assisting both providers and beneficiaries as needed.

Medicare "carriers" handle SMI claims for services by physicians and medical suppliers. Examples of carriers are the Blue Shield plans in a State, and various commercial insurance companies.

Carriers' responsibilities include:

- determining charges allowed by Medicare;
- maintaining quality of performance records;
- assisting in fraud and abuse investigations;
- assisting both suppliers and beneficiaries as needed; and
- making payments to physicians and suppliers for services which are covered under SMI .

Peer Review Organizations (PROs) are groups of practicing health care professionals who are paid by the Federal government to do the general overview of the care provided to Medicare beneficiaries in each State, and improve quality of services. PROs act to educate and assist in the promotion of effective, efficient and economical delivery of health care services to the Medicare population they serve.

ADMINISTRATION of MEDICARE

The Department of Health and Human Services (DHHS) has the overall responsibility for administration of the Medicare program, with the assistance of the Social Security Administration (SSA). The Health Care Financing Administration (HCFA) is a component of DHHS. HCFA has primary responsibility for Medicare, including: formulation of policy and guidelines; contract over-sight and operation; maintenance and review of utilization records; and general financing of Medicare. SSA is responsible for

the initial determination of an individual's Medicare entitlement, and has the overall responsibility for maintaining the Medicare master beneficiary record.

A Board of Trustees, which is composed of two appointed members of the public and four ex-officio members, oversees the financial operations for the trust funds for both HI and SMI. The Secretary of the Department of Treasury is the managing trustee. The Board of Trustees reports the status and operation of the Medicare trust funds to Congress on or about the first day of April each year.

State agencies (usually State Health Departments under agreements with HCFA) assist by helping DHHS to identify, survey, and inspect provider and supplier facilities or institutions wishing to participate in the Medicare program. In consultation with HCFA, they then certify those that arequalified. The State agency also assists providers as a consultant, and coordinates the various State programs to assure effective and economical endeavors.

MEDICARE DATA SUMMARY

The Medicare program covers 95 percent of our Nation's aged population, plus many of those eligible persons who are on Social Security because of disability. In CY 1997, HI covered about 38 million enrollees at a cost of $137.8 billion, and SMI covered 36 million enrollees at a cost of $72.8 billion in 1997. Administrative costs were 1.2 percent of HI and 1.8 percent of SMI disbursements for 1997. Of those persons who were entitled to Medicare in 1997, about 87 percent used Supplementary Medical Insurance services, while only 22 percent used the Hospital Insurance services. The combined HI and SMI benefit payments for all Medicare services in CY 1997 averaged about $6,300 per enrollee. Total disbursements for Medicare for 1997 was $213.575 billion.

Since certain Medicare beneficiaries also receive some assistance from the Medicaid program, please note the brief **Medicare and Medicaid Relationship** summary that is described on pages 21 and 22 herein, after the following **Medicaid Summary**.

MEDICAID: A BRIEF SUMMARY

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OVERVIEW of MEDICAID

Title XIX of the Social Security Act is a Federal-State matching entitlement program that pays for medical assistance for certain vulnerable and needy individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments ("State" used herein includes the Territories and the District of Columbia) to assist States furnishing medical assistance to eligible needy persons. Medicaid

is the largest source of funding for medical and health-related services for America's poorest people. In 1996, it provided health care assistance to more than 36 million persons, at a cost of $160 billion dollars.

Within broad national guidelines established by Federal statutes, regulations and policies, each State: (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex, and vary considerably even among similar-sized and/or adjacent States. Thus, a person who is eligible for Medicaid in one State might not be eligible in another State; and the services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State. In addition, Medicaid eligibility and/or services within a State can change during the year.

BASIS of ELIGIBILITY and MAINTENANCE ASSISTANCE STATUS

Medicaid does not provide medical assistance for all poor persons. Even under the broadest provisions of the Federal statute, Medicaid does *not* provide health care services even for very poor persons *unless* they are in one of the groups designated below. And low income is only one test for Medicaid eligibilityfor those within these groups; their resources also are tested against threshold levels (as determined by each State within Federal guidelines).

States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, however, States are *required* to provide Medicaid coverage for certain individuals who receive Federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to the Medicaid program, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are *not* provided for State-only programs. The following displays the mandatory Medicaid "categorically needy" eligibility groups for which Federal matching funds are provided:

- Individuals are generally eligible for Medicaid if they meet the requirements for the AFDC program that were in effect in their State on July 16, 1996, or-- at State option -- more liberal criteria;
- Children under age six whose family income is at or below 133% of the Federal poverty level (FPL);
- Pregnant women whose family income is below 133% of the FPL (services to women are limited to: those related to pregnancy, complications of pregnancy,delivery and postpartum care);
- SSI recipients in most States (some States use more restrictive Medicaid eligibility requirements that pre-date SSI);
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act;
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time);
- All children born after September 30, 1983 who are under age 19, in families with incomes at or below the FPL. (This phases in coverage, so that by the year 2002, all such poor children under age 19 will be covered); and
- Certain Medicare beneficiaries (described later).

States also have the *option* of providing Medicaid coverage for other "categorically related" groups. These optional groups share the characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups

for which States will receive Federal matching funds for coverage under the Medicaid program include:

- Infants up to age one and pregnant women not covered under the mandatory whose family income is no more than 185% of the FPL (the percentage amount is set by each State);
- Children under age 21 who meet what were the AFDC income and resources requirements in effect in their State on July 16, 1996, (even though they do not meet the mandatory eligibility requirements);
- Institutionalized individuals eligible under a "special income level" (the is set by each State --up to 300% of the SSI Federal benefits rate);
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers;
- Certain aged, blind or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL;
- Recipients of State supplementary income payments;
- Certain working and disabled persons with family income less than 250% of FPL who would qualify for SSI if they did not work;
- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to TB-related ambulatory services and TB drugs);
- "Optional targeted low-income children" included within the Children's Health Insurance Program (CHIP) established by the Balanced Budget Act of 1997 (BBA); and
- "Medically needy" persons (described below).

The Medically Needy (MN) program allows States the option to extend Medicaid eligibility to additional qualified persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State. Persons may qualify immediately, or may "spend-down" by incurring medical expenses that reduce their income to or below their State's MN income level.

The *medically needy* Medicaid program does not have to be as extensive as the *categorically needy* program, and may be quite restrictive in rules as to who is covered and/or as to what services are offered. Federal matching funds are available for MN programs. However, if a State elects to have *any* MN program, there are Federal requirements that certain *groups* and certain *services* must be included. Children under age 19 and pregnant women who are medically needy must be covered; and prenatal and delivery care for pregnant women, and ambulatory care for children must be provided. A State may elect to provide MN eligibility to certain additional groups, and may elect to provide certain additional services within its MN program. In 1996, forty-two States elected to have a MN program, and provided at least some MN services for at least some MN recipients. All remaining States utilize the "special income level" option (above) to extend Medicaid to the "near poor" in medical institutional settings.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) --known as the "welfare reform" bill -- made restrictive changes regarding eligibility for Supplemental Security Income (SSI) coverage that will have an impact on the Medicaid program. The new law may be significant for certain aliens' Medicaid coverage. For most legal resident aliens and other qualified aliens who entered the United States on or after August 22, 1996, Medicaid is barred for five years. Medicaid for most aliens entering before that date is a State option, as is coverage after the five year ban, except for emergency services. For aliens who lose SSI benefits because of new restrictions regarding SSI coverage, Medicaid can continue, except for emergency care, only if these persons can be covered for Medicaid under some other eligibility status. Although a number of disabled children lost SSI as a result

of changes to the P. L. 104-193, their continued eligibility for Medicaid was assured by Public Law 105-33: the Balanced Budget Act of 1997 (the BBA).

In addition, welfare reform repealed the open-ended Federal entitlement program known as Aid to Families with Dependent Children (AFDC), and replaced it with Temporary Assistance for Needy Families (TANF), which will provide grants to States to be spent on time-limited cash assistance. TANF limits a family's lifetime cash welfare benefits to a maximum of five years, and permits States to impose a wide range of other restrictions as well --in particular, requirements related to employment. However, the impact on Medicaid eligibility is not expected to be significant. Under welfare reform, persons who would have been eligible for AFDC under the AFDC requirements in effect on July 16, 1996, generally will still be eligible for Medicaid. Although most persons covered by TANF will receive Medicaid, the law does not so require.

Title XXI of the Social Security Act, known as the Children's Health Insurance Program (CHIP), is a new program initiated by the BBA. In addition to allowing States to craft or expand an existing State insurance program, CHIP will provide more Federal funds for States to expand Medicaid eligibility to include more children who are currently uninsured. With certain exceptions, these are low-income children who would not qualify for Medicaid based on the plan that was in effect on April 15, 1997. Funds from the CHIP also may be used for providing medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options for States to select for providing health care coverage for more children, as prescribed within the BBA's Title XXI program.

Medicaid coverage may begin as early as the third month prior to application-- *if* the person would have been eligible for Medicaid had he applied during that time. Medicaid coverage generally stops at the end of the month in which a person no longer meets the criteria of any Medicaid eligibility group. The BBA allows States to provide 12 months of continuous Medicaid coverage (without reevaluation) for eligible children under the age of 19.

SCOPE of MEDICAID SERVICES

Title XIX of the Social Security Act (the Medicaid program) allows considerable flexibility within the States' Medicaid plans. However, some Federal requirements are mandatory if Federal matching funds are to be received. A State's Medicaid program *must* offer medical assistance for certain *basic* services to most categorically needy populations. These services generally include:

- inpatient hospital services;
- outpatient hospital services;
- prenatal care;
- vaccines for children;
- physician services;
- nursing facility services for persons aged 21 or older;
- family planning services and supplies;
- rural health clinic services;
- home health care for persons eligible for skilled-nursing services;
- laboratory and x-ray services;
- pediatric and family nurse practitioner services;

- nurse-midwife services;
- Federally-qualified health-center (FQHC) services, and ambulatory services of an FQHC that would be available in other settings; and
- early and periodic screening, diagnostic, and treatment (EPSDT) services for children under age 21.

States also may receive Federal matching funds for providing certain *optional* services. The most common of the 34 currently-approved optional Medicaid services include:

- diagnostic services;
- clinic services;
- intermediate care facilities for the mentally retarded (ICFs/MR);
- prescribed drugs and prosthetic devices;
- optometrist services and eyeglasses;
- nursing facility services for children under age 21;
- transportation services;
- rehabilitation and physical therapy services; and
- home and community-based care to certain persons with chronic impairments.

The Balanced Budget Act included another provision for eligible persons as a State option known as PACE (Programs of All-inclusive Care for the Elderly). PACE provides an *alternative* to institutional care for persons aged 55 and over who require a *nursing facility level* of care. The PACE team offers and manages *all* health, medical and social services, and mobilizes other services as needed to provide preventative, rehabilitative, curative and supportive services. This care is provided in day health centers, homes, hospitals and nursing homes -- while helping the person maintain independence, dignity and quality of life. PACE functions within the Medicare program as well as under Medicaid. Regardless of source of payment, PACE providers receive payment only through the PACE agreement, and must make available all items and services covered under both Titles XVIII and XIX without amount, duration or scope limitations, and without application of any deductibles, copayments or other cost sharing. The individuals enrolled in PACE receive benefits solely through the PACE program.

AMOUNT and DURATION of MEDICAID SERVICES

Within broad Federal guidelines and certain limitations, States determine the amount and duration of services offered under their Medicaid programs. States may limit, for example, the number of days of hospital care or the number of physician visits covered. Two restrictions apply: (1) limits must result in a sufficient level of services to reasonably achieve the purpose of the benefits; and (2) limits on benefits may not discriminate among beneficiaries based on medical diagnosis or condition.

In general, States are required to provide Medicaid coverage for comparable amounts, duration and scope of services to all categorically-needy and categorically-related eligible persons. There are two important exceptions: 1) Medically necessary health care services identified under the EPSDT program for eligible children which are within the scope of mandatory or optional services under Federal law, must be covered even if those services are not included as part of the covered services in that State's Plan (i.e., only these specific children might receive that specific service); and 2) States may request "waivers" to pay for otherwise-uncovered home and community-based services (HCBS) for Medicaid-eligible persons who might otherwise be institutionalized (i.e., only persons so designated

might receive HCBS). States have few limitations on the services which may be covered under such waivers as long as the services are cost effective (except that, other than as a part of respite care, they may not provide room and board for such recipients). With certain exceptions, a State's Medicaid Plan must allow recipients to have some informed choices among participating providers of health care, and to receive quality care that is appropriate and timely.

PAYMENT for MEDICAID SERVICES

Medicaid operates as a vendor payment program. States may pay providers directly, or States may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs). Within Federally-imposed upper limits and specific restrictions, each State generally has broad discretion in determining the payment methodology and payment rate for services. Generally, payment rates must be sufficient to enlist enough providers so that covered services areavailable at least to the extent that comparable care and services are available to the general population within that geographic area. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. Excessive use of the DSH adjustment resulted in rapidly increasing Federal expenditures for Medicaid. However, under legislation passed in 1991, 1993, and again within the Balanced Budget Act of 1997, the State allotments for payments to DSH hospitals have become increasingly limited.

States may impose nominal deductibles, coinsurance or co-payments on some Medicaid recipients for certain services. Certain Medicaid recipients, however, must be excluded from cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to the cost of institutional care. In addition, all Medicaid recipients must be exempt from co-payments for emergency services and family planning services.

The Federal government pays a share of the medical assistance expenditures under each State's Medicaid program. That share, known as the Federal Medical Assistance Percentage (FMAP) is determined annually by a formula that compares the State's average per capita income level with the national income average. States with a higher per capita income level are reimbursed a smaller share of their costs. By law, the FMAP cannot be lower than 50 percent nor higher than 83 percent. In 1997, the FMAPs varied from 50 percent (to 13 States and the District of Columbia) to 77.2 percent (to Mississippi), with the average Federal share among all States being 57.0 percent. However, the BBA permanently raised the FMAP for D.C. from 50% to 70%, and raised the FMAP for Alaska from 50% to 59.8% for three years. For the children added to Medicaid through the CHIP program, the FMAP average is higher -- about 70% , compared to the Medicaid average of 57%.

The Federal government also reimburses States for 100% of the cost of services provided through facilities of the Indian Health Service; provides financial help to the 12 States that provide the highest number of emergency services to undocumented aliens; and shares in each State's expenditures for the administration of the Medicaid program. Most administrative costs are matched at 50 percent for all States, with higher rates for certain activities such as development of mechanized claims processing systems. The Medicaid statute does provide, however, higher matching rates for certain functions and activities.

Except for the CHIP program and the QI program (described later), Federal payments to States for medical assistance have no set limit (cap); rather, the Federal government matches (at FMAP rates) State expenditures for the mandatory services plus the optional services that the individual State decides to cover for eligible recipients, and matches (at the appropriate administrative rate) all necessary and proper administrative costs.

MEDICAID SUMMARY and TRENDS

Medicaid was initially formulated as a medical care extension of Federally-funded programs proving cash income assistance for the poor, with an emphasis on dependent children and their mothers, the

disabled, and the elderly. Over the years, however, Medicaid eligibility has been incrementally expanded beyond its original ties with eligibility for cash programs. Legislation in the late 1980s assured Medicaid coverage to an expanded number of low-income pregnant women, poor children andto some Medicare beneficiaries who are not eligible for any cash assistance program. Legislative changes also focused on increased access, better quality of care, specific benefits, enhanced outreach programs, and fewer limits on services.

Since its inception, Medicaid has had very rapid growth in expenditures. Although the rate of increase has subsided recently, acceleration over the years has been noteworthy. This rapid growth in Medicaid expenditures has been due to several factors. The primary ones include:

- expanded coverage and utilization of services, and the increase in the size ofthe Medicaid-covered populations (a result of Federal mandates, of population growth, and of the earlier economic recession);
- the disproportionate share hospital (DSH) payment program, coupled with provider tax and donations programs;
- the increase in the numbers of very old and disabled persons requiring extensiveacute and/or long term health care and various related services;
- the results of technological advances to keep more very low birth-weight babies and other critically ill or severely injured persons alive and in need of continued extensive and very expensive care; and
- increased payment rates to providers of health care services, when compared to general inflation.

As with all health insurance programs, most Medicaid recipients require relatively small average expenditures per person each year. Providing health care coverage for almost 17 million children, who otherwise would usually receive little or no medical care, is and has always been a primary concern of the Medicaid program. Yet the data for 1996 indicate that Medicaid payments for services for these children (who constitute over 46 percent of all Medicaid recipients) averaged only a little over $1,000 per child. There are, however, certain other specific groups for whom Medicaid is at least as essential: those comprising far fewer persons, but ones who have much larger per-person expenditures. Regardless of their initial financial situation, their medical needs are so great and/or continuous that most of these patients must eventually depend upon Medicaid. When expenditures for these high and lower cost recipients are combined, the 1996 payments to health care vendors for over 36 million Medicaid recipients average $3,400 per person.

Long term care is an important and increasingly utilized provision of Medicaid--especially as our nation's population ages. Almost 45% of the total cost of care for persons using nursing facility or home health services in the U.S. in recent years is paid for by the Medicaid program. A much larger percentage is paid for by Medicaid, however, for those persons who use more than four months of such long-term care. As Medicaid has continued to provide extensive nursing facility care over the years, the focus has become the struggle to rely more on community-based long term care alternatives. The data for 1996 show that Medicaid payments for nursing facility (excluding ICF/MRs) and home health care totaled $40.5 billion for more than 3.6 million recipients of these services -- an average 1996 expenditure of more than $12,300 per long-term care recipient. With the percentage of our population who are elderly and/or disabled increasing faster than the younger groups, the need for long term care is expected to increase.

Another significant development in Medicaid is the growth in managed care as an alternative service delivery concept different from the traditional fee-for-service system. Under managed care systems, health maintenance organizations (HMOs), prepaid health plans (PHPs) or comparable entities agreeto provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payments per enrollee. Managed care programs seek to enhance access to quality care in a cost-effective manner. Waivers may provide the States with greater flexibility in the design and implementation of their Medicaid programs. Two major waivers (known as "1915(b)" and "1115") are an important part of

the Medicaid program. Section 1915(b) of the law allows States to develop innovative health care delivery or reimbursement systems. By January 1997, forty two States had a total of 100 approved 1915(b) waivers. Section 1115 of the law allows Statewide health care reform demonstrations for testing various methods of covering uninsured populations, and testing new delivery systems, without increasing costs. Fifteen States now have 1115 projects approved, and ten more States have 1115 projects under review. Finally, the Balanced Budget Act of 1997 provided States a new option to use managed care. Medicaid managed care programs are growing rapidly. The number of Medicaid beneficiaries who are now enrolled in some managed care program continues to increase, and may soon approach 50 percent of all Medicaid enrollees. Several States have converted their entire Medicaid programs into managed care.

Medicaid data as reported by the States indicate that more than 36 million persons received health care service through the Medicaid program in 1996. These data show that, in addition to administrative costs, the total outlays for the Medicaid program in 1996 included: direct payment to providers of $122 billion; payments for various premiums (for HMOs, Medicare, etc.) of more than $16 billion; and payments to the disproportionate share hospitals of $15 billion.

The total expenditure for the nation's Medicaid program was $160 billion ($ 91 billion in Federal and $69 billion in State funds) in 1996. With anticipated impacts from the Balanced Budget Act of 1997, projections now are that total Medicaid outlays may be $250 billion in fiscal year 2003, with an additional $5.8 billion expected to be spent for the new Children's Health Insurance Program.

THE MEDICAID -- MEDICARE RELATIONSHIP

The views expressed herein are those of the author, and do not necessarily reflect the policy or legal position of any aspect of government. This is not a legal document. It is not intended to offer legal, accounting or other professional advice, nor to fully explain all of the provisions or exclusions of the relevant laws, regulations and rulings of the Medicare and Medicaid programs, or of their relationship. The following very brief summary should be used only as a brief overview and brief general guide to the relationship between Medicare and Medicaid.

Medicare beneficiaries who have low incomes and limited resources may also receive help from the Medicaid program. For persons who are eligible for *full* Medicaid coverage, the Medicare health care coverage is supplemented by services that are available under their State's Medicaid program, according to eligibility category. These additional services may include--for example--nursing facility care beyond the 100 day limit covered by Medicare, prescription drugs, eyeglasses, and hearing aids. For persons enrolled in both programs, any services that are covered by Medicare are paid for by the Medicare program before any payments are made by the Medicaid program, since Medicaid is always "payor of last resort."

Certain other Medicare beneficiaries may receive help through their State Medicaid program. Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) are the best known and the largest in numbers. QMBs are those Medicare beneficiaries who have resources at or belowtwice the standard allowed under the SSI program, and incomes at or below 100% of the FPL. This also includes persons who are eligible for full Medicaid coverage. For QMBs, the State pays the HI and SMI premiums and the Medicare coinsurance and deductibles, subject to limits that States may

impose on payment rates. SLMBs are Medicare beneficiaries with resources like the QMBs, yet with incomes that are higher--but still less than 120% of the FPL. For SLMBs, the Medicaid program only pays the SMI premiums. The Medicare law states that disabled and working individuals who previously qualified for Medicare because of disability, but who lost entitlement because of their return to work (despite the disability), are allowed to purchase Medicare HI and SMI coverage. If these persons have incomes below 200% of the FPL, but do not meet any other Medicaid assistance category, they may qualify to have Medicaid pay their HI premiums as Qualified Disabled and Working Individuals (QDWIs).

According to HCFA estimates, Medicaid provided some level of supplemental health coverage for 5.9 million persons who were Medicare beneficiaries in the above three categories for FY 1995. Although they represent only 17% of the total Medicare enrollees, they accounted for 35% of the total Medicaid expenditures ($53 billion in FY 1995)--including $10 billion for Medicare cost-sharing, $5 billion for other acute care services and prescription drugs, and $38 billion and for long-term care.

The Balanced Budget Act of 1997 establishes a capped allocation to States, for each of five years beginning January 1998, for payment of all or some of the Medicare SMI premiums for additional Medicare beneficiaries: those with incomes that are above 120% and less than 175% of the FPL. This exceeds the income levels established for QMBs and SLMBs. These beneficiaries are known as Qualifying Individuals (QIs). Unlike QMBs and SLMBs, who may be eligible for Medicaid benefits in addition to their QMB/SLMB benefits, the QIs cannot be otherwise eligible for medical assistance under a State plan. The payment of this QI benefit is 100% Federally funded, up to the State's allocation. This QI program provides financial assistance to additional persons needing help in acquiring adequate health care coverage.

Top
MEDICARE: A BRIEF SUMMARY
MEDICAID: A BRIEF SUMMARY
THE MEDICAID -- MEDICARE RELATIONSHIP
CONCLUSION

CONCLUSION

The Department of Health and Human Services, the individual States, and the United States Congress continually seek to make improvements in the Medicare and Medicaid programs' quality, effectiveness, and extent of health care services. However, these programs must function within the various Federal and State constraints of serious economic, social and political factors. As a result, Federal and State regulations and laws continue to be reviewed for these very expensive, yet vitally important, Medicare and Medicaid programs.

This report was prepared by

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Top
MEDICARE: A BRIEF SUMMARY
MEDICAID: A BRIEF SUMMARY
THE MEDICAID -- MEDICARE RELATIONSHIP
CONCLUSION

THE NATIONAL FOSTER CARE AWARENESS PROJECT

Recently there has been a great deal of well-deserved attention to the challenges young people face as they make the transition from foster care to adulthood. News articles and young people themselves point to the need for stronger systems of support for these most vulnerable citizens. We must now move toward improvement of programs and coordination of policies that will enhance the child welfare system's ability to help every foster youth become a self-sufficient, contributing member of his or her community. This discussion can be clearly articulated within the framework of existing child welfare reform efforts that focus on ***safety, permanence, and well-being.***

Safety

In the majority of states, emancipation of a foster youth is not determined by readiness, but happens by statute at 18 or upon attainment of a high school diploma or GED. Research demonstrates that young people who emancipate from the foster care system experience great risk in terms of emotional, economic, and physical safety. They are more likely to become homeless, to leave school without a diploma or GED, to experience early parenthood, and to be victims of violence than their mainstream peers. Like all youth in their age bracket, they are more likely to be unemployed or underemployed, with the additional burden of less educational achievement and opportunity. *Young people report that the transition to independence and expected self-sufficiency is often very rapid, sometimes unplanned for and unexpected, and results in their feeling "dumped".*

Strengthen the system of support that contributes to the ***safety*** of young people emancipating from the foster care system.

- Increase early and consistent access to independent living preparation, especially opportunities for realistic practice of employment and life skills.
- Ensure the active involvement of young people in the individual planning and decision making processes that will lead to successful emancipation.
- Increase access to emergency shelter, transitional housing, and longer-term affordable housing options; ensure that no youth is discharged to homelessness.
- Provide support and concrete assistance, including healthcare, basic necessities, and formal aftercare services through age 21.

Permanence

Young people need appropriate information about the strengths and limitations of all permanency options, including adoption, legal guardianship, and other permanent living arrangements, as well as emancipation. Though many foster teens are adopted each year, emancipation to independence is the reality for many others. Long lasting, supportive, and strong connections to family members, friends, and other adults are critical to young people's healthy development while they are in foster care and to their success in adult life. *Young people report that relationships with people who care about them and are there for them consistently make all the difference in the world when they are on their own.*

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Strengthen the system of support that contributes to ***permanence*** for young people emancipating from the foster care system.

- Provide more information about permanency options and support in making decisions related to permanency to young people, families, foster/kinship caregivers, prospective adoptive parents, and service providers.
- Encourage discussions of permanence both inside and outside of the legal context so that child welfare staff can help emancipating youth build the networks of support they need to make successful transitions.
- Ensure early and continuing access to supportive adults, including biological family members, identified family/kin, mentors, former service providers, and other community members who can be part of a long-term network of support.

Well-Being

Personal and social functioning, health, education and employment are all critical areas of well-being for young people as they move toward adulthood. The experiences that result in children and youth being placed in foster care, as well as the experience of foster care itself, can create barriers to achieving well-being in any or all of these areas. Coordinated efforts on the part of policymakers, public officials, caregivers, service providers, educators, community members, and youth themselves are critical to the positive development of young people making the transition to productive interdependence. *Young people who have left the foster care system say that disruptions in education due to changing placements, inadequate preparation for the workplace, lack of access to physical and mental health care, and the immediate struggle for day-to-day survival after leaving care make planning for a good future very, very difficult.*

Ensure the current and future ***well-being*** of transitioning foster youth.

- Provide a continuum of support and preparation for adulthood that begins when a child or youth enters foster care and continues through the post-emancipation period.
- Stabilize foster care placements to ensure educational continuity and achievement.
- Increase youth involvement in the planning and delivery of services to transitioning youth at the local, state, and national levels.
- Create national and local networks of foster youths and former foster youths that will enhance overall levels of support and participation.
- Provide opportunities for organizations serving older youth to network with each other, communicate strategies, and coordinate service delivery.
- Facilitate greater coordination among and between national and local education, housing, health, employment, and assistance programs to better serve this population.

The Casey Family Program

October 28, 1998

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Dear Carol:

We are delighted to see increasing attention to the issues of older youth aging out of the foster care system including Mrs. Clinton's recent column on the issue, the attention of varied media outlets as a result of this summer's *Washington Post* article and new expressions of interest from several foundations. It seems that the drumbeat created through the Foster Care Project that came together in connection with the PBS documentary *Take This Heart* is beginning to have an impact.

Our recent conversations about convening key practitioners, policymakers, and alumni of the system to help develop policy boundaries now seem even more relevant, and the time more urgent. To capitalize on this current attention, we propose to work with you to convene a meeting early in 1999 to take a deliberate and analytical look at current policy and practice regarding self-sufficiency and the transition from foster care to independent living. The outcome for this convening would be to capture best thinking about policy and practice improvements leading to better outcomes for young people aging out of the foster care system.

We suggest convening a group of 25-30 individuals in Washington, D.C. in February or March for a facilitated meeting that will result in concrete recommendations about policy and practice enhancements. Optimum timing for this gathering relates to the presentation of the Administration's year 2000 budget and programs. The Casey Family Program is committed to underwriting the cost of this meeting. Attendees would include policy experts, practitioners, and alumni of the foster care system from across the country, with diverse perspectives but committed to reaching consensus on recommendations for the Administration.

As you and I discussed, we would like the Children's Bureau to be a partner so that this is a joint public/private effort. In light of the First

Lady's interest in this issue, the optimum auspices for this convening would be the White House. Staff from The Casey Family Program and Annie E. Casey Foundation, partners in the Foster Care Project, have a meeting with Nicole Rabner of Mrs. Clinton's staff on November 3rd to discuss independent living and in part to explore possible involvement of the First Lady with this convening.

This gathering is one of a multi-phased effort to work on this issue. We will continue to be responsive to the White House as a resource and want to work with and support the staff of the Children's Bureau in developing ideas and policies that can improve the lives of older youth in care. We will work with our partners as well to continue bringing attention to this population of children and to gathering and sharing 'best practices' across the country.

I would welcome the chance to talk to you this week about this convening. We are prepared to move forward as soon as possible. Thank you.

Sincerely,

Ruth W. Massinga
Chief Executive Officer

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
002. list	Clearance information re Foster Care Emancipation [event] (partial) (2 pages)	11/16/1998	P6/b(6)

COLLECTION:
Clinton Presidential Records
First Lady's Office
Domestic Policy Council (Nicole Rabner)
OA/Box Number: 15410

FOLDER TITLE:
Emancipation-Interagency Issue [1]

2012-1035-S
kc998

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

[002]

Clearance Information for Monday, November 16th, 1998 4:00PM - 5:30 PM
Staff member: Nicole Rabner
RE: Foster Care Emancipation

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Department of Health and Human Services
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SS#: P6/(b)(6)

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November 13, 1998

Mrs. Bernadette Chirac
Palais de l'Eysee
55 rue du Faubourg Saint-Honore
75800 Paris

Dear Bernadette:

Thank you for your thoughtful letter about your recent travel to Correze. I have warm memories of our visit and am delighted to know that les Correziens feel as I do. I am also pleased to know that you had an enjoyable trip to New York and I look forward to seeing you again soon.

With warm regards to you and President Chirac, I remain

Sincerely yours,

Hillary Rodham Clinton

Aging Out

THE WHITE HOUSE
WASHINGTON

Justice -
· Shary
· Sarah Ingram

O Lynn Jennings, DOL (Rich Magahee)
219-6197 x126

Maureen McLaughlin, DOE Dep A S
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205-2987

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Carol Williams, ~~HHS~~ off 4R
205-8618

CNS : - Tess Scannell 606-5000 x300
~~John Gompers~~ x121 | Americorps Res. Program
Susan Weiss 206-282-7300 | Nccc

Donna Shark 410-547-6600

DOL :
Natl Youth Employment Coalition

CDF - Marylee Allen

- Draft

November xx, 1998

MEMORANDUM FOR DISTRIBUTION

FROM: **NICOLE RABNER**
DOMESTIC POLICY COUNCIL

SUBJECT: **Meeting on Foster Care Emancipation Issues**

Please join a discussion on Thursday, November 12th, about young people "aging out" of foster care. As many of you know, when young people in foster care turn 18, federal foster care assistance ends and they begin an often difficult transition to independence. While there are some federal assistance programs run by the Department of Health and Human Services that target this age group, they are small in scale.

The purpose of this interagency meeting is to explore how we can better target existing resources to serve this vulnerable population. As I have mentioned to many of you on the phone, we hope to develop an interagency initiative in this area.

To the extent possible, please come to the meeting prepared to discuss the programs administered by your agency that affect these young people and your agency's possible contributions to an initiative that better targets new and ongoing resources to serve them. Attached please find a background piece on this issue prepared by the Department of Health and Human Services and a recent column by the First Lady on this topic.

The meeting will take place on Thursday, November 12th, at 4:00pm in Room 211 of the Old Executive Office Building. Please call Debra xx to confirm your attendance and provide clearance information (date of birth and SSN). I look forward to seeing you next Thursday. Thanks very much.

DISTRIBUTION:

Friday
3 pm ?

Carol Williams, Department of Health and Human Services
xxx, HHS
Shay Bilchik, Department of Justice ~~xxx~~ 616-3650
Sarah Ingersoll, Department of Justice 307-5911
Maureen McLaughlin, Department of Education
Lynn Jennings, Department of Labor
Fred Karnis, Department of Housing and Urban Development
John Gomperts, Corporation for National Service
Tess Scannel,Corporation for National Service
Jennifer Klein, White House Domestic Policy Council
Trooper Sanders, Mrs. Gore's Office

FACSIMILE TRANSMITTAL SHEET

AMERICORPS*NATIONAL CIVILIAN COMMUNITY CORPS
1201 New York Avenue, NW
9th Floor
Washington, D.C. 20525
(202) 606-5000
(202) 565-2791 (FAX)

TO: Nicole Rabner DATE: 10/23/98

ORGANIZATION: Office of the First Lady

PHONE #: _____ FROM: Erma Hodge for Lt. Gen. Andrew Chambers

FAX #: 456-2878 PHONE EXTENSION #: _____

PAGES, INCLUDING COVER: 2

COMMENTS: _____

What is AmeriCorps*NCCC?

AmeriCorps*NCCC, the National Civilian Community Corps, is a 10-month residential national service program for young women and men of all social, economic, and educational backgrounds. The program takes its inspiration from the Depression-era Civilian Conservation Corps (CCC), which put thousands of young people to work restoring our natural environment. AmeriCorps*NCCC retains the CCC's focus on the environment, but recognizes that as the challenges our nation faces become more diverse, so must the solutions.

AmeriCorps*NCCC encourages citizens to act on their responsibility to themselves, their communities, and their country by mobilizing local community members to work alongside AmeriCorps*NCCC members. AmeriCorps*NCCC combines the best of military service, including leadership and team building, with the best practices of civilian service.

Where do AmeriCorps*NCCC members live?

Four of AmeriCorps*NCCC's regional campuses are located on downsizing or closed military bases — in Washington, DC; Charleston, S.C.; Aurora, Colo.; and San Diego, Calif. The fifth campus is located on the grounds of the VA Medical Center in Perry Point, Md. Members share rooms in residence halls equipped with lounges and other shared areas.

After rigorous training, members work on a variety of projects lasting one day to six weeks. Members may be temporarily relocated from their campuses to projects in communities throughout their region of the country. During their service, members serve in teams with people of all different backgrounds who have one important thing in common — a commitment to serving their communities.

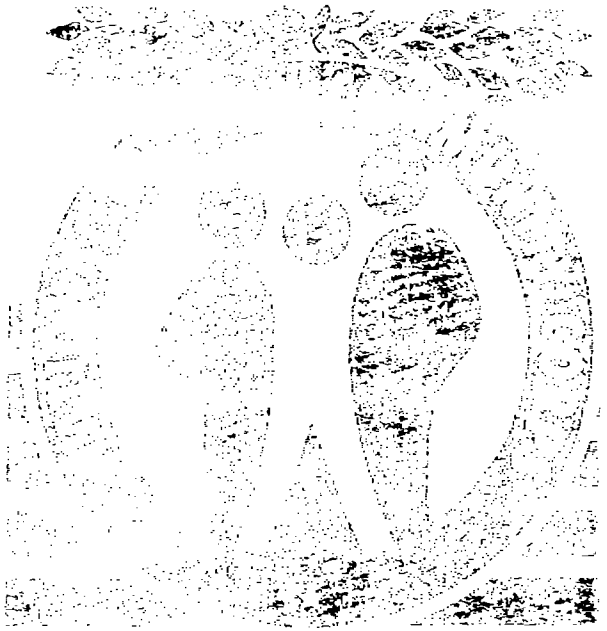
kinds of service AmeriCorps*NCCC members provide?

The number one priority for AmeriCorps*NCCC members is improving the environment. Members construct, map, and improve urban and rural parks; restore streams and rivers; and conduct environmental education programs in schools and community centers.

Projects are as diverse as the communities they serve. Members work to address communities' most pressing needs in the areas of education, public safety, human needs, and the environment. Recently, eight teams painted nearly 300 units and renovated common areas in a public housing apartment complex for senior citizens. In partnership with local health departments, AmeriCorps*NCCC teams developed and implemented a comprehensive immunization outreach campaign that identified over 1,800 children with delinquent records.

In times of special need, AmeriCorps*NCCC members come together to provide intensive disaster relief. Several AmeriCorps*NCCC teams are trained by the U.S. Forest Service for forest fire suppression. All members receive disaster relief training. Members have assisted on a variety of relief efforts, including aiding flood victims in West Virginia, Pennsylvania, Texas, California, and Louisiana.

AMERICORPS*NCCC



What benefits do AmeriCorps*NCCC members earn?

Along with an experience of a lifetime, AmeriCorps*NCCC me bers receive a modest living allowance and room and board wh participating in the program. At the end of their term of servi they receive an education award of $4,725 to help pay for colle graduate school, or training programs — or to repay student loa

Although AmeriCorps*NCCC can help pay child care for memb with dependent children by matching a portion of members' p ments, children are not allowed to live on the campuses.

Who is eligible to join AmeriCorps*NCCC?

AmeriCorps*NCCC is looking for women and men between the a of 18 and 24 who are ready to commit up to a year of their lives to m ing America stronger, safer, smarter, and healthier. Applicants sh also be willing to relocate to any of the five AmeriCorps*NCCC c puses. Members must be citizens, nationals, or lawful permar resident aliens of the United States.

~ mmns – c. 6 approps [illegible] [illegible]

Maureen McLaughlin:

· severely disadvan

· Independent student – quite eligibility

· are they prepared?

New p..

H.E.A – Gear up – middle schools – prepare for – thru h/s. *

It is there – helping to know –

TRIO programs – precollege, in college –

Preparation.

Carroll, etc., IL

HRC - hope, enthusiasm - set tone

six issue areas

1. kinship care - improved
   oversight not same when put w/ relatives - need same preparation / training
   foster care training
   less stringent - why? / conflict res. needed - not line
   subsidy less than before

key issue: training - licensing, subsid

2. foster care youth aging out
   range of services needing
   rec - training, op for job train ed.,
   housing (homelessness), incl. - medicare, TANF
   job training (end up TANF elig.)

3. improving adolescent adoption
   cut thru stereotypes - PSAs (teenage
   deserve an adoptive opportunity, too.

4. Ed issues
   wards of the state, homeless youth
   not harm op - nonscholastic training.
   finish h-s, scholarship - way pos.

5. Ec Opp.
   rec: IL skills & training - need a base
   to start from bef. they can be
   don't start early enough, not intensive
   enough

Bridge to adulthood they need, particularly w/ challenges they have

Transitional Living – safe, stable to be

6. Younger adolescents
   training for kin parents / siblings / older youngsters – foster care

HHS Thinking:

1. kinship care – Dept. encourage States to encourage IL in kinship care – informally w/ relatives. we can't pay for it (only for children in formal foster care system).
   add issue to their deliberation – working group

2. Emancipation:
   - Labor – jobs / training / apprenticeship. targets, Union connections – support
   - HUD – q of housing
     alert local housing auth / discretionary res.
     LA County – need HUD $ to build – use some space – mentors
     (avail only for kids ... some resources)
   - HHS – ACFA
   - Education – fed scholarship program – info gets to kids – targeted – indigent kids
     Tuition remission prog. – state univ – disseminate model – FL

Adolescent Op. – funding – Demo – adoption of older youth – continue to do that – host placement support. – successful

ON ASSIGNMENT

One -on- One

BY LINDA JACOBSON

Seattle

When Marie Buonato met Daniel three years ago, he was on his ninth foster home, he had been expelled from a private school, and he hadn't been enrolled in a new school for several weeks because his social worker didn't know where he would end up being placed.

Buonato began meeting with him in his new foster home once a week—a condominium here on Lake Washington, where he lives with the woman he now calls his grandmother.

"He was very, very angry," says Buonato, a Roman Catholic nun with a background in education and counseling. "In spite of all the bravado he puts on, he's very insecure."

Now 11, Daniel, an engaging and attractive boy who has been in foster care most of his life because his birth mother abandoned him, talks about what he's good at in school.

"I like reading, and I like Marie. She's helping me work on my division," he says. "The best thing is she's here."

Buonato is a tutor for Seattle's Treehouse agency, which serves schoolchildren in King County's child-welfare system. While Treehouse's tutoring program primarily serves elementary students, Buonato is committed to continuing her once-a-week sessions with Daniel as he enters middle school this fall.

"I can't change their lives or take away their pain," Buonato says about the children she helps. "But I can give them the skills to make a better life."

Most children in foster care don't have someone like Buonato—someone whose main purpose is to keep children in school and on grade level in spite of the trouble and instability around them.

With roughly half a million children in foster care—a 74 percent increase since 1986—it's obvious that a greater number of the nation's students are in the child-welfare system. The increase is strongly linked to parents' addiction to crack-cocaine.

Teachers, while sympathetic to the needs of abused and neglected children, often don't know who they are. And even if they did, they've probably never been trained to recognize and handle the behaviors and attitudes that many children in foster care exhibit, such as anger and an inability to concentrate. In addition, many such youngsters have learning disabilities, and some refuse to speak. One study found that foster children are more likely than others to be emotionally disturbed.

What's more, with caseloads of 30 or more children, social workers are so focused on removing children from abusive situations and meeting their basic needs that attending to such concerns as reading scores and homework completion is practically impossible.

But a growing number of efforts around the country are working to bring educators and social workers together and to emphasize that these children need an education along with food, clothing, and safe homes.

Improving the lot of foster children is a tough task. Making it tougher has been what many see as an underlying mistrust between educators and social workers. "The two systems don't understand each other, they don't respect each other, and they see

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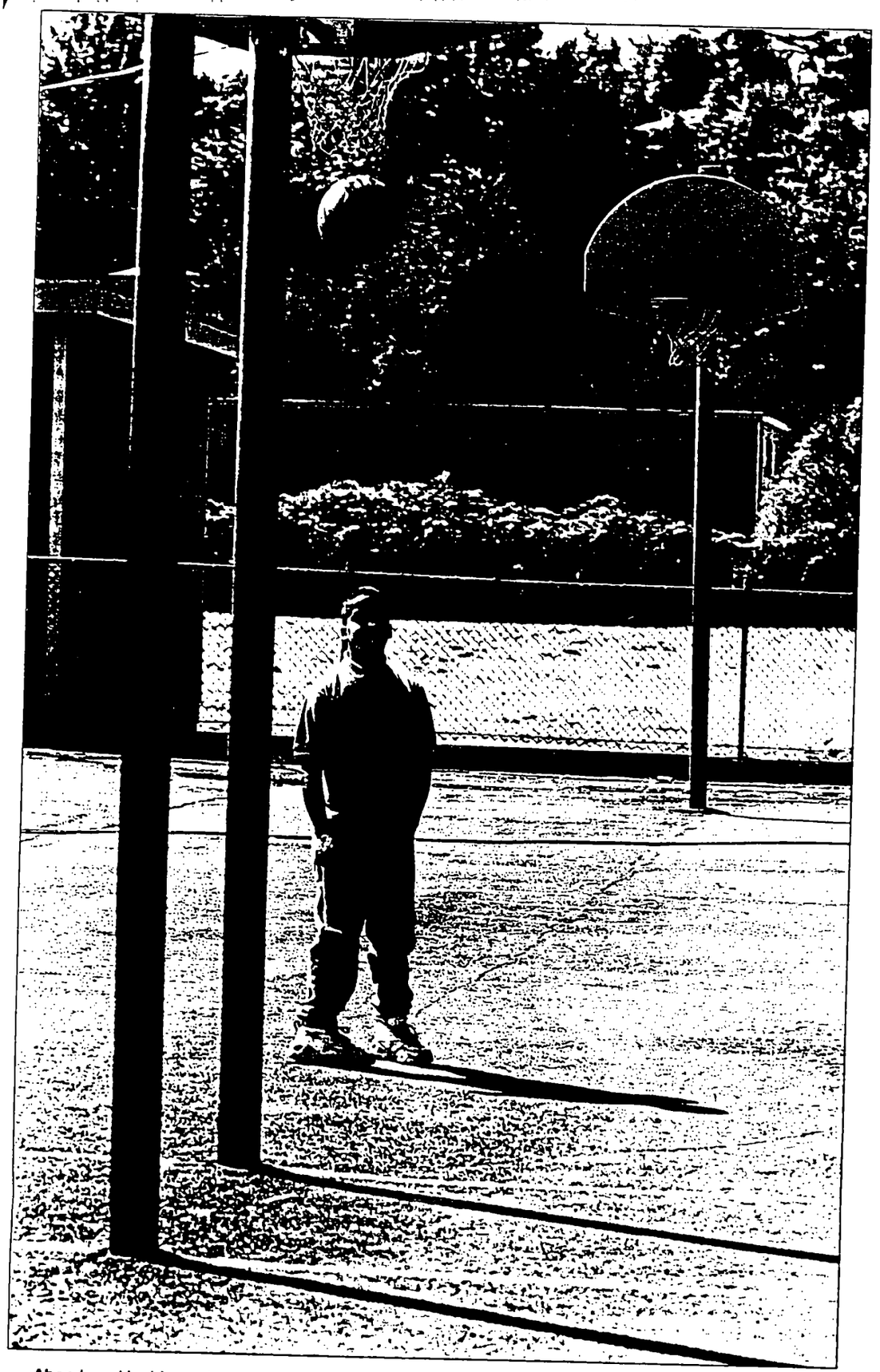
Providing a safe haven has long been the mission of the foster-care system. Now, though, a small but growing number of jurisdictions are counting education among foster children's basic needs.



Abandoned by his mother, Daniel floundered in school until he was matched up long term with a tutor.

PHOTOS BY JIM BATES

no reason to work together," says Sandra Altshuler, an assistant professor of social work at the University of Illinois at Urbana-Champaign. She's been running a research project and mentoring program for foster children at two middle schools in Champaign for the past two years.

Teachers complain that social workers hide behind policies that are intended to protect the privacy of children, while caseworkers contend that schools tend to hold up the transfer of student records when a child is sent to a new school. As a result, students are often caught in the middle.

But it's in the middle where people like Altshuler and Jap-Ji Keating, the director of Treehouse's tutoring program, feel comfortable. They are, in effect, creating a position that hasn't existed before.

Principal Claudia Allan, left, confers with Jap-Ji Keating, about the foster children her agency works with at Concord Elementary School in Seattle.

"To know both systems, and to be able to use both systems—that takes skill," says Keating, who came to the Pacific Northwest four years ago to work on her doctorate in education at Seattle University.

The tutoring program is one of four programs at Treehouse, which was organized four years ago and is subsidized with private donations. But it's not the one that the local newspapers write about. Little Wishes, the project that gives foster children a chance to redeem their wishes, usually gets the attention.

"But education is the gift that keeps on giving," Keating says, laughing at her use of the cliché.

Until last school year, her five tutors drove all over the city to meet with the children they were serving.

"We were spending a lot of money on gas, and the tutors were becoming exhausted," she says.

But now, they are each based at an elementary school with high numbers of children in out-of-home placements. A sixth one is expected to be added this fall at an elementary school in Bellevue, a town east of Seattle, on the other side of Lake Washington.

Being in the schools allows the tutors to meet with the students on a daily basis and to become what many of these children have never had in their lives—a dependable adult.

Lindy Orlin, one of the Treehouse tutors, sits at a standard-sized library table with 9-year-old Ashley (not her real name) at Emerson School, located south of the city in the Rainier Valley. The two flip through a tablet of Ashley's drawings, a collection of flowers, faces, and colorful patterns.

The school day is ending, but it's been a big one for Ashley. Her teacher has enlarged several pieces of her best artwork and plans to exhibit them at parent night later in the week.

But on this afternoon, Ashley is preoccupied with something else that's going on in her life—a move that's about to take place into a family interested in adopting her. She's worried, Orlin later explains, that she'll be gone before parent night because her current foster family is already packing up her clothes, including the dress she plans to wear to the event.

"The teachers don't know what's going on," Orlin says, "but they are very sympathetic" that the girl is going through emotional turmoil over some private matter.

The tutors do much more than their title implies. One role they play is to help the schools become more familiar with child-protective services. Teachers, who are alerted to the foster status of children, also gain more awareness of their needs because they meet with the tutors to set academic and behavioral goals for the boys and girls.

It took a while, however, for the tutors to get access to the information they felt they needed.

"One of the biggest things was finding out if the kids were passing," Keating says. "How could we find out if we were doing our jobs well if we didn't even know if the kid was passing or failing?"

Treehouse tutors have since forged strong relationships with many of the educators they work with. "They are more than trained tutors. They are providing one-on-one support," says Claudia Allan, the principal of Concord School in the southwest section of Seattle. "The students can pick up the academics that they've been shut out of because of a chaotic home life."

Of the 65 children served by Treehouse tutors last school year, 70 percent were found to be living in "turbulent to highly turbulent" family situations, Keating says, referring to a recently completed evaluation of the project.

Despite their circumstances, many of the children made remarkable progress. Only two pupils did not advance to the next grade level. More than half improved their math skills by one or more grade levels. The results were similar in reading and spelling.

More than two-thirds of the group met all or most of their individual behavioral goals, and most of the children achieved all or most of their reading and math goals.

"These are highly capable children," Keating says. "When you put that network of loving care around them, they can do it."

The tutors find that their biggest challenge is helping the children concentrate. And they say it's common for these students to wander away from class or school activities when they don't want to do something.

That's why behavior goals, in addition to academic ones, are set. Sometimes, they are as simple as keeping an organized book bag or turning in homework assignments.

Most of the tutors have also found sneaky ways to help the children focus on their work. Some use candy or small gifts as an incentive—an indulgence that Keating admits she allows. She once gave a little girl 50 cents every time she would ride the school bus and not argue with the driver. The youngster earned $25, and Keating took her shopping.

Marie Buonato, who works out of Wing Luke Elementary School, also in the Rainier Valley, used to carry a stuffed bear for the children to talk to or to hug. One girl, who struggled so much with her writing assignments, gave the bear a hug every time she put a word on paper.

Orlin has incorporated art and poetry into her tutoring sessions, and often tells the students to "draw themselves without their bodies"—an activity that Ashley used to produce several pieces of artwork.

But since her recent school transfer, Keating reports, Ashley hasn't been drawing. And her new school is too far away for her to continue meeting with Orlin.

Daniel works on a lesson with Marie Buonato, who has tutored the 11-year-old for three years, including summers. The tutoring will continue when he goes to middle school.

The odds against children in foster care achieving success in school are great. Studies dating back more than 30 years conclude that when children enter foster care, they are already behind academically, and they don't catch up.

And with a growing emphasis nationwide on higher academic standards and student and teacher accountability, educators and child-welfare experts fear that many students in these circumstances are bound to get left behind without extra help.

"The kids in child welfare are not going to pass those tests," contends Janis Avery, the managing director of Treehouse, referring to new statewide tests in Washington state.

A national study from 1991, conducted by Ronna Cook at Westat, a research company in Rockville, Md., found that out of 810 18-year-olds who had left the foster-care system within a single year, two-thirds had not completed high school.

Children in foster care are also less likely than children living with their parents to be in a college-bound track in high school, even though the grades and test scores of both groups are about the same, according to a 1997 analysis of the U.S. Department of Education's "High School and Beyond" survey. Wendy Whiting Blome, a consultant to the Washington, D.C.-based Child Welfare League of America, also found in her analysis that children in foster care were more likely to report that they had been disciplined in school and that they had been in "serious trouble with the law" during their high school years.

Once out of high school, young adults from foster-care backgrounds were more likely to participate in job-training programs than those who had lived with their parents, but less likely than the comparison group to attend a formal postsecondary education program.

But the educational deficits of children in the child-welfare system can start long before formal schooling begins.

A study, released last year by researchers from Allegheny University of the Health Sciences in Philadelphia, showed higher rates of speech and language delays among infants and toddlers in foster care.

In fact, children younger than 4 represent the fastest-growing segment of the foster-care population. They end up in the system largely because their parents lose custody as a result of crack-cocaine use, which is once again on the rise, surveys show.

Judith Silver, an assistant professor of pediatrics and one of the Allegheny University researchers, says little information is available on whether young children in foster care are receiving early-intervention services.

The success of the foster-care system has always been calculated in terms that have little to do with how a child is faring in school. Words such as "permanency" and "reunification" are commonly used to describe a child's home and family situation, but little, if anything, is said about academic performance or what children are likely to do after they "age out" of the system at 18.

But Treehouse and similar projects are trying to change that by collecting and monitoring school performance data on children in foster care and urging child-welfare agencies to do the same.

"One of the things that has been an ongoing frustration for me is that these case outcomes are not kid outcomes. We measure success by when the kid gets out of the system, not by what happens to the kid," says Mei Lan Loi. Until July, Loi

---

Academic success often eludes foster children. Some new tutoring projects link them with reliable adults who help with their studies and allay their feelings of isolation.

was a planner at the Vera Institute of Justice in New York City, where she worked on a project in which a caseworker from the city's children's services administration was assigned as a liaison to a middle school in Brooklyn. The caseworker provides individual and group-counseling sessions to a handful of foster children and serves as a contact for teachers.

A private, nonprofit agency, the Vera Institute works as a consultant to local, national, and international government agencies on criminal and juvenile-justice issues. A middle school was chosen for the project in an effort to reduce delinquency among young adolescents.

iel talks to William Cook, his former principal at Dunlap Elementary School. For his ve into middle school this fall, his foster mother enrolled him in a Catholic school.

Loi's goal was to see "a body of caseworkers" throughout the city trained to focus on foster children when they are hitting their adolescent years and to increase education and other services to children in their early teens.

To give these programs a chance at success, Loi believes that paid professionals, rather than volunteers, need to work with the children.

"You need people with certain skills. This is not just about getting nice people who want to do some nice things for kids," she says. "These kids need some extreme structure. You can say, 'I will take you home and buy you pizza,' and they still won't come."

Like Loi, the University of Illinois' Altshuler also found the middle school years to be a critical time for young people in foster care. After working with students for two years—in focus groups and through a mentoring program—she particularly noticed their achievement starting to slack off during the last quarter of the school year.

To her, the slippage suggests "that they are very anxious about the summer, and they see school as a safe place."

Most efforts to draw attention to and improve educational results for children in foster care are small, pilot-level programs unconnected to any national network or organization. But one large-scale project under way in New York City could permanently change the way the school system and the child-welfare agency operate there, as well as influence other districts and agencies around the country.

About 1½ years ago, Nicholas Scopetta, the commissioner of children's services in New York City, and Rudolph F. Crew, the chancellor of the city's school system, reached an agreement to share data in a way that would reveal just where the city's 40,000 foster children go to school and how they are progressing.

In addition to making data on such information as repeat school absences available to children's services, the "memorandum of understanding" included the appointment of school system and child-welfare liaisons who would work together on cases. The new relationship between agencies also includes joint staff-development courses.

"When you have two systems that are providing services for the same family, the same child, it's incumbent upon the systems to collaborate," says Pedro Cordero, the director of interagency affairs for children's services.

Another collaborative project is taking place across Massachusetts. It began on a pilot basis in the middle of the 1996-97 school year and has now grown to reach roughly 500 children in 15 districts.

"The goal was really to try to get the different groups to communicate better—teachers, foster parents, and social services," says Susan Stelk, the education coordinator for the state department of social services. In addition to assigning a liaison to work with the schools and the caseworkers and offering training to the various parties involved, the project has provided direct services to children in foster care, such as tutoring, after-school activities, and psychological counseling.

While information was collected on all 551 of the children involved in the project, 41 of them were followed more closely by an outside evaluator, who found small improvements in school attendance and behavior over the course of last school year.

More telling were the numerous anecdotal accounts of better relationships between foster parents, school personnel, and caseworkers, Stelk says.

The plan for the coming year is to reduce funding slightly in some districts while expanding the services to districts that serve more children in foster and adoptive homes.

The Massachusetts project has been paid for with state money so far, and this year it received $470,000. But Stelk hopes the local communities will be able to pay for the activities in the future.

Both private and public foster-care programs are also trying harder to find homes for children in familiar neighborhood surroundings—and near their schools—even though they might be losing a parent.

A 1980 federal law called for such arrangements, but the reality has been that children are often placed outside their communities because of a shortage of foster families.

Children in foster care often miss big chunks of the school year because they are so mobile. And with the transfer of student records sometimes delayed in the process, administrators and teachers often don't know how to serve incoming foster children.

After reviewing Treehouse's data from last year, it became clear to Keating, the director of the agency's tutoring program, just how damaging a disruption during the school year can be.

"What we're finding is that every time a child moves, they go through a period of not being able to re-engage," she says. "They are obsessed with 'Where am I going to go?' "

Sometimes, she adds, they just shut down and quit talking.

A few schools have found creative ways to provide the transportation necessary to keep children from changing schools—yet again.

Gatzert Elementary School in Seattle, for example, receives extra money from the district to cover transportation

One of the biggest challenges facing child-welfare workers and educators is their underlying mistrust of one another. They don't understand or respect each other, one expert says.

costs for homeless children, and it is extending those services to children in foster care.

"If they move across town, it doesn't mean they have to lose their school," says Randy Riley, an intervention specialist at Gatzert.

Keating is pursuing a legislative package in Washington state that would include some funding for transportation so students in foster care wouldn't have to change schools so often. She also wants the state to create a program specifically for foster children in middle school that would give them added support in preparing for high school. And she wants full college scholarships for those students when they graduate.

Both Texas and Florida already offer tuition waivers to foster children who want to attend college.

While most of the projects that seek to bring educators and social workers closer together are just getting off the ground, one program in California dates back to 1972. The Foster Youth Services Program provides tutoring and counseling to children in foster care in six school districts.

But Robert Ayasse, a social-services liaison for the Mount Diablo district, east of San Francisco, wrote in a 1995 article that one of the most valuable things the program does is track down school transcripts and other important documents, such as birth certificates and immunization records. Often, there are big gaps in these students' education histories because of their transience. When they need to start accumulating credits for graduation, turning up the records becomes even more critical.

Foster Youth Services, which served about 3,100 children last school year and received $1.4 million from the state, is one of a few programs to receive state aid—and to receive it for so long.

But Ayasse believes attention to this issue will continue to grow, thanks in part to changes in states' welfare systems under the 1996 federal welfare-reform law. "The percentage of foster kids who end up on public aid is astronomical," he says.

Research shows that anywhere from 30 percent to 50 percent of former foster children wind up on welfare as adults. Moreover, adolescent girls in foster care are twice as likely as other girls in their age group to get pregnant, according to Kathy Barbell, the director of foster care for the Child Welfare League of America.

Experts recommend that schools of education train new teachers on how the child-welfare system works and inform them about some of the common effects that foster care has on children. Teachers should also be more careful about asking students to do such assignments as making a family tree or bringing baby pictures from home, says Lynne Steyer Noble, a senior consultant for the Center for Child and Family Studies at the University of South Carolina in Columbia.

"It's not so much that school people want to be mean. It's that they don't know in a lot of cases what goes on with these kids," says Noble, a foster parent for 20 years. She also conducts training workshops for new foster and adoptive parents, as well as caseworkers.

But Allan, the principal in Seattle, believes that teachers should be shielded from some information about their students so they can concentrate on teaching.

Showing foster parents how to better navigate their way through the school system and become advocates for their foster children is another key to helping schools address these students' needs, Noble says.

Foster parents, however, are often handicapped by the fact that biological parents generally retain many decision-making rights in the education of their children, particularly when it comes to special education.

A not-uncommon scenario, according to caseworkers and foster parents, is that school officials might believe a child needs to be tested for special education, but the birth parents won't give permission. They might be angry with the school in the first place for reporting suspected child abuse or neglect.

Such situations further complicate the relationship between schools and social workers and keep students from getting the instruction they need.

Other foster parents note what they describe as a prejudice against children in foster care and an automatic response from the schools to label such youngsters with a behavior disorder or learning disability.

"The first place the school wants to stick them is in special education," says Pearl Graham, a foster parent from Austin, Texas, and a former teacher.

A 1992 study on the use of special education services by foster children in Illinois found that more than six times as many foster children were receiving special education as had been identified by the state's children and family-services department. Researchers concluded that social workers didn't know enough about the needs of the children they were responsible for.

Shirley Hedges, the president of the National Foster Parent Association, based in Crystal Lake, Ill., and a foster parent for 23 years, says she eventually home-schooled some of her charges because they were constantly being sent home from school for disruptive behavior. She also served on the local school board in Hopkins County, Ky., for eight years, and saw to it that foster parents were invited to serve on local school councils.

Fortunately for Daniel, the Seattle 11-year-old, his foster "grandmother," 70-year-old Cornelia Bosley, is one of those advocates. She enrolled him in a Catholic school this fall because she was worried about how he would fare in a public middle school. She's also in the process of adopting him.

"Daniel's got some tough little ways, but he's come a mighty long way since he's been with me," Bosley says, as Daniel steps out on the patio to play with a Nerf toy that Keating brought him.

Bosley also gives Treehouse much of the credit for Daniel's improvement.

Daniel, whom Keating describes as a "little Denzel Washington," had the chance to share his own thoughts recently at a citywide fund-raiser. He and hundreds of other foster children were given scholarships to attend summer camp, and the proceeds from the evening were going to the Treehouse camp program.

Going to camp, Keating says, has been Daniel's first successful social experience—one of the first places he hasn't been kicked out of.

"Campfire in the evening was a time for talking about the day, for saying positive things about each other and singing songs," Daniel read to the audience from a speech that Buonato helped him write. "Every night, I went to bed feeling very tired and very, very happy." ■

IL program

HELPING MORE STUDENTS PREPARE FOR COLLEGE THROUGH "GEAR UP"

"I also ask this Congress to support our efforts to enlist colleges and universities to reach out to disadvantaged children starting in the sixth grade so that they can get the guidance and hope they need so they can know that they, too, will be able to go on to college."

--President Clinton, State of the Union address, January 27, 1998

The Higher Education Amendments of 1998 launch GEAR UP, a new national effort to encourage more young people to have high expectations, stay in school and study hard, and go to college.

High-achieving students from low-income families are five times less likely to attend college than high-achieving students from high-income families [NELS 1998].

In a recent survey, almost 70% of parents indicated that they have little information or want more information about which courses their child should take to prepare for college, and 89% of parents want more information about how to pay for college, including the use of tax credits [Gallup, Sept. 1998].

The President's High Hopes Proposal. Earlier this year, President Clinton proposed the High Hopes for College initiative to create a national ethic that every college should partner with at least one middle school in a low-income community to help raise expectations and ensure that students are well-prepared for college. In the new HEA law, the High Hopes proposal and the National Early Intervention Scholarship and Partnership (NEISP) program are joined, as two different types of grants, under the new GEAR UP program.

GEAR UP (Gaining Early Awareness and Readiness for Undergraduate Programs). This new competitive grant program, authorized at $200 million in FY99, supports early intervention and college awareness activities at both the local and the state level. The Senate's FY99 Appropriations bill allocates to GEAR UP $75 million of the $140 million the President requested for High Hopes. The House Appropriations bill did not include funding for GEAR UP. The final appropriations legislation is now pending in Congress. GEAR UP funding will be split between partnership grants and state grants, with at least one-third allocated to each.

GEAR UP Partnership grants. As outlined in the President's High Hopes for College proposal, this initiative will award multi-year grants to locally-designed partnerships between colleges and high-poverty middle schools, plus at least two other partners -- such as community organizations, businesses, religious groups, state education agencies, parent groups, or non-profits -- to increase college-going rates among low-income youth. To be most effective, partnerships will be based on the following proven strategies:

Informing students and parents about college options and financial aid, and providing students with a 21st Century Scholar Certificate -- an early notification of their eligibility for financial aid;

Promoting rigorous academic coursework based on college entrance requirements;

Working with a whole grade-level of students in order to raise expectations for all students; and

Starting with 6th or 7th grade students and continuing through high school graduation with comprehensive services including mentoring, tutoring, counseling, and other activities such as after school programs, summer academic and enrichment programs, and college visits.

GEAR UP State grants. These grants are based on the current National Early Intervention Scholarship and Partnership (NEISP) program and will be awarded to states to provide scholarships, college information and early intervention activities. State programs will target services to low-income students and will provide college scholarships for participating students. College and community partnerships are not required but are encouraged, and many NEISP programs involve local organizations. Nine states received NEISP grants in FY98 totaling $3.6 million. These NEISP programs provide a variety of early intervention services and college awareness activities to students from 1st to 12th grade.

We anticipate that GEAR UP grant applications will be available in the beginning of next year. Questions or requests for more information can be directed to gearup@ed.gov.

EXAMPLES OF MENTORING AND EARLY INTERVENTION PROGRAMS

Many states education agencies, colleges, and secondary schools have had success working together to increase college enrollment rates among low-income students. To this end, the new GEAR UP program will support early intervention initiatives with elements of the successful practices described below.

Early Identification Program (Fairfax, Virginia): George Mason University (GMU) and the Fairfax County Public Schools developed the Early Identification Program (EIP) in 1987 to increase the number of minority students who enter college. Since then, additional school districts and new partners have joined the effort, including Booz Allen and Hamilton, Mobil Corporation, NationsBank and Crestar Bank. The program works with minority students that demonstrate academic potential and provides year-round tutoring, mentoring and other support throughout high school, including weekend and summer academic programs, special projects in math, science, English and computer science, campus visits, and workshops for parents. The program reports having graduated 6 classes from high school with a 71% retention rate. Of those who completed 4 years in EIP, 95% have gone on to college.

Pace Hispanic Outreach Program (White Plains, NY): The program is a unique tutorial initiative for Hispanic immigrant students at the White Plains High School that is run through a collaborative effort involving the White Plains School District, Pace University and Centro Hispano. One-to-one tutorial sessions are held during study hall periods and are designed to complement and reinforce classroom instruction in English, mathematics and social studies. In addition, the program enlists high school counselors to provide weekly clinics to help high school seniors prepare college applications, financial aid forms and essays. Active community support and parental involvement has helped build confidence among participants by reducing the sense of powerlessness that language barriers cause in some Hispanic families.

Passport to College (Riverside, California): At the core of this effort is a partnership between Riverside Community College in California, the local school district, and a number of schools and local businesses. Its purpose is to encourage disadvantaged students to continue on to college. The program works with an entire grade of students, beginning in 5th grade, and follows them through high school graduation. Currently, 11,500 students are participating. Volunteers work with the students, teachers and parents in activities, including: campus tours, classroom presentations, teacher training workshops, parent meetings, and financial aid workshops. All

participating students who graduate from high school are guaranteed admission to Riverside Community College.

Project GRAD (Houston, Texas): Project GRAD (Graduation Really Achieves Dreams) is a school-community collaboration to improve the instructional quality and school environment for children in Houston's inner city schools. This effort combines research-based curricular reform in math, reading and language arts with comprehensive services, including tutoring, mentoring and counseling, for children in kindergarten through high school. The project works with whole networks of schools -- elementary through high school -- to develop a consistent emphasis on high standards for all students. Project GRAD also promises all 9th grade students a $1,000 per year college scholarship if they reach basic academic standards. Currently, 24 schools in Houston and over 17,000 students are involved with Project GRAD. This massive effort is supported by a partnership of school, corporate, and community-based organizations and foundations.