WORK RE-ENTRY FOR PEOPLE WITH HIV: Access to Health Care and Disability Benefits

1999 Task Force Report

Department of Human Services
Continuing Care for Persons with Disabilities
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LEGISLATIVE DIRECTIVE

A task force was convened to meet the following 1998 legislative mandate:

The commissioner of human services shall study, in consultation with the commissioner of health and a task force of affected community stakeholders, the impact of positive patient responses to new HIV treatment on re-entry to the workplace, including but not limited to, addressing continued access to health care and disability benefits. The commissioner shall submit a report on the study with recommendations to the legislature by January 15, 1999.

1998 Laws of Minnesota, chapter 407, Article 4, Section 61

EXECUTIVE SUMMARY

The Human Immunodeficiency Virus (HIV) is a complex, life threatening condition. It is chronic in nature, affects many aspects of a person's life, and often takes an unpredictable course. Many people living with HIV experience serious health consequences that limit their ability to function independently in society and the workplace. Until recently, research and mortality rates suggested that recovery from the HIV disease was unlikely.

Over the last couple of years, new HIV treatments have begun to produce beneficial results for some people that have allowed them to consider new life possibilities including re-entering the workforce. Advances in medical treatments, access to appropriate health care, the availability of supportive services and effective civil rights protections (such as the Americans with Disabilities Act) have presented opportunities for some people living with HIV to consider work re-entry. At the same time HIV treatments are very complex, their results are inconsistent and their long term effectiveness not yet known. Strains of the HIV virus not responsive to the new treatments have been detected. These conflicting realities have led to challenges for people living with HIV, those who support them, and policy makers alike.

The Minnesota Legislature requested that the Department of Human Services and the Department of Health convene a task force of community stakeholders to analyze the effects of new HIV treatments on work re-entry possibilities for people living with HIV The following findings of the task force indicate that the decision to re-enter the workforce can be problematic for many people due to concerns about the stability of their health, the impact of work re-entry on existing income and health care benefits, and concerns about workplace issues such as confidentiality and possible discrimination. Given the current risks associated with an employment change which are outlined in this report, the task force believes it is likely that only a small number of individuals with HIV/AIDS will re-enter Minnesota's work force without additional policy changes.

The HIV Health Care Access and Work Re-entry Task Force (the Task Force) recommends that state policy makers pursue policy changes that allow the talents, skills, and abilities of persons living with HIV, who are able and willing to work, to be utilized. The Task Force recommends that the legislature assure that people living with HIV/AIDS seeking to re-enter the workforce have:

- Continuous health care coverage with uninterrupted access to needed services, benefits, and providers,

- Accurate and individualized information about the impact of work re-entry on continued access to needed health care and disability benefits;

- On-going access to supportive services to effectively manage their health conditions, economic situations, and daily living needs; and

- Options to work in flexible arrangements that vary based on individual health conditions and needs.

Specifically, the Task Force requests that the Legislature take the actions that :

- Support provisions in state and federal law, including a Medicaid Buy-in Option, which allow persons with HIV/AIDS (and other disabilities) attempting work re-entry to:

  1) work for periods of time without losing cash and medical benefits,
  2) retain health coverage for longer periods of time after cash benefits cease, and
  3) resume cash and health care benefits immediately if a change in a person's health condition occurs.

- Support Minnesota's Social Security Administration (SSA) Demonstration project that establishes a state information and benefits counseling center.

- Expand reimbursement of HIV case management services to allow people to receive adequate levels of case management services when they attempt to re-enter work.

- Support the development of a Business Leadership Network (BLN) to build the state's work place capacity to effectively support people living with HIV/AIDS and other disabilities.

- Identify a state entity responsible for on-going data collection and analysis that allows a better understanding and monitoring of the issues, impacts, and trends of people with HIV (and other disabilities) entering or re-entering the workforce.

TASK FORCE COMPOSITION AND PROCESS

COMPOSITION OF TASK FORCE

The Department of Human Services appointed 26 people to the HIV Work Re-entry: Health Care and Disability Benefit Access Task Force to develop recommendations for this report. The Task Force was comprised of persons living with HIV, AIDS service organizations, vocational service providers, county agencies, advocacy organizations, the Social Security Administration, the Minnesota Department of Commerce, and the Minnesota Departments of Health and Human Services.

STRUCTURE OF TASK FORCE MEETINGS

The Task Force met seven times to establish a common understanding on the key issues, challenges, and options faced by people with HIV when considering work re-entry. Portions of each meeting were spent gathering information from local experts on relevant topics. The focus of individual meetings included:

TASK FORCE MEETING FOCUS

- Legislative Charge & Initial Task Force Plan

- Responses to new HIV treatments
- Health care needs of persons living with HIV/AIDS
- Private health care coverage

- Employment barriers facing persons with disabilities
- Impact of work re-entry on disability & health care benefits

- Decision-making about returning to work
- Workplace Issues - "Supporting Employees with HIV/AIDS"
- Current resources and supports

- State and federal legislative activity
- Additional Issues and Concerns
- Recommendations

- Public Forum
- Review Draft of Issues, Concerns, and Recommendations

Task force meetings were held at the Minnesota AIDS Project in Minneapolis with the exception of the Public Forum which was convened at the Aliveness Project also in Minneapolis.

BACKGROUND

The Human Immunodeficiency Virus (HIV) is a retrovirus that infects several kinds of cells in the human body, the most significant is a type of white blood cell called the CD4 lymphocyte (also known as the "T-cell"). The CD4 cell is a major component of the human immune system that helps keep people free from many infections and some cancers. HIV can disable the body's immune system and destroy its ability to fight diseases.

HIV is not the same as AIDS. A person who is HIV positive is given a diagnosis of Acquired Immunodeficiency Syndrome (AIDS) when he/she comes down with one of several diseases or cancers, such as: Tuberculosis, Toxoplasmosis, PCP, wasting syndrome (involuntary weight loss), candidiasis, or HIV dementia (memory impairment). People who have not had one of these diseases, but whose immune system is shown by a laboratory test to be severely damaged is also diagnosed as having AIDS. [1] Early in the HIV/AIDS epidemic people living with AIDS were given a two year life expectancy, treatments were limited and very few people had access to the care.

Since 1996, the widespread introduction of new drug therapies and combinations have resulted in improvements in how people living with HIV are treated. The drug therapies have enhanced the health of many people living with HIV. It is now more common for people to recover from one of the diseases that are associated with AIDS. Recently, the Center for Disease Control (CDC) reported that the number of HIV/AIDs related deaths in the United States has decreased to its lowest level since the 1980s. HIV/AIDS no longer ranks as one of the top ten causes of deaths in the U.S.

People living with HIV/AIDS who are re-entering the workforce face a multitude of complex issues and decisions. They often are not sure if they can sustain work at a level that will allow them to meet their income and health care needs. Many people will only be able to work on a part-time basis due to the roller coaster nature of the HIV disease. Some Minnesotans living with HIV/AIDS are highly dependant on local, state, and federal assistance for support, particularly to access necessary health care coverage through Medicaid and Medicare. Work re-entry could significantly impact their continued access to disability benefits, health care coverage, and other needed services or supports. It also could effect their ability to obtain and pay for needed HIV drug therapies. They may also experience additional barriers to full employment such as confidentiality issues, discrimination, and lack of support from their employer. Each individual must thoughtfully weigh these potential impacts against the benefits of returning to work.

On both state and federal levels, the need to remove policy barriers that hinder the

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[1] "HIV Basics". HIV Insite: Gateway to AIDS Knowledge. http://hivinsite.ucsf.edu/topics/basics

employment of persons with disabilities has been recognized. The Minnesota Legislature previously highlighted its recognition in a 1998 Resolution urging the United States Congress to reduce work disincentives for persons with disabilities (Appendix 2). The Legislature declared that effective federal action is needed to allow more people with disabilities (including those with HIV/AIDS) to reduce their dependence on Social Security, Medicare, Medicaid, subsidized housing, food stamps, and other state, local, and federal government programs.

This perspective has been reinforced by recent national studies and surveys of persons with disabilities. Following a series of national focus groups, the National Council on Disability submitted a extensive proposal to President Clinton entitled "Removing Barriers to Work: Action Proposals for the 105th Congress and Beyond" in September of 1997.. The proposal outlined a number of key issues that resulted from their review of work re-entry issues and recommended legislative actions that would make work pay and provide people with disabilities a safety net when re-entering the workforce. [2] The Social Security Administration (SSA) also has interviewed Social Security Disability Insurance (SSDI) recipients who have successfully returned to work. Factors most prominently cited in assisting workers with disabilities successfully return to work were necessary health care and encouragement from family, friends, health care providers, and co-workers. Many of the Council's recommendations were introduced to the 105th Congress in the Jeffords-Kennedy Work Incentives Act. Unfortunately, the legislation was not adopted during the 105th session. The Clinton Administration recently endorsed these ideas and included funding for them in his budget proposals. The Jeffords-Kennedy Work Incentives Act will be reintroduced during the 106th Congress.

A 1998 survey of Americans with disabilities conducted by the National Organization on Disability/Lou Harris Poll also has substantiated the need for change. The national study found that the greatest area of disparity between the disabled and non-disabled was employment. Nationally, only 30% of working age adults with disabilities are employed on a full or part-time basis compared to 80% of the non-disabled population. The survey further found that 72% of the persons with disabilities (age 16-64) who are not employed prefer to work.[3] These findings were echoed on a state level by a 1999 Minnesota Consortium of Citizens with Disabilities (CCD) survey which found that 52% of the survey respondents (over 600 people throughout Minnesota) would seek or increase their

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[2] "Removing Barriers to Work: Action Proposals for the 105th Congress and Beyond.", National Council on Disability. September 24, 1997 http://www.teleport.com/~enygma/ncdproposal.html

[3] "Americans with Disabilities Still Face Sharp Gaps in Securing Jobs, Education, Transportation, and in Many Areas of Daily Life." National Organization on Disability/Lou Harris Poll 1998. http://www.nod.org/presssurvey.html

employment if their health care benefits would not be affected. [4]

The HIV Health Care Access and Work Re-entry Task Force (Task Force) affirms that work is a quality of life issue for all people, including people with HIV. Work allows people to increase their standard of living, keep in touch with other people, and make meaningful societal contributions. State level actions to build on existing work incentives for persons with disabilities would provide persons with HIV the confidence that they can return to work while retaining needed health care and income protection benefits.

Treatment advances and the potential for some people with HIV to re-enter the workforce should not be misinterpreted as reasons to become complacent about HIV education and prevention. HIV treatment advances do not prevent HIV infection and the HIV infection rate continues to rise. Recent reports indicate that the annual number of new HIV infections hasn't been reduced in recent years; the total number of people living with HIV in Minnesota is increasing. As of July 1, 1998 the Minnesota Department of Health reported 3,464 people to be living with HIV/AIDS in Minnesota. Public education to prevent further transmission of the HIV virus remains a critical strategy to battle the spread of the HIV disease.

Changes in the HIV epidemic in Minnesota have also resulted in a greater demand for HIV-related services. The Minnesota HIV Services Planning Council in its September 1998 Comprehensive Plan reports that the HIV epidemic is affecting communities that are also dealing with numerous other issues such as poverty, homelessness, chemical dependency, and mental health issues. [5] On both the state and national levels, people of color are disproportionally impacted by HIV. The HIV Planning Council report indicates that while African Americans/Blacks account for 2.1% of Minnesota's population, they now make up 25% of the people living with HIV/AIDs. Also, while Latinos comprise 1.2% of Minnesota's population; they account for 5% of the people living with HIV and AIDs. Analysis of state HIV transmission patterns also indicate that transmission through injection drug use and heterosexual contact is on the rise within Minnesota. Given the wide range of needs of Minnesotans at risk of contracting HIV and now living with HIV/AIDS, the Task Force believes efforts to support work re-entry cannot result reductions to state resources that assure the continuation of HIV prevention efforts and the availability of needed HIV treatment/support options.

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[4] Minnesota Consortium of Citizens with Disabilities Survey results shared at Task Force meeting

[5] "Towards a Continuum of Care". Minnesota HIV Services Planning Council Comprehensive Plan. September, 1998.

KEY ISSUES AND FINDINGS

The HIV Health Care Access and Work Re-entry Task Force (Task Force) studied and analyzed a number of key issues to evaluate realities faced by Minnesotans living with HIV feeling well enough to consider a return to work. These key issues and findings have been summarized in the following sections: health care, disability (or income) benefits, supportive services, work place capacity issues, and existing work incentive reform efforts.

The Task Force efforts reveal that complex variables interact with one another when a person with HIV considers work re-entry. These variables include health related aspects of the HIV disease, limitations of health care benefit programs, and thresholds of disability benefit programs. Improved policy mechanisms are needed to assist people with HIV seeking to make additional contributions to their communities by returning to work. The Task Force findings include recommended strategies on how state policies and resources may be developed or better coordinated to meet the needs of people with HIV. Without changes it will be difficult for interested people to move from being dependant on benefits to being more self sufficient on either a combination of work/benefits or a job with benefits.

HEALTH CARE:

Effective health care is absolutely essential for people living with the HIV. Multiple studies and extensive research emphasizes the need for treatment at the earliest stages of the disease. New drug treatments have shown great promise and are producing longer periods of wellness. They do not, however, cure a person infected with HIV; at best, they only control the HIV disease progression. On-going health care management of HIV/AIDS provides optimal health for the person, reduces the potential for transmission of the HIV virus, and reduces long term health care costs. Without on-going medical care, counseling, and treatment, it is unlikely that a person living with HIV will be able to maintain his/her health and re-enter the work force. Medication management is difficult for some people because of the numerous medications they need to take, as well as the timing and conditions under which the medications are to be taken. On-going side effects of the drug treatments must be carefully monitored and their impact on a person's ability to work must be assessed and reassessed on a continual basis. The total health care needs of people living with HIV/AIDS must be addressed if they are to pursue work re-entry.

Two major components were identified by the Task Force as essential to effective health care for people with HIV - access to speciality care and continuity of care. The need for access to speciality care is in part due to the fact that HIV/AIDS treatment is a dynamic arena constantly impacted by changing treatment options. Effective HIV care management requires the involvement of health care professionals who are knowledgeable about new HIV treatments, emerging HIV research, and the complexities of HIV disease progression. The impact, benefits, and combinations of HIV drug treatments must be closely monitored because they vary greatly from one individual to

another. Ineffective care can result in poor outcomes for the individual and the development of strains of the HIV virus which are resistant to therapeutic drugs. Ideally, health care team members with knowledge of the person, his/her disease progression, treatment history, and current health status will play an meaningful role in evaluating the individual's ability to work.

Given the unpredictable nature of HIV disease, the Task Force found that it is difficult to establish specific clinical indicators which accurately predict each person's ability to work. The National AIDS Fund Return to Work Initiative recommends that consumers take into consideration clinical markers of their HIV status (such as viral load and T cell counts), the drug treatments they are receiving and their side effects, and whether they have had any opportunistic infections when contemplating a return to work. [6] Additionally, Task Force members emphasized the need to consider possible health issues a person may have experienced such as the impact of drug-induced diseases (e.g., kidney failure, cirrhosis of the liver, diabetes); co-infections (such as hepatitis and tuberculosis); and co-factors (e.g., depression, chemical dependency). Each person will require individualized assessment, planning, and support as he/she weighs the benefits and risks associated with returning to work against their health status.

Maintaining continuity of health care becomes a significant issue when considering work re-entry since health care access and benefits are typically tied to a person' s employment status. A change in health care coverage due to work re-entry could result in a disruption of a person's health care and treatment. Factors cited as concerns by some Task Force member include the increasing number of employers turning to self insured health plans. Self-insured plans are not covered by same state insurance regulations as fully-insured plans and can more readily limit benefits. People benefitting from HIV treatment understandably want to maintain their relationships with the health care providers that are successfully supporting them. Continued and uninterrupted access to needed services, benefits, and knowledgeable providers results in better health outcomes for persons with HIV.

Minnesota has taken some important steps to provide continuous access to health care for people living with HIV/AIDs. Minnesota state law has many relevant provisions which assist people living with HIV/AIDS maintain or obtain needed health care coverage. The DHS HIV/AIDS Insurance program advises people about health insurance options and, for those who are eligible, pays health insurance premiums. This program enables people with HIV to maintain third party coverage for health care other than public health care programs. Even with these efforts, the Task Force identified multiple issues related to health care coverage which may impact a person re-entering the workforce.

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[6] "Return to Work Issues for Persons Living with HIV and AIDS: A Health and Medical Checklist ". The National AIDS Fund Return to Work Initiative. http://www.aidsfund.org/workinit.html

Task Force Findings Related to Health Care Benefits:

- Continuity of care and access to speciality care are crucial for people with HIV.

- People with HIV often lack knowledge about existing insurance, benefits, options, programs and protections. This can make it difficult and anxiety-producing to consider any changes to their current situations.

- Many potential employment opportunities for people with HIV do not include health care benefits; especially part-time jobs.

- Obtaining employment with health care benefits may require people with HIV to switch health plans and raises questions about care continuity questions which include:
  - Are the same providers in the new network?
  - Are the same health care benefits covered?
  - Are out-of pocket expenses comparable to current coverage?
  - What deductibles and co-pays is an individual responsible for?
  - Are there pre-existing clauses in the plan that will limit health care coverage?

- Many employer-based plans contain waiting period provisions that require an employee to be on the job for a period of time before coverage exists. Concerns exist that the time needed to qualify for new benefits will not coincide with the discontinuation of current health benefits.

- People considering work re-entry need support and assistance to navigate their existing health insurance benefits, evaluate their options and to weigh the risks and benefits of returning to work. Each person needs to carefully consider the health coverage offered by a potential employer and the degree to which that coverage meets his/her health care needs.

- People re-entering the workforce will need to know whether a potential employer is fully insured or self-insured. People receiving health coverage from a self insured plan may not have the same continuation rights as fully insured plans. Self-insured plans may also be more restrictive about coverage.

- People with HIV worry that selecting employer based coverage may impact their new employer's insurance rates. This is especially a concern with smaller employers. People express concerns that a significant rate change may eventually lead to employer knowledge of their health condition, care needs, and care claims; followed by a breech of their confidentiality and discrimination.

Strategies Recommended by the Task Force Related to Health Care Benefits:

- Assure that a safety net exists that allows people with HIV seeking work re-entry to maintain health care continuity.

- Grant legislative authority to establish a Medicaid buy-in option for working persons with disabilities as one means to allow people with HIV(and other disabilities) to maintain health care coverage when re-entering the workforce.

- Support the development of work incentive centers in the state to assist people with HIV to understand health plan provisions and the extent to which the coverage meets their individual health care needs.

- Strengthen employer based health care coverage by ensuring coverage of HIV speciality care

- Continue efforts to disseminate information on an employee's rights to retain health care coverage and reasonable accommodations (*e.g. - COBRA benefits, HIPPA, ADA)*

- Modify MinnesotaCare income standards and benefits to allow a smooth, seamless transition between General Assistance Medical Care, Medical Assistance, and Minnesota Care

- Increase the state's capacity to enforce health plan compliance to existing laws and assist people seeking to resolve benefit disputes with both self-insured and fully-insured health plans..

DISABILITY BENEFITS

Many people with HIV/AIDS receive assistance from a variety of state, federal, and private disability benefit programs to meet their daily living needs. These programs provide income protection, cash assistance, food stamps, subsidized housing, financial assistance with drug costs and insurance premiums, and emergency financial assistance. These programs are designed to ensure that people with disabilities have at least a minimally adequate level of income, housing and health care. It is crucial to persons with disabilities that this minimal standard of living be maintained - through non-employment, trial employment, partial employment, full employment, and, if necessary, non-employment again. Given the current uncertainty about the long term benefits of new HIV drug treatments, the need to ensure continuity of an existing standard of living while trying to return to work is crucial.

The Task Force found that work re-entry creates the potential for serious disruption to the standard of living achieved through various benefit supports. Many benefits are tied to "total and complete" disability; many are also tied to low-income and asset requirements.

Even a slight change in one's reported "ability to work" or a minimal increase in income could result in a person becoming ineligible for a benefit they rely on. Some working people with disabilities must turn down raises or limit their hours of working to keep their earnings low enough to maintain public health care coverage. People with disabilities considering work re-entry must be confident that the net gain of a move to work is worth the loss in benefits and assistance.

The process to obtain benefits through multiple public and private sources is also complicated, time-consuming and is usually undertaken by people who are, at the same time, struggling with serious health problems. The required knowledge for determining benefits is extensive and complex. Benefits vary by source, program requirements, and income. Program requirements are constantly changing and complex interactions can occur between the multiple programs that support a person. Most programs guidelines differ greatly and are not very flexible. Often even professionals are only familiar with specific programs they work with and their requirements; they too can lack an understanding of how various programs interact with one another.

Some benefits that are lost when the beneficiary returns to work are not reinstated easily or without a waiting period. Once people put these combination of benefits together, they are understandably slow to risk unraveling their whole system of support, especially when they know that potential exists that their health condition may deteriorate and force them, once again, out of the workforce. Private disability products have changed over the last twenty years and tend to provide greater flexibility that public benefit programs to accommodate a gradual transition back to work. At the same time, each private disability policy is unique and must be carefully analyzed and understood. People living with the uncertainty of HIV must be assured that there will be stability in their minimal standard of living without burdensome waiting periods and excessive paperwork. They must be prepared for a future unforeseen changes in their employment situation or health status.

State and federal policies must be reformed to provide assurances and support to people wishing to return to the workplace. Without additional work incentive reforms it is unlikely people will be able to move from being benefit supported to being employment supported.

Task Force Findings Related to Disability and Income Benefits:

- Obtaining an adequate income and health care benefit package can be very difficult and complex. For most people with disabilities it has taken a lot of time, effort, and energy to obtain the benefits they now receive. People don't want to risk having to start the process of obtaining benefits all over again if their health fails and/or their efforts to re-enter the work force are not successful.

- People with HIV need stability in their benefits if they are to return to work. They need to know that, minimally, they will be able to maintain their pre-work level of income and health care benefits when re-entering the workforce.

- Some disability income programs, including SSDI, are based on a criterion of "total and complete" disability. There is minimal recognition that a person' ability to return to the workforce may only be on a limited scale due to their health condition.

- For many people with HIV part-time employment is the most realistic and sustainable option. Since part-time work typically does not provide a livable wage or necessary health care benefits, some level of public/private benefits are necessary to supplement a person's income and to assure needed health care coverage.

- Wages earned from part time employment may be high enough to render persons with disabilities who work ineligible for means-tested public benefits programs.

- People with HIV have concerns that a return to work could result in a number of negative outcomes which include:
  - a loss of benefits,
  - a period of "no income" resulting in the inability to meet living expenses,
  - a loss of their current living arrangement,
  - the increased likelihood for a review of their disability status;
  - the increased likelihood of benefit overpayment during a transition period; and
  - the inability at times to resume benefits given a change in health or work status.

<u>Strategies Recommended by the Task Force to Address Disability Benefit Barriers:</u>

- Establish work incentive counseling centers that assist persons with disabilities through the complex process of returning to work; particularity by providing education and counseling about the interaction of earned income and employer-sponsored health plans with public benefits.

- Work with the federal government to establish a means to resume a person's SSDI benefits if it becomes necessary due to a change in health care condition which results in the loss of a job or an inability to continue to work.

- Create flexible trial work options, as part of public benefit programs, that enable people to retain greater amounts of their earnings when they return to work.

- Encourage the continued development of private disability insurance products that include flexible provisions that allow people to re-enter the workforce on a part-time or intermittent basis and receive partial benefits.

- Establish more fluid mechanisms for Minnesotans to move on and off public disability income benefits and re-qualify for benefits if necessary.

- Support state efforts to obtain federal authority to test the effect of phasing out disability benefits as people earn more income.

- Support state efforts to obtain federal authority to coordinate federal and state benefits programs and waive certain penalties or negative consequences for people with disabilities who attempt a return to work and experience unforeseen impacts to their benefits.

- Support national legislation which would require people with permanent disabilities to complete only one waiting period for disability benefits in their lifetime and provide a lifelong extended period of eligibility for needed benefits.

- Support the establishment of a coordinated data collection effort within the state of work re-entry experiences to assist people with disabilities, professionals, employers and policy makers to better understand the impact of work re-entry on both the public/private disability benefits.

- Provide training to consumers, case managers, and providers on how disability determinations are made, the criteria that is used, how work re-entry relates to disability determinations, and how to effectively advocate for oneself during the redetermination process.

SUPPORTIVE SERVICES

Information and decision-making support are crucial to people with HIV considering work re-entry. People living with HIV report difficulty getting information when they try to go through this process and that they often receive conflicting, incomplete, or even inaccurate information from various sources. It was clear to the Task Force that no one individual or agency currently has or could perhaps be expected to have all the information that a person with HIV would need to know when considering a return to work.
The Task Force found that support to persons with HIV in gathering information and making decisions about work re-entry, at this time, typically comes from one of two sources - a person's HIV case manager or his/her vocational rehabilitation counselor. Both systems identified challenges which limit its ability to meet all of the needs of persons with HIV considering work re-entry. One major limitation is that not all people with HIV are receiving case management or vocational rehabilitation services. Another limitation is that workers in neither system, but especially case managers are not trained in all the specifics of back-to-work issues.

Minnesota's HIV case management system goals include creating access to needed services, identifying unmet health and social service needs, and locating appropriate supports and resources. HIV case management is currently funded by combining three funding streams - federal Ryan White Act dollars, administrative Medicaid dollars, and state appropriated general funds. Case management is provided to people living with HIV who meet eligibility criteria established by the Department of Health. (Appendix C) Providers contract with the Minnesota Department of Health to provide case management services to a specified number of clients. Some providers report the need to prioritize who

they will serve and/or at what level based on the severity of people's needs given the demand for their services and their current level of funding.

As a population, people living with HIV are a varied group with a variety of needs that can include health maintenance and education, psycho-social issues related to living with HIV, chemical dependency, chronic poverty, homelessness, mental health issues, and support accessing benefits. The Task Force heard that within the current over-taxed system, persons whose health has stabilized and are considering work re-entry may not be considered a priority for on-going case management services. HIV case management providers also indicated their current case loads are too large to provide the intensive individualized work re-entry and benefits counseling.

People with HIV seeking a return to work may also need support dealing with practical employment issues such as job training, job placement, completing employment application forms, and locating transportation. This type of support is often provided by a Vocational Rehabilitation (VR) counselor from the Rehabilitation Services Branch of the Minnesota Department of Economic Security.

VR counselors seek to work in partnership with private non-profit community rehabilitation programs and other service organizations to meet these employment related service needs. VR counselors help arrange and provide individualized services that assist people with disabilities to obtain, retain, or maintain employment. Many services are provided at no charge, including career counseling, on the job training, job coaching, job development, workday modifications, placement, and employer education. Some selected services (i.e., college training, computers, tolls, vehicles modifications) may involve the person receiving services to participate in the cost of the service.

The Task Force found that large VR caseloads mean that there is limited time for individual support and benefits counseling. Some people with HIV who wish to return to work do not need or require "rehabilitation" or the other services offered by VR and therefore do not access the vocational rehabilitation system, even though they need benefits counseling. Between the current limitations of HIV case management system and those of vocational rehabilitation, some people with HIV are not able to access supportive services at the level they need to successfully complete a work re-entry process.

<u>Task Force Findings Related to Supportive Services:</u>

- Changes in the HIV epidemic require that additional services be developed and funded to assist and support people living with the disease.

- There is a lack of centralized resources and expertise about work re-entry issues for persons with HIV (and other disabilities) within the state.

‣ The current eligibility criteria for HIV case management services does not include work re-entry. People wanting to return to work may be assessed as a lower priority by an agency in great demand and may have difficulty getting case management services.

‣ The case management needs of people with HIV do not diminish or disappear when they re-enter the workforce; some people's need for case management services may actually increase as they deal with new, complex issues.

‣Many HIV case managers and VR counselors have had limited training and experience with the work incentives components of disability benefit programs. Many are not comfortable addressing the impact of work re-entry on a person's disability and health care benefits because of the complexity of the various program requirements.

‣ VR counselors currently have very large case loads averaging 120 people per counselor. The size of these case loads case loads limit the ability of a VR counselor to provide the intensive counseling/support a person with HIV may need.

‣Given the changing face of the state's population with HIV; it is important that a more diverse staff provide culturally competent supportive services.

Strategies Recommended by the Task Force Related to Supportive Services:

‣ Support individuals with HIV to voluntarily make a choice to return to work if this is appropriate in their circumstance.

‣ Assure HIV case management, advocacy assistance, and decision-making support are available statewide to address issues related to health status and care; disability and health care benefits; vocational interests, abilities, and training needs; and legal rights.

‣Develop and fund services that assist and support each person with HIV/AIDS considering work re-entry to make an informed choice about their future. Decisions should be made following a complete review and discussion of employment options and their impact.

‣Expand the capacity of the current HIV Case Management system by improving reimbursement mechanisms and clarifying minimal service standards.

‣ Reduce Vocational Rehabilitation counselors caseloads.

WORK PLACE CAPACITY

Minnesota employers play a crucial role in enabling people with HIV (and other disabilities) to participate meaningfully in our state's workforce. Work re-entry for people living with HIV/AIDS will be most successful in workplaces that are supportive of the employee.

Workers with HIV must balance a number of complex and challenging issues in the workplace. Current HIV treatment standards often include a strict and hefty regimen of medications. These medications must be administered at specific times and under specific conditions; the medications can include significant side-effects. To maintain his/her HIV treatment regimen, workers may need accommodations in the workplace. Some people living with HIV may also have fears about how they will be treated in the workplace. Task Force members were reminded that a great deal of stigma continues to be associated with HIV; both about the disease and how it may have been transmitted. People with HIV worry that the confidentiality about their health condition may be breeched and they will face discrimination in the workplace. An employer's ability to create a work atmosphere and environment in which each employee is supported and can focus on his/her work responsibilities will allow valuable time and energy not to be wasted.

The Task Force recognized that employers too can be challenged by the complexity of issues presented when a person living with HIV/AIDS returns to work. A well informed employer is better able to form effective internal policies and provide helpful assistance to an employee. Effective employer policies ensure that confidentiality of an employee's health condition will be maintained by employers, supervisors, union representatives, and human resource departments. They also assure that necessary accommodations are made to support the worker. Employee Assistance Programs (EAPs) can assist in providing pro-active HIV training and education for managers, supervisors, and employees. They can provide valuable assistance to workers dealing with additional challenges such as stress, depression, co-worker relationship problems, and workplace difficulties. Some EAPS also can assist workers to ensure they receive adequate health care coverage and support to coordinate their earnings and benefits when returning to work.

The Task Force heard concerns that many small and medium-size Minnesota employers seem to lack basic information about how to support employees with HIV/AIDS. Many have not developed policies and procedures which adequately support these individuals in their work force. Some employers also appeared to lack knowledge about their responsibilities under the American with Disabilities Act (ADA). Additionally, it was noted that employer knowledge of how to recruit, hire and support people with disabilities could increase Minnesota's work place capacity to successfully employ people with disabilities. Broad based strategies on a state level involving the employer community were seen as desirable. Potential areas for inclusion in work place capacity development efforts include policy review, policy development, and training focused on confidentiality, disclosure, universal precautions, and reasonable accommodations. Employer representatives of the Task Force also indicated an interest in having access to detailed case scenarios that illustrate approaches to successfully employ and support persons living with HIV/AIDS and other disabilities in the workplace.

On a national level, the President's Committee on the Employment of People with

Disabilities has established a service venture called the Business Leadership Network (BLN) to achieve these goals on a national level. The BLN Initiative seeks to work with state level committees to develop an extensive network of small, medium, and large companies who are supportive to persons with disabilities in their workplaces. BLNs enable companies who successfully employ people with disabilities to advocate with their business counterparts about the benefits of hiring and supporting people with disabilities. They offer participating employers access to hiring information, information on best practices for employing persons with disabilities, training and work experience opportunities, and they expose employers to qualified applicants with disabilities. Currently, BLNs are operational in the ten states: Colorado, Florida, Georgia, Indiana, Massachusetts, Michigan, Oregon, Texas, Wisconsin, and Wyoming. They are in the process of being established in 14 additional states including Minnesota..

The Minnesota Council on Disability is working within the state to establish and develop a BLN. It is hopeful that within the next year the necessary organizational structures and partnerships will be established to move the initiative forward. The Minnesota effort hopes to provide participating employers with knowledge of best practices that support workers with disabilities and support to develop local resources that meet the changing human resource needs of our state. Eventually, it is hoped that the state network will pursue additional ways that state employers can develop quality hiring practices and supports for both persons with disabilities.

Task Force Findings Related to Workplace Capacity Issues:

- Significant issues of confidentiality and disclosure in the workplace must be carefully considered by people with HIV seeking to return to work.

- The fear of work place discrimination can be a major barrier to individuals with HIV to seeking and maintaining employment.

- A person with HIV can face multiple stigmas and challenges in the workplace. They include co-worker fear of HIV and possible discrimination related to a person's race, sexual orientation, or other behaviors associated with acquiring HIV.

- Fear of a breech of their confidentiality may cause people to not access health benefits, accommodations and protections available to them under state and federal law.

- People with HIV need on-going education, support and advocacy to understand and apply their rights in the workplace.

- Employers can make a tremendous difference in how successful a person's return to work is.

- Additional state efforts that cultivate and support employers' capacities to include people

with HIV (and other disabilities) into their work forces are needed.

Strategies Recommended by the Task Force to Address Workplace Capacity Issues:

▸Make available supports to people with HIV to deal with an employer or co-workers who treat them differently than others. They need information on their legal rights, how to effectively deal with discrimination, and useful strategies to work with employers and co-workers. Some individuals may also need support/coaching to effectively deal with workplace discrimination.

▸ Involve the business community in on-going efforts that allow the development and sharing of best practices which effectively support workers with HIV (and other disabilities.

▸ Support efforts to establish a Business Leadership Network within the state.

▸ Pursue mechanisms that allow smaller businesses to access EAP services that enable their workers with HIV (and co-workers) to obtain information and support they need.

EXISTING WORK INCENTIVE REFORM EFFORTS

The Task Force found that many of the issues raised during its efforts were not unique to people living with HIV/AIDS. Complex interactions between earnings and benefits have challenged beneficiaries and state/federal policy makers alike for many years. People with disabilities indicate that complex and burdensome requirements that prevent them from becoming employed and taking greater control of their own lives must be removed. Recent reforms initiated on both the state and federal levels to improve work incentives and work re-entry have begun to create new opportunities for people with disabilities. The Task Force felt that the Minnesota Legislature should be aware of these existing efforts as it considers how state approaches to resolve work re-entry issues can be strengthened.

The Minnesota Department of Human Services has sought federal approval as required by the 1995 Legislature to implement a small scale work incentive demonstration for persons with disabilities using an earned income disregard. This request was made as part of the MinnesotaCare Health Care Reform Waiver - Phase 2. Federal approval of the earned income disregard waiver is pending. The request is designed to make continued access to MA eligibility and necessary health care benefits more feasible. The current proposal is limited to SSDI recipients who are receiving personal care attendant (PCA) services and is expected to effect only a small number of persons. The Task Force believes the state must develop a work incentive approach that serves a broader population if it seeks to support people with HIV desiring to re-enter the workforce. Persons with HIV/AIDs who are eligible for PCA services typically are at a point in the HIV disease progression that it is not feasible for them to work. It is therefore unlikely that people with HIV would benefit from the existing earned income disregard waiver request.

Since the submission of the Health Care Reform Waiver, new work incentive initiatives have been undertaken by the state including a Medicaid buy-in proposal under Section 4733 of the Balanced Budget Act (BBA) of 1997. This provision permits states to provide Medicaid (MA) coverage to people with disabilities who but for earned income would be eligible for SSI and who have incomes below 250% of Federal Poverty Guidelines (FPG). To assist all persons with disabilities seeking to return to work, the Task Force supports authorizing legislation to allow a state Medicaid buy-in option.

Oregon is the first state in the nation which has utilized the legal authority available in the BBA to launch an initiative that allows its citizens with disabilities to work without losing access to MA health care benefits. Oregon indicates that its goal is to enable people with disabilities to be less dependant on public programs. The Oregon plan enables persons with disabilities who desire to return to work to do so while retaining MA eligibility. It also requires those who earn over $18,000 per year to pay for part of their MA costs on a sliding scale. It allows those who eventually earn enough money and receive adequate health care coverage through an employer based plan to drop MA coverage. [7] These workers with disabilities can use their employer's health insurance plan and claim a tax benefit to cover disability-related work expenses(like PCA). Oregon's plan also creates additional state incentives for businesses to employ people with disabilities. Colorado, Michigan, Massachusetts, and North Dakota reportedly are considering similar initiatives.

On a federal level, work-incentive reform efforts are being pursued both on legislative and administrative levels. These reforms would allow working Social Security beneficiaries to keep more of their earnings, safeguard their health coverage, and receive enhanced vocational rehabilitation services. During the 105th Congressional session, legislative efforts to improve work incentives were proposed in the Work Incentives Improvement Act of 1998 (S.1858) co-sponsored by Sen. James M. Jeffords (R.-Vt.) and Sen. Edward Kennedy (D-Mass). The Jeffords-Kennedy Bill aimed to make it easier for persons with disabilities to work without losing health care benefits and included a more extensive state option to allow a MA buy-in for people with disabilities who return to work. Unfortunately, the bi-partisan plan was not acted upon last year by the full Congress. Recently, President Clinton indicated his administration would embrace this proposal and include full funding for its implementation in its budget proposals. The President also proposes to allow additional tax credits for work related expenses, to extend Medicare coverage for working persons with disabilities, and to improve access to assistive technology to help people with disabilities seeking to return to work.

The Social Security Administration (SSA) has recognized the need for administrative reforms. They are striving to allow beneficiaries to work for longer periods of time without losing cash benefits and to retain health coverage for services not covered by employer-

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[7] Hoover Barnett, Erin. "New Initiative Allows Disabled to Work". The Portland Oregonian. January 2, 1999.

based health plans. They have cited the lack of an empirical analysis which accurately predicts the outcomes of possible administrative interventions as the reason to test and evaluate alternatives. SSA is searching for policy options which can best tap the work potential of beneficiaries without jeopardizing the availability of benefits for those who cannot work by authorizing a series of state demonstration projects. In the fall of 1998, SSA awarded eleven demonstration grants nationally to reduce the barriers to employment that exist for people receiving Social Security benefits based on disability (SSI and SSDI). Minnesota's Department of Economic Security (DES) and the Department of Human Services (DHS) were jointly awarded one of the eleven grants. (Appendix D)

Minnesota's approved SSA Grant project has two major components: first, to provide outreach to implement the earned income disregard waiver that DHS has requested from the Health Care Financing Agency (HCFA) and secondly to establish a Work Incentives Assistance Center. The state received funding of $517,243 for the first year with grants of similar size expected for four subsequent years. Accessing these federal funds for the next five years is contingent on the state providing a small 5% match of $28,000.

The Work Incentives Assistance Center will initially be established under the Department of Economic Security (DES); it will be spun off as a private, non-profit by the end of the five year grant period. The purposes of the Work Incentives Assistance Center include:

- providing training and consultation to rehabilitation counselors, case managers, county financial workers, and other professionals so that information provided to consumers about work re-entry is accurate and understandable;

- providing individualized risk analysis for SSI and SSDI recipients who are interested in obtaining or increasing their employment. This analysis will determine the effect of work on public benefits, project a person's anticipated net income from working, and assist people in developing a plan to ensure that their acute, primary, and long term health care needs are addressed; and

- providing advocacy services to ensure that people with disabilities are able to access work incentives that they are entitled to.

Unfortunately, a third component of Minnesota's SSA Grant request could not be approved at this time. The state sought authority to waive the extended period of eligibility under Social Security so an individual could resume SSDI benefits if his/her health status changed unexpectedly. The Social Security Administration indicated that it lacked the legal authority to grant this request at this time. It is believed that approval of the Jeffords-Kennedy Bill would provide the Social Security Administration the necessary legal authority to be responsive to the request.

Task Force Findings Related to Existing Work-Incentive Reform Efforts:

▸Legal authority exists under the Balanced Budget Act (BBA) of 1997 to establish a Medicaid Buy-In option for employed persons with disabilities

▸Minnesota is one of eleven states receiving a five year Social Security demonstration grant. It will establish a Work Incentives Assistance Center for persons with disabilities.

▸The SSA demonstration project design and evaluation can effectively address and serve the unique issues presented by people with HIV seeking work re-entry.

▸ Information on the impact of work incentives/disincentives on Minnesotans with HIV (and other disabilities) will help consumers, advocates and policy makers pursue needed work incentive refinements if gathered and tracked.

▸ Support and full funding of the Work Incentives Improvement Act sponsored by Senators Jeffords and Kennedy will allow significant steps to be taken on a federal level that reform work incentives for persons with HIV (and other disabilities).

Strategies Recommended by the Task Force to Build on Existing Work Incentives Reforms:

▸ Exercise existing authority under the Balanced Budget Act (BBA) of 1997 to establish a Medicaid Buy-In option for employed persons with disabilities in Minnesota.

▸ Fund the small state match needed for the SSA Grant project that establishes a Work Incentives Assistance Center for persons with disabilities.

▸ Actively support the establishment of a Business Leadership Network (BLN) to further engage business in effectively supporting and employing workers with disabilities.

▸ Gather information, track relevant data, and regularly report on the impact of work incentives on Minnesotans with disabilities ability to work or return to work.

CONCLUSIONS:

HIV disease treatment is a rapidly evolving arena. There is a great deal of unpredictability about the HIV disease. Recent advances that allow some people living with HIV to consider work re-entry need to be understood and realistically viewed. Minnesota must now support the simultaneous needs of both individuals with improved health status and those with declining health. The Task Force encouiages state policy makers to keep two important things in mind as they seek to support people seeking work re-entry. First, every person living with HIV must have access to necessary health care and income benefits in order to maintain their health and well-being. Second, state prevention efforts can not be decreased to allow some people the opportunity to re-enter the workforce.

As these Task Force findings establish, the work re-entry process contains many steps, challenges and potential risks. Minnesotans living with HIV need to feel secure about their health, health and income benefits and support systems before they will risk pursuing work re-entry. Effective state and federal policies that provide bridges to successful work re-entry and assure a safety net during a transition period are needed. Obtaining the best and most accurate information which allow informed decisions is a critical starting point for people living with HIV.

Time, planning, and careful consideration will be required by each person to weigh the benefits and risks associated with working. Given the complexity of the issues individuals face, it is preferable that the decision to return to work is a voluntary one. People with HIV/AIDS will need to deal with many agencies and professionals when seeking to re-enter the workforce. A coordinated, team approach is recommended to support them. Planning teams must include experts with health care, case management, vocational rehabilitation, benefits counseling, and other ancillary expertise as needed.

Resource and policy barriers currently exist which limit people living with HIV/AIDS (or other disabilities) who want to re-enter the state's workforce. Focusing the necessary resources within the state to further assist people with HIV (and other disabilities) will allow people to navigate the existing benefit and supports systems and policy makers to develop health care and disability benefit policies that are more flexible and consumer friendly. The Task Force believes that the legislative it recommends will enable more Minnesotans with HIV to contribute their skills and abilities in our state's workplaces.

RECOMMENDED LEGISLATIVE ACTIONS

The following recommendations are made by the task force to the Minnesota Legislature to reduce barriers which impact Minnesotans living with HIV seeking to re-enter the workforce:

1) Fund on-going public education and HIV prevention efforts and programs.

2) Fund the SSA Grant Demonstration project to assure people living with HIV have information that allows them to evaluate their interest and ability to work. Funding will establish an information and counseling center which supports individuals with disabilities to understand the impact of a return to work on their health care and disability benefits.

3) Provide a safety net for people living with HIV/AIDS re-entering the workforce that assures continued access to appropriate health care (including speciality care and prescription drugs) and flexible income and disability benefits so a return to work does not cause a loss of income and benefits.

4) Assure that a work re-entry decision remains a voluntary one.

5) Provide a state Medicaid Buy-in option for people living with HIV (and other disabilities) who are working. This will allow continuous access to appropriate and affordable health insurance as people transition back to work.

6) Improve reimbursement mechanisms for HIV case management services.

7) Urge swift federal action on the Jeffords-Kennedy Bill which brings necessary federal work incentive reform.

8) Support state efforts to establish a Business Leadership Network.

9) Identify a state entity with lead responsibility for on-going data collection and analysis that enable people with HIV (and other disabilities), policy makers, employers, advocates, and provider organizations to better understand and monitor the issues, impacts, and trends of work re-entry.

Appendix A

HIV Work Re-entry and Health Care Access Task Force Membership

NAME	AFFILIATION
Julia Ashley	Minnesota Department of Health AIDS/STD Services Unit
Pam Benson	Community Advocate
Anita Boucher	Courage Center
Tom Brick	Minnesota Council on Disability
Judy Donohue	Lutheran Social Services - Human Resources
Karen Gibson	Department of Human Services Health Care for Families and Children Division
Irene Goldman	Minnesota Department of Health Managed Care Systems
John Gross	Minnesota Department of Commerce
Randy Hornstine	Community Advocate
Diane Knust	Minnesota Aids Project Case Management Services
Pat Lamb	Cargill Human Resources
Lori Lippert	Department of Human Services HIV/AIDS Programs
Allan Lunz	Minnesota Department of Economic Security Rehabilitation Services Branch

Lynn Mickelson	Minnesota AIDS Project Legal Services
Eduardo Parra	Hennepin County Community Health
Larry Parker	Community Advocate
Michael Peterson	Park House
Robert Preston	African American AIDS Committee
Timothy Schacker, M.D.	University of Minnesota Medicine/Infectious Diseases
Scott Schlaffman	Aliveness Project
Bob Tracy	Minnesota AIDS Project Public Policy
Lori Welh	Sister Kenny Institute
Rhonda Whitenack	Social Security Administration
Shirley Wilson	Hemophilia Foundation
Dan McCarthy	Department of Human Services Continuing Care Planning
Bobbi Kreb	Kreb Consulting

Appendix B

1998 Resolution of the Minnesota Legislature Memorializing the Congress of the United States to Remove Medicaid Policy Barriers to Employment for People with Disabilities.

WHEREAS, seventy-four percent of working-age adults with severe disabilities are unemployed; and
WHEREAS, many people with disabilities are highly dependent on local, state, and federal assistance for support and survival, particularly for necessary health care; and
WHEREAS, a 1995 Lou Harris poll reported that two-thirds of unemployed people with disabilities are eager to work; and
WHEREAS, advances in technology, the civil rights protections of the Americans with Disabilities Act, and the current labor shortage are opening up many new employment opportunities for people with disabilities; and
WHEREAS, current government policies, particularly those relating to Medicaid, discourage people with disabilities from working; and
WHEREAS, existing Medicaid work incentives are flawed and are completely unavailable to people with disabilities who do not qualify for the SSI 1619(b) program; and
WHEREAS, removing policy barriers to employment would enable more people with disabilities to reduce their dependence on Social Security, Medicaid, Medicare, subsidized housing, food stamps, and other state, local, and federal government programs; and
WHEREAS, becoming employed allows individuals with disabilities to contribute to society by becoming taxpayers themselves; and
WHEREAS, employer-based health care and government programs, such as Medicare, Minnesota Comprehensive Health Association, and MinnesotaCare, do not typically cover long-term supports needed by people with disabilities;
NOW, THEREFORE, BE IT RESOLVED by the Legislature of the State of Minnesota that it urges the Congress of the United States to adopt Medicaid buy-in legislation that would allow people with permanent disabilities to retain Medicaid coverage to address unmet health needs when they become employed.
BE IT FURTHER RESOLVED that such Medicaid buy-in legislation should require individuals to take advantage of employer-based health coverage, if available and affordable, and should further require individuals to purchase needed Medicaid coverage on a sliding fee scale, based on their ability to pay.
BE IT FURTHER RESOLVED that the Secretary of State of the State of Minnesota is directed to prepare copies of this memorial and transmit them to the President and the Secretary of the United States Senate, the Speaker and the Clerk of the United States House of Representatives, and Minnesota's Senators and Representatives in Congress.

Appendix C

Current Eligibility Criteria for HIV Case Management Services

Persons receiving HIV Case Management services in Minnesota through existing funding streams must meet at least one of the following eligibility criteria:

- on or eligible for Medical Assistance (MA),
- use English as a second language or are non-English speaking,
- under 24 years of age,
- are HIV+ and pregnant,
- have a mental illness or dementia,
- have a low income (under 300% of the federal poverty standard),
- have potential transmission issues,
- are physically ill or disabled without an adequate support system,
- have unstable housing,
- have a visual or hearing impairment,
- live in a household with more than one HIV+ member,
- are developmentally disabled,
- are chemically dependent, or
- have another crisis situation with an inadequate support system.

Source:
Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Title I and II Funds
HIV Services Request for Proposals Application Guide, September 21, 1998

Appendix D

"Making Work Pay: Reducing Medicaid and Social Security Barriers to Employment" An Overview of Minnesota's SSA Demonstration Grant

Rehabilitation Services and the Department of Human services have received a grant from the Social Security Administration to reduce the barriers to employment that exist for people receiving Social Security benefits based on disability (SSDI and SSI). The project is currently being implemented, with the goal of hiring a permanent Project Director in November, 1998. Funding is in the amount of $544,467 annually for five years ($517,243 federal and $27,224 in local match). The project has two major components:

1) Provide outreach to implement the 1115 Medicaid waiver:
DHS has requested a waiver to allow persons on SSDI who 1) qualify for Medical Assistance under the "medically needy" standard and 2) need personal attendant services, to maintain their MA eligibility if they return to work. Currently, work is unattractive for many people on SSDI because the person must keep assets below $3,000 to avoid the spend down.

DHS has no funding available to market this new waiver that they hope to implement in 1998. Grant funds would be used to educate and inform the 1.030 Minnesotans who would be potentially eligible for this waiver.

2) Establish a Work Incentives Assistance Center:
Fear is a major barrier to employment. Many people with disabilities are hesitant to return to work or to increase their work hours because they don't understand the impact that earned income has on public benefits. When they ask questions, the person seldom will get he same answer twice.

Grant funds will be used to establish a private non-profit Work Incentives Assistance Center. The Center will have three primary functions:

- provide training and consultation to rehabilitation counselors, case managers, county financial workers and other professionals so that information provided to consumers is accurate and understandable.
- provide individualized risk analysis for SSDI and SSI recipients who are interested in obtaining or increasing their employment. This analysis will assist the person determine the effect of work on all their public benefits, project the anticipated net income from working, and assist the person develop a plan to ensure that acute, primary and long term health care needs are addressed.
- Provide advocacy services to ensure that the person is able to access work incentives that they are entitled to.

National Study:
The Social Security Administration has awarded eleven grants nationally. In addition to the components discussed above, the project will participate in a national study to determine the effectiveness of the various approaches being used to assist people with disabilities return to work.