Nicolette Highsmith [redacted]

Record Type: Record

To: Diana Fortuna/OPD/EOP
cc:
bcc:
Subject: Re: DISABILITY RIGHTS ADVOCATES WILL RALLY TO SUPPORT MEDICAID

We'll send this to Josh when we send an e-mail about the hearing (our intern went to it).

As for the other 2 items:
1) yes, we have had cash and counseling for awhile -- but this a major issue for Medicaid. We are currently seeking policy guidance.

2) as for DME, we've only had it for a week. This impacts Medicare Part B. Although this is important to the disability advocacy community, the Medicare Part B folks also need to take a look at it.

Diana Fortuna

Diana Fortuna 03/12/98 03:25:54 PM

Record Type: Record

To: Nicolette Highsmith/OMB/EOP@EOP

cc:
Subject: Re: DISABILITY RIGHTS ADVOCATES WILL RALLY TO SUPPORT MEDICAID

thanks. Make sure Josh sees this. If you don't want to send it to him, let me know, and i will.

Nancy-Ann just called me complain that you guys are sitting on cash and counseling and DME demos. I told her she should also worry about Jeffords-Kennedy.

JOSHUA
GOTBAUM
03/11/98 03:22:09 PM

Record Type: Non-Record

To: Diana Fortuna/OPD/EOP@EOP
cc: See the distribution list at the bottom of this message
bcc:
Subject: Re: Potential compromise language on conclusion to CASA testimony HOW ABOUT THIS?

Conclusion:

We believe it is critically important to continue and develop models both at the state and Federal level that support and encourage the move from reliance on institutional care to a broader array of consumer-directed home and community-based services.

We embrace these goals and will continue to work toward them. The challenge of course is to balance our goal of providing more flexibility and choice for people with disabilities with the need to ensure that any legislation is affordable. Preliminary cost estimates raise very real questions about whether the balance has yet been achieved. However, we remain committed to working together with you and other interested parties.... [continue as HHS draft does in second paragraph]

Message Copied To:

robert j. pellicci/omb/eop@eop
christopher c. jennings/opd/eop@eop
sarah a. bianchi/opd/eop@eop
mark e. miller/omb/eop@eop
nicolette highsmith/omb/eop@eop
jill m. pizzuto/omb/eop@eop
william h. white jr./who/eop@eop

NIKKI

Double check mtg notes (Bob was there)

Total Pages: 14

LRM ID: RJP216

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

URGENT

Monday, March 9, 1998

LEGISLATIVE REFERRAL MEMORANDUM

TO: Legislative Liaison Officer - See Distribution below

FROM: Janet R. Forsgren (for) Assistant Director for Legislative Reference
OMB CONTACT: Robert J. Pellicci
PHONE: (202)395-4871 FAX: (202)395-6148
SUBJECT: **HHS Testimony on HR2020 Medicaid Community Attendant Services Act**

DEADLINE: **5:00 p.m. Tuesday, March 10, 1998** Today @ 5

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. **Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.**

COMMENTS: Hearing is before the House Committee on Commerce on Thursday, March 12th. Sally Richardson, HCFA's Director, Center for Medicaid and State Operations is the witness.

DISTRIBUTION LIST

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Janet R. Forsgren
OMB LA

LRM ID: RJP216 **SUBJECT:** HHS Testimony on HR2020 Medicaid Community Attendant Services Act

RESPONSE TO
LEGISLATIVE REFERRAL
MEMORANDUM

If your response to this request for views is short (e.g., concur/no comment), we prefer that you respond by e-mail or by faxing us this response sheet. If the response is short and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a legislative assistant.

You may also respond by:
(1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); or
(2) sending us a memo or letter
Please include the LRM number shown above, and the subject shown below.

TO: **Robert J. Pellicci Phone: 395-4871 Fax: 395-6148**
Office of Management and Budget
Branch-Wide Line (to reach legislative assistant): 395-7362

FROM: _____ **(Date)**

_____ **(Name)**

_____ **(Agency)**

_____ **(Telephone)**

The following is the response of our agency to your request for views on the above-captioned subject:

_____ **Concur**

_____ **No Objection**

_____ **No Comment**

_____ **See proposed edits on pages** _____

_____ **Other:** _____

_____ **FAX RETURN of** _____ **pages, attached to this response sheet**

DRAFT

STATEMENT OF

SALLY RICHARDSON

DIRECTOR, CENTER FOR MEDICAID AND STATE OPERATIONS

HEALTH CARE FINANCING ADMINISTRATION

ON

"MEDICAID COMMUNITY-BASED CARE"

BEFORE THE

HOUSE COMMERCE HEALTH & ENVIRONMENT SUBCOMMITTEE

MARCH 12, 1998

HCFA
MEDICARE · MEDICAID

INTRODUCTION

I'm pleased to be here today to talk about our commitment to expanding and promoting consumer-directed home and community-based services so people with disabilities can live the best lives possible. It is consistent with our views about the basic rights of all Americans to control and direct their own lives. It is consistent with our strong and rigorous support for equal rights for people with disabilities, as articulated in the Americans with Disabilities Act.

Like everyone here today, we feel strongly about empowering people with disabilities -- including children, working age adults, and older people who need help with basic daily activities -- and their families, by increasing their independence and quality of life. One of the best ways to do this is to provide opportunities for individuals to choose to decrease their reliance on nursing homes, by increasing their options to choose self-directed personal assistance in home and community-based settings.

I will use my time today to discuss our multi-faceted approach to achieving these goals, recognizing that while we won't achieve our goals all at once, we can be aggressive about making real progress toward them. Our strategy includes legislative, regulatory, research/demonstration, and other activities.

OUR COMMITMENT

In May of 1995, after a series of meetings with individuals from the disability community, Secretary Shalala issued a set of principles supporting home and community based care. She

reaffirmed her support for emphasizing home and community based care services and offering consumers the maximum amount of choice, control and flexibility in how these services are organized and delivered. We continue to be guided by these principles.

This past September, the President and Vice President met with a group of disability community representatives and Federal officials to discuss how to move forward on a long term agenda. The President has a strong interest in the challenges facing people with disabilities who need long term care services; here is what he told the group. He said that this Administration has a continuing commitment to increase the availability of home and community based personal assistance services. He also expressed appreciation that the Community Attendant Services Act (CASA) bill had been introduced, noting that it will help focus attention on the expansion of home and community based care. He was particularly pleased that it would enable us to have a discussion about how to move more toward a system where "the money can follow the person" when a person leaves a nursing home or institution, no matter in what setting he or she chooses to receive the services needed. Finally, he noted that a lot of the activity and decision-making regarding home and community-based care and personal assistance services (PAS) is happening in the States. He charged those present with enlisting the help of those States that are moving in the right direction, to provide leadership in educating and helping others who are not so far along.

HHS WORKGROUP

As a result of the meeting with the President, and in an effort to pull together all our activities in this area, Bob Williams, HHS's Deputy Assistant Secretary for Disability, Aging, and Long-Term Care Policy, and I were asked to co-chair a work group on home and community based services. The goals of that work group, which began meeting in September, are to review all available information and make recommendations about how to reduce the institutional bias in State Medicaid long-term care services and spending and promote home and community-based care. Specifically, we are working to:

- Identify and address the "institutional bias" in the Medicaid program -- so fewer people are forced to move into nursing homes because it is the only way they can get long term care services;

- Provide more opportunities for consumers and their families to choose the setting in which long term care services are received, with increased flexibility for the "money to follow the person." as opposed to the payment determining the setting in which a person receives services; and,

- Promote consumer direction of home and community based/personal assistance services.

Our group members include HHS and other Administration officials interested in the issue, as well as an expanded group of "constituency partners" -- representatives of consumer groups,

providers, and state agencies -- with whom we consult to ensure that the Work Group's activities and products take a variety of perspectives into account. The Work Group is moving ahead on a number of fronts.

Overcoming Institutional Bias

We are exploring a range of demonstration strategies, including opportunities we can offer States to modify their Medicaid programs and try some new ways of helping people who want to and are able to live in the community. I am happy to announce that we will soon be asking States to submit proposals to begin to develop a research design to identify individuals who could successfully move out of nursing homes into the community and to begin to develop the services that would be needed to support these individuals in the community. This solicitation is in response to the Congressional directive in the Appropriations Bill and the commitment made by President Clinton to the disability community. We believe that we will be able to fund 3 to 5 States with this money.

Another component of this work involves using HCFA data to improve our understanding of the numbers and characteristics of nursing home residents who may be good candidates for moving back to the community and what they would need in the way of supports. We will then be better able to help the States design strategies that succeed when these individuals attempt to move to the community.

We are also developing strategies to address the President's charge that states should learn from each other how to support and promote home and community based services. Some States are much further along than others in developing innovative and cost-effective service delivery models for home and community-based services. Staff have been talking to a wide range of experts in the aging, disability, and long-term care fields in order to hear what they have learned. We have gotten positive feedback from a growing number of States about the value of developing a "State to State" technical assistance strategy.

We learned from our constituent partners that some States are not fully aware of the flexibility available to them under current regulations. Therefore, we want to clarify some of the things that States can do right now to reduce the institutional bias. We are planning to produce, within the next six to eight months, a primer on Medicaid that explains to State officials and consumers what is already available under the Medicaid personal care option home and community-based waivers, as well as other Medicaid services. This primer will be clearly stated, so readers can understand what is allowable within the existing framework of Medicaid. The primer will also include some examples of States that have used the flexibility of Medicaid to do some excellent work in reducing nursing home use and increasing community supports.

Finally, last year's CASA bill required a study of the "institutional bias" in the Medicaid program. The President was very interested in that idea, so HHS commissioned an independent contractor -- the University of California at San Francisco -- to conduct such a study. A few weeks ago we received the contractor's draft report. Let me note that this report has already been

reviewed by a Blue Ribbon Panel on Personal Assistance Services that includes many consumers with disabilities and other Medicaid and personal assistance services experts.

The report reviews the Medicaid statute and regulations, as well as policy guidance from HCFA, and makes a series of policy options to address the "institutional bias" in Medicaid. The majority of the recommendations would involve statutory change (and many would involve significant new costs). We are now developing a list of potential regulatory and policy changes on which we can take some more immediate action.

Expanded Settings & Eligibility for Receiving Services (Legislation)

In addition to this work group, HHS has been supporting a strong home and community care and personal assistance services agenda for many years. This agenda also includes legislative, regulatory and research components.

On the legislative front, we were pleased that Congress included in BBA our proposal to allow certain workers with disabilities to purchase Medicaid. Losing health coverage can devastate anyone. Losing health care and personal assistance services is even more devastating for some people with disabilities -- to the point where they are afraid to even try to work, because if they lose SSI or SSDI eligibility, and thus health care, they lose their life line. The new BBA provision should enable many individuals to make ~~a real attempt at working~~ the transition to work. Two days ago, we mailed to State Medicaid Directors a letter that revised the definition of income for the purpose of calculating the eligibility standard in this provisions. Under our revised definition, States will

apply this standard to income net of income disregards. In addition to increasing personal independence and productivity for participants, we have the potential to support a whole new group of taxpayers. Everybody wins.

Also included in BBA was our proposal to allow States to include prevocational, supported employment, and educational services for all home and community-based services waiver recipients with developmental disabilities. Before this provision was enacted, only those who were formerly institutionalized could receive these services through a home and community-based services waiver.

Finally, BBA establish a new type of service provider called Program of All-Inclusive Care For the Elderly (PACE). States may elect to provide PACE program services to individuals who are Medicaid eligible and are enrolled in a PACE program agreement. PACE provides for a coordinate set of services to frail elderly individuals living in the community.

Expanding Settings & Eligibility for Receiving Services (Regulation & Policy)

On the regulatory and policy fronts, this Administration has been very supportive of expansions in home and community based services. All States are now operating at least one and sometimes several home and community based waivers. Many provide additional supports with other Medicaid services as well. Thirteen States provide attendant care under their home and community-based waiver programs, while thirty-nine States provide personal care under their home and community-based waiver programs. The waiver program has flourished and grown

well under President Clinton's leadership, and currently there are 226 approved home and community-based waiver programs. We expect the program to continue to expand at an even greater pace as we work with States to find new ways to promote the use of existing services in States that have not provided them yet. I wrote to the State Medicaid Directors in July of 1997 to promote the use of Medicaid home and community-based waivers. I also reinstated HCFA policy that self-directed care should be encouraged and that every individual has the right to assume risk, commensurate with the person's ability and willingness to assume responsibility for that risk.

We also recently issued revised regulations, to increase the responsiveness of the Medicaid personal care option to better meet the needs of people with disabilities. There are currently 31 States providing personal services under their State plans. Individuals are now permitted to receive services both in the home, and outside the home. The new regulation also eliminates the requirement that a registered nurse must supervise personal care services, thus reducing cost and making the service more consumer responsive and less "medicalized."

Consumer Directed Purchasing

Our home and community based care and PAS research agenda is a key part of efforts to help ourselves, and help states and consumers, to find out what works, for whom, how well, and at what cost. A central component of this research component of our agenda is the Cash and Counseling experiment, that we are supporting in collaboration with the Robert Wood Johnson

Foundation. The four states participating in Cash and Counseling will be permitted to offer consumers cash allowances along with counseling to purchase their own attendant services.

OMB — not yet

We are also about to start testing, at four sites, a model to help consumers purchase their own equipment, such as wheelchairs. "Consumer direction" is key to the proposed demonstration project where:

(1) sponsoring Centers for Independent Living must assure that people with disabilities guide the agencies as board members and are active as employees and consumer advocates;

(2) a system of prior authorization of payment for medically necessary equipment is intended to accommodate benefit flexibility in the acquired equipment; and

(3) prior authorization and beneficiary credit accounts enable beneficiaries, in partnership with the Center sponsors, to negotiate with suppliers over equipment prices, features, warranties, maintenance and 24-hour repair services for wheelchairs and related accessories.

Finally, we are promoting our home and community based services agenda by working with States to develop and implement Medicaid demonstrations under the 1115 authority of the Social Security Act. Some focus on the integration of acute and long term care, such as the projects underway in Minnesota and the District of Columbia. Others, such as the newly- approved Colorado home health demonstration address different aspects. Colorado's demonstration will permit home health services to be provided in settings other than the home, such as schools.

work sites, or day treatment centers. Wisconsin and Rhode Island have applied for 1115 Waivers to serve beneficiaries under age 65 with physical disabilities and adults with developmental disabilities respectively. We expect to complete our review of these waiver applications soon. We are very interested in finding new ways of doing business in Medicaid and encourage states to bring us their ideas and proposals.

CONCLUSION

The bottom line is that we believe the CASA bill and this hearing will start the conversations needed not only at the federal level but in the states as well. The key is finding the most powerful incentives possible to support States to move in the direction of reducing reliance on institutional care, and at the same time, expanding and promoting consumer-directed home and community-based services.

While we do not have a formal position on CASA or other long term care reform legislation, we embrace the goals and want to continue doing all we can to reach them. We want to work together with you and other interested parties to craft an affordable, consumer responsive system that takes advantage of the flexibility of our current programs to help people obtain and keep the help they need to lead ~~the best quality, most independent lives~~ possible.

In conclusion, I would like for all of us to remember that people with disabilities are a very diverse group of individuals. They are children, working-age adults, and the elderly. They have developmental disabilities, emotional or cognitive disabilities, and physical disabilities. This is

not a group of people for which a "one solution fits all" answer is appropriate. These individuals need more opportunities, more choices on where and how they are to receive services. Nursing homes, intermediate care facilities should be available, but home and community based services must also be available. We cannot afford to have any bias in service delivery.

OMB Proposed Testimony:

We share the goals.... However, at a cost of $10-20 we can't support the casa bill because we don't see how the bill can be funded. we want to work together....

Gingrich letter:

Because of the complexity and importance of the issues involved, it is premature to endorse either of these bills in full in their current forms. We both recognize the fact that these bills are projected to have significant costs. However, I believe the bills present Congress and the Administration a critical opportunity to work together in a bipartisan manner to address these issues in a way that assures budget neutrality, flexibility for states, and increased choice and control for people with disabilities, older persons, and their families in decisions affecting their lives and futures. Striking such a delicate and crucial balance will not be easy, but I am convinced it can and must be done.

Cost prohibitive

Clearly [illegible] can be better

Scoring complications

Casa reps an impt attempt to...

chall of course is to bal the des of provdg more flex + choice to pwd w/ nd to ensure that all to fed sort. Prel ests 15 very real $'s about wh the goal has yet bn achvd, however we rem comtt

Fax to Jane Horvath 690-7450
2 pages

What does Fortuna do?

From: Diana Fortuna 03/03/98 06:07:56 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: William H. White Jr./WHO/EOP, Anne E. Tumlinson/OMB/EOP
Subject: Draft letter to Gingrich on CASA

Here at last is the draft letter to Gingrich. Since we are facing a hearing on this topic a week from Thursday (the 12th), I need comments asap -- by close of business Thursday if possible, certainly by Friday. Kathy, can you coordinate comments within HCFA, and also make sure other relevant parts of HHS are aware of our plans and this draft?

Also, has the Administration been invited to testify at this hearing? If so, who will testify?

DRAFT

Dear Speaker Gingrich:

As I have said many times, America can not afford to waste any of its citizens' abilities or talents. Empowering people with disabilities by increasing access to consumer-directed home and community-based services must be part of our bipartisan efforts to make this a reality. Since I know that you share my commitment to this goal, I am writing to inform you of my Administration's recent actions in this area.

Secretary Shalala recently created a work group based at the Department of Health and Human Services that is actively focusing on how to expand and promote consumer-directed personal assistance and other home and community-based services for people with disabilities. The work group is ~~soliciting~~ input by the disability community, aging community, states, and others on steps that might be taken to increase access to these services. Among its other activities, the work group has undertaken a major review of the Medicaid program to identify what needs to be done to eliminate or reduce particular instances of institutional bias arising from the existing statute, ~~program~~ regulations, and policy guidance. The work group is also developing a concept paper on a proposed pilot or demonstration strategy and exploring state interest in participating in such pilots and demonstrations. In addition, HHS is embarking on a multifaceted effort to support successful state practices on home and community-based services, such as offering technical assistance on demonstrations and waivers; gathering information from a range of experts in aging, disability, and long-term care; and disseminating information on successful practices. Finally, the work group is formulating and reviewing policies that could ~~assist~~ people leaving the welfare rolls to become employed as community-based personal assistance workers.

These new efforts build on our efforts over the past five years. This Administration has aggressively pursued a strategy to expand and promote consumer-directed home and

community based services, through legislative change, regulatory and other administrative guidance, and research and demonstrations. For example, the Administration developed a number of proposals that were included in the Balanced Budget Act, including a new state option for a Medicaid buy-in for people with disabilities seeking to return to work; expanding the availability of supported employment to people with disabilities; making durable medical equipment more widely available under Medicare; and expanding the PACE program of community supports. Similarly, the home and community-based waiver program has flourished, in large part due to HHS's ongoing support for state waiver programs.

I would like to build on this progress by working collaboratively with you and with others in Congress on this issue. Last year, you introduced HR2020, the Medicaid Community Attendant Act (exact name?), which seeks to create incentives in the Medicaid program for disabled and older Americans to get the support they need to lead fuller, more productive lives as members of their families and communities. Similar legislation introduced by Senator Feingold also focuses on addressing this major challenge.

Because of the complexity and importance of the issues involved, it is premature to endorse either of these bills in full in their current forms. We both recognize the fact that estimators project that these bills will have significant costs. However, I believe the bills present Congress and the Administration a critical opportunity to work together in a bipartisan manner to address these issues in a way that assures budget neutrality, flexibility for states, and increased choice and control for people with disabilities, older persons, and their families in decisions affecting their lives and futures. Striking such a delicate and crucial balance will not be easy, but I am convinced it can and must be done.

I look forward to having the benefit of your leadership as we work with Congress, the states, the disability and elderly communities, and others on this essential venture.

Sincerely,

Message Sent To:

kking @ hcfa.gov @ inet
djohnson4 @ hfca.gov @ inet
Bwilliam @ osaspe.dhhs.gov @ inet
Christopher C. Jennings/OPD/EOP
Jeanne Lambrew/OPD/EOP
Nicolette Highsmith/OMB/EOP
Cynthia M. Smith/OMB/EOP

Office of Legislation

HCFA MEDICARE • MEDICAID

Number of Pages: _____ Date: _____

To: Dina Fortuna

From: Dr. Johnson

Fax: _____

Phone: _____

Fax: _____

Phone: _____

REMARKS: Gingrich letter comments from staff.

HEALTH CARE FINANCING ADMINISTRATION
200 Independence Ave., SW
Room 341-H, Humphrey Building
Washington, DC 20201

CMSO Comments on White House letter to Gingrich re: CASA

Paragraph 2 -- Sentence 4 beginning "The work group is also developing a concept paper.." Change to **The work group is also exploring a range of demonstration strategies to offer States opportunities to try new ways to help people who want to and are able to live in the community to move out of nursing homes and other institutions. These strategies will include expanding options for receiving supports in the community. We anticipate a formal announcement soon.**

Paragraph 3 --Sentence 3 beginning "For example.." , change phrase to expanding the availability of pre-vocational, supported employment and educational services to people with disabilities,

Paragraph 3, end of last sentence, substitute of State innovations instead of "for State waiver programs.

Don, we hope you know the name of HR2020.

We have not yet received comments from Sally Richardson.

Any questions, please call Kathy Rama 410-786-6659

1. Chris + Jeanne

2. OMB

3. HCFA - Bonnie
+ Don → asking Bonnie
+ Sally 410.786.6768 Terry Dervilla

4. ASL - Horvath

5. Bob W

pick up testimony - more specific

"ask States to submit proposals to begin to develop a research design to identify persons who could successfully be deinstitutionalized + to develop svcs that wld be needed to support them in the community."

TO: Diana Fortuna, DPC

From: Terry Deville, HCFA
(410) 786-6768

Per my email, here's some more specific language for page one of your letter.

forced to move into nursing homes because it is the only way they can get long term care services;

- Provide more program opportunities for consumers and their families to choose the setting in which long term care services are received, with increased flexibility for the "money to follow the person," as opposed to the payment determining the setting in which a person receives services; and,

- Promote consumer direction of home and community based/personal assistance services.

Our group members include HHS and other Administration officials interested in the issue, as well as an expanded group of "constituency partners" -- representatives of consumer groups, providers, and state agencies -- with whom we consult to ensure that the Work Group's activities and products take a variety of perspectives into account. The Work Group is moving ahead on a number of fronts.

Overcoming Institutional Bias

We are exploring a range of demonstration strategies, including opportunities we can offer States to modify their Medicaid programs and try some new ways of helping people who want to and are able to live in the community. I am happy to announce that we will soon be asking States to submit proposals to begin to develop a research design to identify individuals who could successfully move out of nursing homes into the community and to develop the services that would be needed to support these individuals in the community. This solicitation is in response to the Congressional directive in the Appropriations Bill and the commitment made by President Clinton to the disability community. We believe that we will be able to fund 3 to 5 States with this money.

Another component of this work involves using HCFA data to improve our understanding of the numbers and characteristics of nursing home residents who may be good candidates for moving

bwilliam @ OSASPE.DHHS.GOV
01/13/98 01:29:00 PM

Record Type: Record

To: diana fortuna

cc:
Subject: hcbs -Reply

Several things:

Last thing I heard there was something like $2 million in HCFA's budget for FY 99 to do some kind of consumer directed demo. What that will like us I am not sure. As you know, Mrs. Gore likewise got $5 million in what I understand is new money for implementation of the Families of Children with Disabilities Support Act. HHS left it out of our final appeal to OMB. Hence, that was helpful and I will see the community expresses its appreciation at the appropriate time. From what I understand it will have its dander up on most other aspects of the budget but perhaps we can get some bonus points for this.

I have not seen Nancy Ann's accomplishments memo and would appreciate seeing it. I have seen ADAPT's most recent letter. What is your take on it?

As far as next steps, my focus is now on FY 2000. Peggy Hamburg had 1 conversation with the Secretary and we are asking for a more indepth conversation with her. The Secretary's take to date which coincides with some of my thinking as well is that we need to look at creating some non Medicaid Performance based incentives for States to to use their Medicaid more for HCBS. In practice, what this might look like is using discretionary dollars for things like technical assistance, Performance bonus awards, covering the transition expenses of helping individuals leave nursing home, etc. I think the rationale for doing this on the non entitlement side is to avoid building it into the base. Another strong reason for doing it this way is that whenever you attach something to Medicaid there are always unforeseen strings and consequences involved in doing so (especially in terms of over medicalizing services). So my thinking is we be able to leverage more progressive change in Medicaid LTC programs at the State level by introducing some non Medicaid dollars to goose the system. The more effective DD Councils have used this approach for years and really met with significant success. Also I think it builds off the CHIP experience as well.

Right now we are still talking about something which would cost in the neighborhood of fifty million dollars. But, I would like to develop 2 more options as well. one costing between $250 to $500 million and the other costing between $500 million and a billion dollar over a 3 to 5 year period.

?

Tony is speaking at the Chamber of Commerce,
& the President may too.

I also want develop either as a stand alone proposal or one which could be folded into what I have just outlined dealing with the nexus between hardest to employment and health care access for people with disabilities. Don Johnson, myself and assorted others from HHS have now met with the Senate and House staffs working on these issues a couple of times and I am convinced that what they are proposing even if it had our blessing would not significantly move the ball forward in this area. And, I have said that. I think a much better approach is to use CHIP as a point of reference, have Congress commit to 10 years of Performance based appropriations, run several well controled demos to figure out what really works, provide national TA concurrently on what are known to be at least some best practices, offer some other types of statutory and regulatory reliefs and then after the first 5 years open it up to all fifty States. That's my take on it.

As for your last question on the national center idea, we are looking at ways to do some of that with existing resources. Thanks!

>>> <Diana_Fortuna@oa.eop.gov> 01/09/98 04:20pm >>>
Message Creation Date was at 9-JAN-1998 16:20:00

Well, after my rosy predictions, it looks like we will end up with nothing in
the budget on hcbs. Have you seen Nancy-Ann's long accomplishments memo to me,
along with ADAPT's January 5 letter? I'll send them to you if not.

What do you think we do now? I guess keep plugging away at the workgroup? Is
there any way to do the center for long term care idea you proposed but within
existing resources?

CASA

CMSO Comments on White House letter to Gingrich re: CASA

Paragraph 2 -- Sentence 4 beginning "The work group is also developing a concept paper.." Change to **The work group is also exploring a range of demonstration strategies to offer States opportunities to try new ways to help people who want to and are able to live in the community to move out of nursing homes and other institutions. These strategies will include expanding options for receiving supports in the community. We anticipate a formal announcement soon.**

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Paragraph 3, end of last sentence, substitute **of State innovations** instead of "for State waiver programs.

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1. Chris + Jeanne
2. OMB
3. HCFA - Bonnie
   - Don → asking Bonnie
   - Sally
4. ASL - Horvath
5. Bob W

Fax to Jane Horvath 690-7450
2 pages

From: Diana Fortuna 03/03/98 06:07:56 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: William H. White Jr./WHO/EOP, Anne E. Tumlinson/OMB/EOP
Subject: Draft letter to Gingrich on CASA

Here at last is the draft letter to Gingrich. Since we are facing a hearing on this topic a week from Thursday (the 12th), I need comments asap -- by close of business Thursday if possible, certainly by Friday. Kathy, can you coordinate comments within HCFA, and also make sure other relevant parts of HHS are aware of our plans and this draft?

Also, has the Administration been invited to testify at this hearing? If so, who will testify?

DRAFT

Dear Speaker Gingrich:

As I have said many times, America can not afford to waste any of its citizens' abilities or talents. Empowering people with disabilities by increasing access to consumer-directed home and community-based services must be part of our bipartisan efforts to make this a reality. Since I know that you share my commitment to this goal, I am writing to inform you of my Administration's recent actions in this area.

Secretary Shalala recently created a work group based at the Department of Health and Human Services that is actively focusing on how to expand and promote consumer-directed personal assistance and other home and community-based services for people with disabilities. The work group is soliciting input by the disability community, aging community, states, and others on steps that might be taken to increase access to these services. Among its other activities, the work group has undertaken a major review of the Medicaid program to identify what needs to be done to eliminate or reduce particular instances of institutional bias arising from the existing statute, program regulations, and policy guidance. The work group is also developing a concept paper on a proposed pilot or demonstration strategy and exploring state interest in participating in such pilots and demonstrations. In addition, HHS is embarking on a multifaceted effort to support successful state practices on home and community-based services, such as offering technical assistance on demonstrations and waivers; gathering information from a range of experts in aging, disability, and long-term care; and disseminating information on successful practices. Finally, the work group is formulating and reviewing policies that could assist people leaving the welfare rolls to become employed as community-based personal assistance workers.

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These new efforts build on our efforts over the past five years. This Administration has aggressively pursued a strategy to expand and promote consumer-directed home and

community based services, through legislative change, regulatory and other administrative guidance, and research and demonstrations. For example, the Administration developed a number of proposals that were included in the Balanced Budget Act, including a new state option for a Medicaid buy-in for people with disabilities seeking to return to work; expanding the availability of supported employment to people with disabilities; making durable medical equipment more widely available under Medicare; and expanding the PACE program of community supports. Similarly, the home and community-based waiver program has flourished, in large part due to HHS's ongoing support for state waiver programs.

I would like to build on this progress by working collaboratively with you and with others in Congress on this issue. Last year, you introduced HR2020, the Medicaid Community Attendant Act (exact name?), which seeks to create incentives in the Medicaid program for disabled and older Americans to get the support they need to lead fuller, more productive lives as members of their families and communities. Similar legislation introduced by Senator Feingold also focuses on addressing this major challenge.

Because of the complexity and importance of the issues involved, it is premature to endorse either of these bills in full in their current forms. We both recognize the fact that estimators project that these bills will have significant costs. However, I believe the bills present Congress and the Administration a critical opportunity to work together in a bipartisan manner to address these issues in a way that assures budget neutrality, flexibility for states, and increased choice and control for people with disabilities, older persons, and their families in decisions affecting their lives and futures. Striking such a delicate and crucial balance will not be easy, but I am convinced it can and must be done.

I look forward to having the benefit of your leadership as we work with Congress, the states, the disability and elderly communities, and others on this essential venture.

Sincerely,

Message Sent To:

kking @ hcfa.gov @ inet
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Bwilliam @ osaspe.dhhs.gov @ inet
Christopher C. Jennings/OPD/EOP
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Cynthia M. Smith/OMB/EOP

CASA

FORTUNA_D @ A1
03/12/98 02:57:00 PM

Record Type: Record

To: diana m. fortuna

cc:
Subject: CONGRESS EXPLORE NEW RIGHTS FOR PEOPLE WITH DISABILITIES

Date: 03/12/98 Time: 14:26
DCongress explore new rights for people with disabilities

WASHINGTON (AP) Eight years after passage of a landmark disabilities law, Congress has opened a new debate about further expanding the rights of disabled people.

Advocates for the disabled are pressing for a bill that would give them more control over their care. It would allow a larger portion of the Medicaid funds that now pay for care in institutions to be used for community- or home-based care, if that's where the individual wants to live.

The debate opened Thursday with support from two House members who rarely agree on anything: Speaker Newt Gingrich, R-Ga., and Minority Leader Richard Gephardt, D-Mo.

Gingrich told the House Commerce health and environment subcommittee that government shouldn't force people with disabilities into institutions and nursing homes for care that can be delivered more effectively and cheaply in a home or community living arrangement.

``Everyone deserves the opportunity to lead a full and independent life,'' Gingrich said, adding that ``people with disabilities are no exception.''

His remarks drew applause from the audience of advocates, many of whom sat in motorized wheelchairs and took notes or were accompanied by seeing-eye dogs. Others wore purple buttons that said ``There is no place like home'' or red T-shirts printed with ``Mi Casa,'' the bill's acronym, which also means ``My Home'' in Spanish.

Gingrich introduced the bill last June, with Gephardt as a co-sponsor.

The 1990 Americans with Disabilities Act banned discrimination against people with disabilities.

Gephardt said too much of the Medicaid funds spent on the disabled goes to institutions. With the right services, he said, many people with disabilities can live productive lives on their own.

``Further, they have a right to do so,'' he said. ``People with disabilities have that right as much as others that don't have disabilities.''

But some are already questioning the potential price tag.

Margaret Hamburg, an assistant secretary at the Department of Health and Human Services, said the Clinton administration embraces

the goals but has concerns about the cost and whether the bill is the best way to achieve those goals.

The Congressional Budget Office says the bill could cost between $10 billion and $20 billion a year, depending on how many people use the benefit and other factors.

Rep. Ted Strickland, D-Ohio, told advocates that it's easy to get support for bills, but harder to get lawmakers to vote to spend the money. ``Talk is cheap in Washington,'' he said.
APNP-03-12-98 1438EST

CASA

Version: September 8 - 10:00 am

Briefing Materials for the President's Meeting with Disability Groups
September 10, 1997

The Clinton Administration has achieved some remarkable milestones toward promoting the agenda of individuals with disabilities to live a full, productive, and independent life. With the help of the disability community this Administration has been able to focus the attention of the country, and the Congress on these important issues. This paper highlights some of those achievements.

The Balanced Budget Act of 1997

- Under section 4733 of the recently enacted Balanced Budget Act, States are permitted to allow certain Supplemental Security Income (SSI) beneficiaries who are disabled and would lose eligibility because of their earnings to purchase Medicaid coverage. Eligibility is extended to SSI beneficiaries whose income is less than 250 percent of the Federal poverty level for the applicable family size. Currently, 250 percent of the poverty level for one person is currently a little over $2,210 per month. States will set premiums based on an income-related sliding scale. **The Administration originally proposed Medicaid buy-in with no income limit, so this provision should not be over emphasized.**

- The Act in section 4743, also amended the home and community-based waiver program by eliminating the requirement that individuals be discharged from a nursing facility or intermediate care facility for the mentally retarded to be eligible to receive habilitation services under a home and community-based waiver.

- The Act in section 4701 exempts certain children with disabilities including SSI beneficiaries, and children in foster care from being required to receive care through a managed care entity under freedom of choice waivers..

- The Act in section 5305 reinstates Medicaid eligibility for certain aliens who receive SSI. Medicaid benefits were denied to this group of elderly and disabled aliens in the Personal Responsibility and Work Opportunities Reconciliation Act (PRWORA) of 1996 but have subsequently been terminated from SSI because of the PRWORA's tighter definition of childhood disability. It should be noted that disability groups perceive the Administration's interpretation of the new SSI definitions for children as overly harsh resulting in large numbers of children losing eligibility.

- Similarly, the Act in section 4913 restores Medicaid eligibility to disabled children who were receiving SSI at the time of enactment of the PRWORA of 1996.

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

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

Personal Care Services Regulation

- The Personal Care Services Regulation which makes personal care services an optional Medicaid benefit which may be covered under States' Medicaid programs has been signed by the Secretary of Health and Human Services and will be published in the *Federal Register* in the very near future. **(***This is clearly a candidate for White House intervention. OMB has had the regulation for 60 days, but is believed to be finalizing their review. The President could announce the date of publication if cleared. However, it should be noted that States have been able to provide personal care services under waivers without the regulation, and it has taken DHHS 4 years to finalize the regulation.)**

  - The regulation permits States to cover personal care services in the home and at the State's additional option, in locations outside the home including the work place.

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

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

Home and Community-Based Care Services

- The Health Care Financing Administration continues to support and promote community- based long-term care for the elderly and people with developmental or physical disabilities through the home and community-based waiver program authorized under section 1915 © of the Social Security Act. Currently over

250,000 individuals with disabilities receive a wide array of services from personal assistance to home modifications and assistive devices (to name only a few) under 226 of these programs in 49 States and the District of Columbia. Similar services are provided in Arizona under their 1115 waiver. Through the use of this Medicaid waiver provision, four States have entirely eliminated their large publicly-funded institutions for people with developmental disabilities and replaced them with integrated community services. Most others have significantly phased down reliance on inappropriate institutional care for people with disabilities as a result of the waiver program.

- Under the Clinton Administration numerous changes have been implemented to simplify the home and community-based waiver application and approval process. One of the most lasting and meaningful changes to promote home and community care and "level the playing field" with institutional care was the elimination of the rule that required States to show that without the waiver an equal number of beds would have to exist in institutions or nursing homes to accommodate those receiving waiver services.

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

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

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

Research and Demonstration Activities

- To honor its commitment to the disability community to move toward the goal of encouraging provision of long-term care services in the community, rather than in

institutional settings, HCFA in consultation with leaders of the ADAPT movement has modified its current contract with the University of California, San Francisco, to undertake two related studies. The two studies will consist of a comprehensive review and analysis of Medicaid policies, regulations and statutes which relate to long-term care services to identify:

- the institutional bias in Medicaid law, regulation, All State Medicaid Directors Letters, and other documents ,
- requirements that overly promote the medical model in long-term care,
- identify ways we can promote home and community-based care, and
- identify to the extent to which Medicare and Medicaid are unnecessarily linked.

- A project Advisory Committee composed of between 8 and 10 individuals knowledgeable about disabilities as these relate to Medicaid beneficiaries will inform the work of the contractors. Representatives could include individuals from ADAPT, the National Council on Aging, and other relevant groups, as well as health services researchers familiar with disability issues.

- The contractor will make interim reports to the DHHS/OMB work group discussed below at 30, 60, and 90-day intervals after beginning work under the contract. The interim reports will identify policies, regulations, and statutes identified by those dates which need to be addressed by the work group. These interim reports are to expedite action by DHHS to eliminate the institutional bias in Medicaid and to delink Medicare and Medicaid regulations when found to be appropriate.

- The final report will describe all the regulations and statutes which were reviewed, and describe the problem areas identified and the potential areas for change. The final report will include policy recommendations, as well as potential research and demonstration projects.

o HCFA has established a work group to review the findings of the studies on eliminating the institutional bias in Medicaid and delinking problematic Medicare policies from Medicaid. The work group consists of Health and Human Services staff, and staff from the Office of Management and Budget. The members will consult regularly with a group of "constituency partners" representing the disability community, State agencies, and other appropriate Federal agencies. The work group will work with the advocacy community to identify States which are willing to participate in pilot studies designed to implement the " date certain" concept. We believe these pilots could serve the symbiotic purposes of helping States which have mandates to reduce their institutionalized populations and HCFA's desire to explore identifying the barriers to implementing the

"date certain" concept. The "date certain" concept identifies the date on which all individuals who are in institutions on that date will have the option to move into a community-based living arrangement, and receive needed services without the requirement for a waiver. **(The "date certain" issue has been identified by representatives of ADAPT as the one step the President could take at this meeting to show real support. ADAPT argues that the "date certain" concept is a win-win concept because by definition it is cost neutral, and does not expand the numbers of people eligible for service. Two versions of the concept proposed by ADAPT are - 1) the "date certain" would be the day those eligible could begin to move to the community from institutions, and 2) the "date certain" is the date on which all persons in institutions on that date would be permitted to move to the community when administratively feasible. The first is preferred. The second is considered a "no brainer" by ADAPT. Given the history of deinstitutionalization of the mentally retarded and mentally ill, which has identified the many benefits and the serious risks involved, HCFA is committed to proceeding in a manner which serves to protect the interests of beneficiaries .)**

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

- The experimental model for the demonstration would permit States to allow clients to choose cash payments in lieu of traditional case management services.

- The experimental group members who receive cash payments in lieu of arranged services will be required to account for how they spend the funds. Minimal restrictions will be placed on beneficiaries' use of the cash benefits so long as purchases are related to disability needs. Where the relationship of a planned use of the cash benefit to a disability need is not self-evident, prior approval may be required.

- In addition to purchasing personal assistance services, the waiver would permit States to offer a range of optional supportive services, including, but not limited to: recruitment of workers, screening of workers, training of the consumer and worker, back-up or emergency services, and assistance with tax forms and

insurance paperwork.

- The availability of counseling services would be integral to a consumer-directed approach and to this demonstration. At a minimum, counseling involves helping consumers to decide whether to choose the cash option and how they might best spend the money available to them. Counselors should give consumers the facts and options they need to make informed choices for themselves.

- Each State proposal contains detailed provisions for monitoring the quality of care provided under the demonstrations. Monitoring is provided by the counselors, registered nurses and/or the fiscal intermediaries depending on the State.

- The demonstration would accommodate participation of approximately 9,750 elderly, 7,125 non-elderly individuals with disabilities, and 1,750 children with disabilities. The demonstration is a collaborative effort by representatives of the Robert Wood Johnson Foundation, the Office of the Assistant Secretary for Planning and Evaluation, the Health Care Financing Administration, the National Program Office at the University of Maryland's Center on Aging, the National Council on Aging, and Mathematica Policy Research (the evaluator).

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

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

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

o HCFA will release a program announcement to Centers for Independent Living (CILs) intended to test a model of consumer-directed durable medical equipment (CD-DME) that covers a range of activities such as assessment and purchasing related to wheelchairs and accessory items. CD-DME sponsors will provide assistive technology information and facilitate consumers' access to expert assessment and care coordination. In partnership

with consumers with physical disabilities, sponsors will also more efficiently acquire Medicare-financed DME products and services through a process of prior authorization. Savings accrued from more efficient purchasing will be used to establish beneficiary credit accounts that may be used by beneficiaries to acquire enhanced equipment and/or services not covered by Medicare. Up to four sites are expected to be awarded pre-waiver development grants of approximately $150,000 each.

o In their fiscal year 1997 research agenda, HCFA is sponsoring a grants program to foster a more integrated and flexible service delivery system for Medicaid and Medicare dually-eligible beneficiaries by working collaboratively with States and providers to develop more effective systems of care to meet the diverse and complex needs of these beneficiaries.

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

- Twelve proposals were received by the August 29 deadline. HCFA is planning to award approximately six grants of $150,000 each in October 1997.

o The State of Wisconsin submitted an application for Medicare and Medicaid demonstration waivers to establish a partnership model of care delivery for under age 65 beneficiaries with physical disabilities and frail elderly beneficiaries who are eligible for Medicare and Medicaid and meet nursing home level of care criteria. The model is similar to the Program of All-inclusive Care for the Elderly (PACE) model in the use of multi-disciplinary care teams, prepaid capitation and the sponsorship by a community-based service provider. The partnership model for people with disabilities would use Centers for Independent Living a s the community-based provider. Waiver approval is anticipated this fall with implementation targeted for January 1, 1998. The model is a voluntary enrollment model, and Wisconsin expects to enroll up to 300 individuals at each of three sites. The Wisconsin Partnership model is the first known comprehensive capitated model of service delivery specifically designed for Medicare and Medicaid beneficiaries with physical disabilities.

o The State of Rhode Island was awarded a HCFA planning grant to design an integrated approach to health/medical care and for life-long community supports for adults with developmental disabilities. Staff from Rhode Island Division of Developmental Disabilities along with Department of Human Services, people with disabilities, service providers, and

advocates worked for over 2 years to design this waiver proposal. The planning was completed in July 1996. HCFA is currently reviewing the implementation proposal submitted by the State in May 1997 which will consolidate the current Medicaid and other Federal funding streams into a single coherent funding resource. This will help enable the restructuring and transition of the service system to promote more personally directed supports and services. The program will serve 3,500 beneficiaries statewide.

Status of HCFA Initiatives Announced at the June 25 White House Meeting

- Contract to review Medicaid regulations for institutional bias and delink Medicare and Medicaid policy - Covered above.

- Establish a workgroup to address bias issues - Covered above.

- Analyze Community Assistant Services Act (CASA) - Analysis attached.

- Analyze ADAPT's data on cost effectiveness - HCFA's actuaries and the Office of the Assistant Secretary for Planning and Evaluation in DHHS are currently reviewing data provided to them by OMB.

- HCFA Central Office staff will visit several independent living centers - HCFA's Center for Beneficiary Services (CBS) is to set up visits in collaboration with the Department of Education and ADAPT.

- Announcement of the Consumer-Directed DME solicitation - CBS plans an early FY 1998 solicitation.

ATTACHMENT

"MEDICAID COMMUNITY ATTENDANT SERVICES ACT OF 1997" (H.R.2020)
Introduced by Speaker Gingrich on June 24, 1997

Summary of H.R.2020

Coverage of "Qualified Community-based Attendant Services." The bill would require a State Medicaid plan to include qualified community-based attendant services for any individual who is entitled to nursing facilities or intermediate care facilities for the mentally retarded (ICF/MR) and who requires such services based on functional need (without regard to age or disability).

Individual choice of care setting. A State would permit an individual who is entitled to Medicaid and qualified for care in a nursing facility or an ICF/MR to choose to receive qualified community-based attendant services in the most integrated setting appropriate to the individual so long as the aggregate amount of Federal expenditures for such individual does not exceed the total that would have been spent in an institution plus the transitional allotment for the State involved.

Definitions.

- **"Qualified Community-based Attendant Services."** A new section is added that defines "qualified community-based attendant services" as attendant services furnished to an individual:

  (1) on an as-needed basis under a plan of service that is based on an assessment of functional need and that is agreed to by the individual;
  (2) in a home or community-based setting, which may include a school, workplace or recreation or religious facility, but does not include a nursing facility, ICF/MR or other institutional facility;
  (3) under either an agency-provider model or other model; and
  (4) the furnishing of which is selected, managed and controlled by the individual (as defined by the Secretary).

  The term would include: backup and emergency attendant services; voluntary training on how to select, manage and dismiss attendants; and health-related tasks (as defined by the Secretary) that are assigned to, delegated to, or performed by, unlicensed personal attendants. Excluded services would include: provision of room and board; and prevocational, vocational and supported employment. The Secretary would promulgate regulations that the term may include expenditures for transitional costs such as rent and utility deposits, first months's rent and utilities, bedding, basic kitchen supplies and other necessities.

- **"Agency-provider model"** means a method of providing community-based services under which a single entity contracts for the provision of such services.

- **"Other model"** means a method, other than agency-provider, for provision of community-based attendant services. Such a model may include vouchers, direct cash payments or use of a fiscal agent to assist in obtaining services.

Transition allotments. Transitional allotments would be provided of: $580 million in fiscal year (FY) 1998; $480 million in FY 1999; $380 million in FY 2000; $280 million in FY 2001; $180 million in 2002; and $100 million in 2003. The Secretary would provide a formula for distribution of the allotment to States.

In order to receive transitional funds, a State would be required to develop a long-term care services transition plan that establishes specific action steps and specific timetables to increase the proportion of long-term care services provided under the plan in home and community based settings, rather than institutional settings. The plan would be developed with "major participation" by both the State Independent Living Council and the State Developmental Disabilities Council, as well as input from Councils on Aging.

State Quality Assurance Program. No Federal financial participation would be available with respect to qualified community-based attendant services unless the State establishes and maintains a quality assurance program that is developed after public hearings and that is based on consumer satisfaction. For services furnished under the agency-provider model, they would have to meet the following requirements:

(1) The State must periodically certify and survey provider agencies on an unannounced basis at least once a year;
(2) The State adopts standards relating to minimum qualifications and training requirements for provider staff, financial operating standards and a consumer grievance process;
(3) The State provides a system for monitoring boards consisting of providers, family members, consumers and neighbors to advise and assist the State;
(4) The State establishes reporting procedures to make available information to the public;
(5)The State provides ongoing monitoring of the delivery of attendant services and the effect of those services on the health and well-being of each recipient.

The regulations promulgated under section 1930(h)(1) would apply with respect to health, safety and welfare of individuals receiving qualified community-based attendant services in the same manner as they apply to individuals receiving community supported living arrangement services. The Secretary would promulgate additional regulations to protect the health, safety and welfare for individuals receiving qualified community-based attendant services other than under an agency-provider model.

Secretarial requirements. The Secretary would be required to submit to Congress periodic reports on the impact of this section on beneficiaries, States and the Federal government.

The Secretary of HHS would be required to review existing Medicaid regulations as they regulate the provision of home health services and other services in home and community-based settings and submit a report to Congress on how excessive utilization of medical services can be reduced by using qualified community-based attendant services.

The Secretary would be required to develop a functional needs assessment instrument that assesses an individual's need for qualified community-based attendant services.

The Secretary would be required to establish a task force to examine appropriate methods for financing long-term care services. The task force would include "significant" representation of individuals (and representatives of individuals) who receive such services.

Other requirements. Effective 1/1/99, a State could not elect to cover individuals in a medical institution without also electing to cover individuals who would be eligible for care in a medical institution, but are receiving home and community based care.

The definition of "medical assistance" is amended to add "qualified community-based attendant services" (to the extent allowed and as defined in section 1932).

Each time "section 1915" appears in the eligibility section, the term "or qualified community-based attendant services" is added.

States would have the option of waiving the income limitation in section 1903(f) if the State finds the potential for employment opportunities would be enhanced through the provision of such services. The State may impose a premium based on a sliding scale relating to income.

Effective Date: 1/1/98

HHS Preliminary Analysis of CASA Bill

We are committed to addressing the imbalance between institutional and community-based services within the Medicaid program and to promoting consumer-directed home and community based services and personal assistance services. This legislation takes great strides in both these areas. The legislation extends actions of the Clinton Administration achieved through the Balanced Budget Act of 1997, the Personal Care Services Regulation (soon to be published), and Medicaid programmatic actions through the home and community-based care waiver program.

- The Administration supports the bill's concept of providing community attendant care services in locations other than the home.

- We also support the bill's concept of making community-based care an option for those in need of long-term care services.

    - The Personal Care Services final regulation, scheduled for publication this week, will contain specific provisions that support expansion of home and

community-based care.

- The regulation removes the requirement for supervision by a registered nurse, reducing the cost and making this a more affordable option for States to elect. The regulation further supports the direction the CASA bill takes in expanding provision of services to locations other than in the home.

- The CASA bill contains provisions that address the provision of high quality services, and controlling the costs in providing all long-term care services which are major concerns of the Department. Recognition of these two concerns in the CASA bill reflects the disability community's understanding of these two important issues. We are doing a number of things to examine these issues in a controlled and deliberate way, and will continue to need the support of the disability community to inform this process.

Despite our strong support for the goals of increased community integration and consumer direction and control for beneficiaries with disabilities, the legislation presents several policy and operational concerns.

Policy Concerns

Cost

There are several facets to the cost issue. The bill intends to offer individuals currently residing in institutions the option of receiving personal assistance services in the community. While there might be some savings from people who are currently receiving more expensive care moving to less expensive care givers, we are concerned that these savings will not be enough to offset new costs.

- *Filling of beds* -- While services might be provided in the community at a cost equal to, or lower than the institutional cost for a given individual, it is quite likely that the institutional beds will be filled by persons waiting for institutional services, increasing overall costs.

  It is difficult to imagine how one might prohibit States from filling beds freed up under this bill. Our experience with the Home and Community Based Waiver program demonstrated the difficulty in constraining State and/or provider behavior in this respect.

- *Transitional Costs* -- For States seeking to shift more services to the community and to ultimately close larger institutional settings, there are transitional costs related to covering fixed institutional costs with declining populations that are difficult to resolve in a budget neutral way.

- *Increased Utilization* -- It is likely that the availability of personal attendant services will induce more utilization, through the so-called "woodwork effect," so that overall costs will increase as individuals who would not seek institutional care would seek community care

under this new program.

- *Paying Family Members* -- Compounding the possible cost expansion is the lack of specific language regarding payment to family members for care which could otherwise be furnished without charge. The language should be amended to specify that payment is not available for services furnished by a spouse to a spouse or a parent to a child.

Cost Limitations

- The bill does have some mechanisms for the State to control costs through a cost neutrality requirement, however, we are unclear how this requirement would be enforced, given the previously identified concerns.

- The bill also permits cost-sharing that could be used to moderate State and Federal spending.

Actuaries' Concerns

- HCFA actuaries are concerned that even with the limitations on cost in place, implementation of this benefit will result in **significant additional spending, above and beyond the $2 billion transitional pool that is specified in the bill.**

- HCFA actuaries question how the limitation on expenditures provided for in CASA is based. Is the limitation based

  1) on what is paid under Medicaid for those currently receiving institutional care, or

  2) on what would have been paid if all those who receive CASA services instead received institutional care? (Our reading of the bill language would support interpretation 2.)

- Interpretation 1) would implicitly place a limit on who could be served1, even though the benefit is envisioned as an entitlement.

- Interpretation 2) would allow all eligible individuals to be served but would result in additional costs to Medicaid if significant numbers of CASA-eligible individuals not now being served by Medicaid in institutions participate in the CASA program.2

- Additional costs may also arise to the extent that CASA participants make use of other services (e.g., skilled nursing, therapy) which are not included in the definition of CASA services.

- An operational concern regarding the cost limitation under either interpretation is the difficulty of determining what "would have" been expended as institutional care. Prior experience under demonstrations indicates that such determinations are very problematic in practice.

Cash Payments

The bill identifies that community attendant services could be provided through an agency-based model or an "other" model, with the latter conceivably including vouchers or direct cash payments.

- To date, cash payments have not been authorized in the Medicaid program. There are several issues, ranging from the appropriate amount of Federal oversight to more technical questions such as the possibility that these payments could be considered "income" for purposes of all other Federal and State programs, causing the individual receiving such payments to lose eligibility for services because of their increased "income".

- Although HCFA is interested in exploring well-designed demonstrations to test the effects of these types of models, through demonstrations such as Cash and Counseling, it is premature to support legislation authorizing models such as these absent any understanding of their impact on beneficiaries' health and quality of life, services used, and overall program expenditures.

Protection of Beneficiaries' Rights and Quality Standards for Personal Attendants

We need more information regarding what is meant by the quality standards and beneficiary rights.

Exclusion of Institutionalized Individuals

The legislation excludes payment for services to institutionalized (including those in hospitals) individuals. Over the past several years, we have received complaints from many sources (including ADAPT) that our lack of ability to pay for personal attendants while a person is hospitalized causes hardship for both the provider, the provider agency and the hospital. Reactions from States have been mixed on this issue.

Operational Issues

Many States would face significant capacity issues, including the availability of providers of attendant care, necessary staff training, development of quality oversight mechanisms, development of fiscal agent and other cash or voucher related requirements, as well as funding.

Room and Board Exclusion

While this issue is not addressed in the bill language, it will likely be an implementation issue. Similar issues prompted Congress to amend section 1915 © to specifically allow for the payment of the portion of rent and food that can be attributed to the personal care attendant while living in the home of the individual receiving services. It is reasonable to expect that the attendant will have needs and expectations of food and accommodations.

Distribution of Transitional Funds

The bill is silent on how transitional funds allocated to a State would then be allocated to individuals. There is some concern that these funds may not be targeted to persons most in need.

CASA

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1 of 1 items CQ's WASHINGTON ALERT 02/06/98

*** COSPONSOR REPORT -- CURRENT COSPONSORS IN ALPHABETICAL ORDER ***

MEASURE: HR2020

SPONSOR: Gingrich (R-GA)

BRIEF TITLE: Medicaid Community Attendant Services Act of 1997.

INTRODUCED: 06/24/97

COSPONSORS: 31 (Dems: 19 Reps: 12 Ind: 0)

CURRENT COSPONSORS:

Baldacci (D-ME)	Gutierrez (D-IL)	Reyes (D-TX)
Brown, S. (D-OH)	Hall, T. (D-OH)	Rivers (D-MI)
Clement (D-TN)	Hilliard, E. (D-AL)	Rush (D-IL)
Cook, M. (R-UT)	Hyde (R-IL)	Ryun (R-KS)
Cunningham (R-CA)	Jackson, J. (D-IL)	Shimkus (R-IL)
Davis, D. (D-IL)	Jefferson (D-LA)	Underwood (D-GU)
Ehlers (R-MI)	Kaptur (D-OH)	Weller (R-IL)
English, P. (R-PA)	Lampson (D-TX)	Yates (D-IL)
Eshoo (D-CA)	Leach (R-IA)	Young, D. (R-AK)
Gephardt (D-MO)	Pryce, D. (R-OH)	
Green, G. (D-TX)	Redmond (R-NM)	

There are no more items to display.

Results: 1 items in BILLTRACK
Search criteria used:
BILL:HR2020
Results are: Bill number as entered

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2 REFINE your search on prime topic	14 ACTION detailed action (no speeches
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SUMMARY AND TALKING POINTS ON CASA
(Community Attendant Service Act of 1997:H.R.2020)
FOR PRESIDENTS MEETING WITH DISABILITY GROUPS

BILL SUMMARY

H.R. 2020 mandates that states provide "community based attendant services" as a matter of choice to persons of all ages residing in institutions and individuals living in the community who would be eligible to receive institutional services based on functional need. Community based attendant services are to be defined by the Secretary, provided in home and community-based settings, and include emergency and back-up attendant services, training on how to manage attendants, and health related tasks by unlicensed attendants. Services are to be provided on an "as needed basis" under a plan of care based on an assessment of functional need. Such services could be provided by agencies or be directed and managed by the consumer. In the latter case, direct cash payments, vouchers and payments to family members would be allowed. Matching Federal medical assistance payments and unmatched "transitional allotments" to increase the availability of home and community-based settings are available to states. The Secretary is to distribute two billion dollars in transitional allotments across states with approved plans over six years with preference given to states with higher proportions of institutionalized individuals. Quality assurance is based on consumer satisfaction. Agency providers are subject to survey and certification and other requirements. The Secretary is required to develop additional health and safety standards that maximize consumer independence and control.

States would be able to limit the amount, duration, and scope of services but could not limit freedom of choice, state wideness or comparability.

TALKING POINTS ON CASA FOR PRESIDENT'S MEETING WITH DISABILITY GROUPS

- The Administration fully supports the basic goals of CASA, including:
  - addressing the "institutional bias" in the Medicaid program;
  - enabling consumers and their families to choose the setting in which long term care services are received; and
  - promoting consumer direction of home and community based/personal assistance services.
- The Administration has actively supported these goals in a variety of ways:
  - The recently enacted Balanced Budget Act includes a Medicaid buy-in for certain SSI beneficiaries with disabilities who want to work. It also allows home and community based waiver participants to receive supported employment and related services regardless of prior institutionalization. Small victories...but progress nonetheless.
  - I am particularly proud of the commitment we have made to working with the states to streamline the home and community based waiver program. Under this program over 250,000 people now receive the services they need in home and community based settings.
  - I am also happy to announce that we have approved a new Medicaid Personal Care Services regulation which allows states to cover personal care services in the home or in locations outside the home including the work place and removes the requirement that a registered nurse supervise personal care services.
  - The work that HHS is now engaged in with the Robert Wood Johnson Foundation is also significant. Over a year ago HHS and the Foundation joined together to design a research experiment called the "Cash and Counseling Demonstration." The demonstration will test the cost effectiveness of providing Medicaid beneficiaries with significant disabilities the choice of receiving cash allowances to purchase needed assistance in lieu of receiving agency directed care. Waivers for the demonstration have just been submitted to HCFA and are under review. When implemented, the demonstration is expected to enroll almost 10,000 older persons, 7,000 working age adults and over 1,700 children with disabilities in four states.

- While these are important accomplishments, I recognize that we need to do more.

  - Based on a meeting that Dr. Vladeck had with some of you in June, HCFA has recently initiated a comprehensive review of Medicaid policy to identify provisions which contribute to the program's institutional bias and to the perpetuation of medical rather than social models of care. He has also ordered an examination of the extent to which Medicaid may need to be "delinked" from Medicare to promote consumer directed services. This review will be completed by the end of the year.

  - In addition, the Department of Health and Human Services has now established a home and community-based services working group of senior staff from across the department to develop options for eliminating the institutional bias in Medicaid, promoting consumer directed home and community based services and reducing unnecessary "medicalization" of long-term care services. An important part of the work of this group will be to explore ways to deinstitutionalize by a "date certain" nursing home residents who want to live in the community.

  - I am also asking the work group to examine options for linking the need for increasing the supply of qualified attendants with the work requirements of state welfare reform under TANF. Linking the needs of people with physical disabilities for attendants and the needs of low-income families for jobs seems to be well worth pursuing.

  - The work group will actively engage partners from the states and disability and aging communities. The group will be chaired by Bob Williams, my new Deputy Assistant Secretary for Disability, Aging and Long-Term Care Policy and by Sally Richardson, HCFA's head of Medicaid and State Operations. I have asked them to report to me by the end of February with an action plan.

- Now I would like to talk to you briefly about the CASA Legislation, which was introduced early in the summer and which many of you support. The goals are important ones, and I am pleased that you now have a vehicle which will allow them to be discussed and debated. I support the basic goals of CASA... but I also have some serious concerns about its potential consequences, particularly in regard to creating a new entitlement, to the cost consequences of expanding the eligible pool of recipients of community based care, the prematurity of opening up Medicaid to permit cash payments prior to understanding the cost effectiveness of this approach, and to some of the quality provisions. (Probably makes sense for Bruce to do the more detailed discussion and then turn it back at the end??)

  - CASA mandates that all states include community-based services in their Medicaid plans. The Administration has repeatedly gone on record in favor of state flexibility and no new mandates under Medicaid.

- CASA eligibility criteria would entitle all people who currently live in nursing facilities or ICFs/MR , and those who live in the community but meet the criteria for institutional services to receive community-based attendant services or other models of support such as vouchers or cash. Our preliminary estimates suggest that almost one million people now living in the community may meet CASA's eligibility criteria. This is in addition to the potentially large number of persons now in institutions who may also choose CASA services.

- While the architects of CASA have made some important strides in trying to address cost control issues, far larger numbers of people are likely to opt for CASA services than are currently receiving long-term care services today. The result would be a substantial increase in Federal and state costs.

- Although the bill includes a cost neutrality provision, it appears to tie cost neutrality to what it would cost if the states were to actually serve all eligible individuals in an institution--not to what states are spending or plan to spend on the much smaller number of people who currently receive institutional services.

- The cost containment provisions of CASA are inadequate in today's budget and political climate.

- CASA also contains important provisions that address the need to assure high quality services. But these provisions also raise concerns. For example, the bill would require greater federal regulatory and enforcement requirements for agency provided services than what is now required in our home and community-based waiver program. At the same time, there are only minimal quality assurance and beneficiary protections for consumer directed services models. While we strongly support such models of service delivery, we believe that much more attention needs to be paid to quality concerns.

- I also understand that there is not yet consensus in the disability community about CASA. Some groups believe it is cast too narrowly and should be decoupled from eligibility for institutional care. Others are concerned that the bill's benefits may not be responsive to the needs of certain populations. Some may also be concerned about the latitude given to the Federal Government and to states to define the benefits and the amount, duration and scope of the benefits to be offered.

♦ Nevertheless, CASA offers us a good platform for discussing our mutual interests and goals. I expect we will be doing much more of this in the months ahead. I believe that one basis for making progress is to experiment with a number of options for addressing the imbalance in Medicaid between community- based and institutional services, and for promoting an expanded array of consumer driven community services and an improved community services infrastructure. I am confident that the steps we are now taking are

moving us in the right direction.