

## OLMSTEAD CONSUMER TASKFORCE AGENDA

*Friday May 14, 2010, 10:00 a.m. – 3:00 p.m.*

*Conference Phone 1-866-685-1580, Conference Code 8957365810*

*Urbandale Public Library, Urbandale, Iowa*

*Conference Room B-C*

*All handouts will be available on the Wiki for May 14 meeting at*

<https://wiki.uiowa.edu/display/Olmstead>

- 10:00 AM Welcome, introductions, review of agenda
- 10:05 AM Minutes (handout 1 draft minutes of March 5, 2010 meeting)
- 10:10 AM Membership vote, Election of 2010 officers (handouts 2 membership explanation, 3 roster, 4 committee list)
- 10:30 AM Sharing Information by Members & State Representatives (including written Institutional Bias Campaign update from Ingrid Wensel handout 5)
- 10:50 AM 2010 by 2010 campaign by Angie Plager, Ms. Wheelchair Iowa, <http://www.adasymposium.org/2010.html>
- 11:00 AM DHS Report: Jeanne Nesbit, MHDS Administrator
- 12:00 PM Lunch (available onsite, individual order and individual pay)
- 1:00 PM State Plan Committee leads discussion of State Plan input by Olmstead Consumer Taskforce
- 2:00 PM Taskforce Donation to Iowa ADA Celebration activities (handout 6 ADA celebration update, 7 ADA projects to fund)
- 2:30 PM Presentation on Aging and Disability Resource Center, Iowa Department on Aging, Mary Anderson

<http://www.state.ia.us/government/dea/resources/ADRCHandouts.html#HO>

2:50 PM Public Comment

3:00 PM Adjourn

### Upcoming Events

May 19-20	Joint Mental Health Planning Council & Mental Health & Disability Services Commission Retreat
July 16	Olmstead Consumer Taskforce Meeting, location to be announced
Sept 10	Olmstead Consumer Taskforce Meeting, United Way Conference Rooms, 1111 9 <sup>th</sup> Street, Des Moines
Nov 12	Olmstead Consumer Taskforce Meeting, United Way Conference Rooms, 1111 9 <sup>th</sup> Street, Des Moines

### Next meeting

- Discuss United Spinal Injury Assoc Report and 2010 Patient Protection and Affordable Care Act- led by Alice Holdiman (handouts 8 and 9)
- Discuss Direct Care Alliance Long Term Care Brief- led by Terry Cunningham (handout 10)
- Discuss United Cerebral Palsy Policy 2010 Case for Inclusion- led by Casey Westhoff [http://www.ucp.org/uploads/Case\\_for\\_Inclusion\\_10Apr7.pdf](http://www.ucp.org/uploads/Case_for_Inclusion_10Apr7.pdf) (7MB).
- Presentation on Adopting Veterans with Disabilities in Iowa- Janice O'Briant

## Membership explanation for May 14 vote

- Minutes of December 2009 reflect unanimous vote to remove Jeremy Karli, Jeanne Theis, Candace Mueller, Genette Zimmerman, and Nika Naylor from membership roles. Nevertheless, by word of mouth and not reflected in any minutes, Jeanne Theis and Gennette Zimmerman expressed interest in remaining members. Jeanne Theis attended the March 2010 meeting by phone, and Gennette Zimmerman attended the January 2010 meeting. Names on Jeremy Karli, Candace Mueller, and Nika Naylor have been removed from the Roster.
- Minutes of December 2009 meeting reflect that terms of Connie Smith, Rik Shannon, and Jim Paprocki were set to expire in 2009. The Nominations Committee was to poll these members to see if they want to renew their membership. Further, the Nominations committee was to recommend lengths of terms so that approximately ½ of the memberships expire each year. Vote on their renewals was to occur at the next meeting, but that did not happen. Subsequently all three expressed interest in renewing their membership.
- These member's terms expire at 2010 annual meeting (May 14<sup>th</sup> because no quorum at March meeting): Ben Brandenburg, Jerry Mayes, Doug Sample, Genette Simmerman, Ingrid Wenzel, Janie Woodhouse. All have expressed interest in renewing their membership.
- These new members were added to the membership roster by unanimous vote at the October 2009 meeting: Kathleen Crisp, Carrie England, Steve Garrison, Janice Hoffman, Cassie Johannes, Richard Mockmore, Linda Moore, Arnie Silvers. Subsequently, we have had no communication with and been unable to contact Kathleen Crisp, Arnie Silvers and Steve Garrison. As we have been unable to contact Kathleen Crisp, Arnie Silvers, and Steve Garrison, their names do not appear on the roster.
- Cheri Clark and Amy Rickels have indicated that they no longer wish to be members of the Olmstead Consumer Taskforce, though they would like to

be kept informed. Their names have been removed from the roster and moved to the informational mailing list.

Recommended May 14, 2010 vote:

- That current membership be 21 members as indicated on the Membership Roster as updated May 7, 2010 and distributed at the May meeting. Membership of those not on the roster would be removed, for all the reason cited in the explanations above.
- That current membership include renewal of these members for terms ending in March of these years: Ben Brandenburg 2011; Jerry Mays 2011, Jim Paprocki 2012; Doug Sample 2013; Genette Simmerman 2013; Connie Smith 2013; Rik Shannon 2013; Jennie Theis 2013; Ingrid Wensel 2013; Janie Woodhouse 2013.
- If this membership vote was approved: 15 would need to be present for a quorum, and 7 memberships would expire in each of years 2011, 2012, and 2013.

**Iowa Olmstead Consumer Taskforce  
Membership Roster**

Name	E-Mail	Phone, Fax	Address	Type of Membership	Representing	Term Ends
Brandenburg, Ben	<a href="mailto:Benzrecovery@yahoo.com">Benzrecovery@yahoo.com</a>	319-493-2289	910 Western Ave. Waterloo, IA 50702	Person with a Disability (PWD), Family Member of PWD	DBSA, Nat'l Assn of Peer Specialists, NAMI, Mental Health Advocate	March 2010 Renew to March 2012?
Connolly, Paula	<a href="mailto:paula@askresource.org">paula@askresource.org</a>	515-243-1713	Ask Resource 321 E. 6 <sup>th</sup> Street Des Moines, IA 50319	Child w disability, Disability Advocate	Parent, Family Voices, Ask Resource	March 2012
Davis, Randy	<a href="mailto:Randy.davis@mahaska.org">Randy.davis@mahaska.org</a>	641-672-1673	328 North D. St. Oskaloosa, IA 52577-2706	PWD	Consumer Advocate, South Central IA Center for Independent Living	March 2011
England, Carrie	<a href="mailto:Cengland@leagueofhumandignity.com">Cengland@leagueofhumandignity.com</a>	712-323-6863	1520 Ave M Council Bluffs, IA 51501-1185	Disability Advocate	League of Human Dignity	March 2012
Francis, Dawn	<a href="mailto:dawn@iowasilc.org">dawn@iowasilc.org</a>	515-282-0275 515-282-0278 FAX	300 E. Locust, Suite 330 Des Moines, IA 50309	Disability Advocate	Iowa Statewide Independent Living Council	March 2011
Gerke, Raymond	<a href="mailto:RayRym@hotmail.com">RayRym@hotmail.com</a>	515-465-4535	Woodward, IA	Person over 60, PWD	DHS, retired, Disability Advocate	March 2011
Hoffman, Janice	No e-mail	319-277-4683	1209 Maplewood Drive, Apt. #4 Cedar Falls, IA 50613	Person Over 60, PWD	Consumer Advocate	March 2012

Holdiman, Alice	<a href="mailto:holdimal@yahoo.com">holdimal@yahoo.com</a>	563-382-3600	405 E. Water Decorah, IA 52101	Person Over 60, PWD	Mental Health Planning Council, IDRC Advisory Committee	March 2011
Johannes, Cassie	No -email	712-527-3825	217 West Florence Glenwood, Iowa 51534	PWD, Institutional experience	Consumer Advocate	March 2012
Mayes, Jerry, PHD, Chair	<a href="mailto:Jrmayes96@yahoo.com">Jrmayes96@yahoo.com</a>	319-961-3046	106 East 3 <sup>rd</sup> Street Apt. #307 Waterloo, IA 52703	Person Over 60, PWD	Mental Health Planning Council, Mental Health Advocate	March 2010 Renew March 2011?
Mockmore, Richard	<a href="mailto:richardmockmore@hotmail.com">richardmockmore@hotmail.com</a>	712-527-9351	111 Harold's Drive Glenwood, IA 51534	PWD, Institutional Experience	Consumer Advocate	March 2012
Moore, Linda	<a href="mailto:Lsmiley123@mchsi.com">Lsmiley123@mchsi.com</a>	319-342-3650	204 Pheasant Drive La Porte City, IA 50651	PWD	Consumer Advocate	March 2012
Paprocki, Jim	<a href="mailto:jpaprocki@mchsi.com">jpaprocki@mchsi.com</a>	319-296-3737	874 Rose Lane Waterloo, IA 50702	PWD, Family Member of PWD	Disability Advocate	March 2009, Renew to March 2012?
Sample, Doug	<a href="mailto:d.sample.gov@gmail.com">d.sample.gov@gmail.com</a>	563-383-0676	419 Kirkwood Blvd. Davenport, IA 52803	PWD	National MS Society, Consumer Advocate	March 2010, Renew to March 2013?
Simmerman, Genette	<a href="mailto:gsimmer66@iowatelecom.net">gsimmer66@iowatelecom.net</a>	712-625-2003 712-310-6113 (cell phone)	1666 330 <sup>th</sup> Ave Randolph, IA 51649	Child w Disability	CMH Waiver Advisory Committee Child Mental Health Advocate	March 2010, Renew to March

						2013?
Smith, Jean "Connie"	<a href="mailto:conniesmith@iowatelecom.net">conniesmith@iowatelecom.net</a>	563-724-3588	2262 Lange Avenue Atalissa, IA 52720	Person Over 60, Provider	Consumer Advocate	March 2009, Renew to March 2013?
Shannon, Rik	<a href="mailto:Rshanno1@dhs.state.ia.us">Rshanno1@dhs.state.ia.us</a>	515- 281- 9086 515- 281- 9087 FAX	617 E. 6 <sup>th</sup> St. Des Moines, IA 50309	Advocacy Organization	Governor's DD Council	2009, Renew to March 2013?
Theis, Jeannie	<a href="mailto:Jeannie@trilc.org">Jeannie@trilc.org</a>	712-255-1065	Three Rivers ILC Suite 324 Commerce Bldg. 520 Nebraska Street Sioux City, IA 51101- 1315		Three Rivers Independent Living Center	Renew to march 2013?
Wensel, Ingrid	<a href="mailto:Ingrid.wensel@kirkwood.edu">Ingrid.wensel@kirkwood.edu</a>	319-398-5559	6301 Kirkwood Blvd SW Cedar Rapids, IA 52404	Provider	Heritage Area Agency on Aging	March 2010, renew to March 2013?
Westhoff, Casey	<a href="mailto:arcia@arceci.org">arcia@arceci.org</a>	800-362-2927 515-210-6686	3821 71 <sup>st</sup> Street Urbandale, IA 50322	Disability Advocate	The Arc of Iowa	March 2011
Woodhouse, Janie	<a href="mailto:Jw5257771@yahoo.com">Jw5257771@yahoo.com</a>	641-672-8821	415 South 1 <sup>st</sup> street Oskaloosa, IA 52577	Family Member of PWD		March 2010, renew to March 2013?

22 members  
2/3 quorum is 15

### State Agency Representatives

Agency	Representative	E-mail	Phone	Address
Department of Administrative Services (DAS)	Brenda Reilley	<a href="mailto:Brenda.reilley@iowa.gov">Brenda.reilley@iowa.gov</a>	515-281-6889	1305 E. Walnut St. Hoover State Office Bldg. Des Moines, IA 50319
Department of Aging (DOA)	Mary Anderson	<a href="mailto:Mary.Anderson@iowa.gov">Mary.Anderson@iowa.gov</a>	515-725-3346	510 E. 12 <sup>th</sup> Street Jessie Parker Bldg. Des Moines, IA 50319
Department for the Blind	Shan Sasser or Rebecca Criswell	<a href="mailto:Shan.sasser@iowa.gov">Shan.sasser@iowa.gov</a> <a href="mailto:Becky.criswell@iowa.gov">Becky.criswell@iowa.gov</a>	515-281-1293	524 4 <sup>th</sup> Street Des Moines, IA 50309
Iowa Civil Rights Commission (ICRC)	Nancy Witt or  Dawn Peterson	<a href="mailto:nwitt@sppg.com">nwitt@sppg.com</a> <a href="mailto:nwitt@prairieinet.net">nwitt@prairieinet.net</a>  <a href="mailto:dawn.peterson@iowa.gov">dawn.peterson@iowa.gov</a>	515-281-4121  515-281-8086	Grimes State Office Bldg. 400 E. 14 <sup>th</sup> Street Des Moines, IA 50319
Department of Corrections (DOC)	Kris Weitzell	<a href="mailto:Kris.weitzell@iowa.gov">Kris.weitzell@iowa.gov</a>	515-725-5723	Jessie Parker Bldg. 510 E. 12 <sup>th</sup> Street Des Moines, IA 50319
Department of Economic Development	Donna Grgurich	<a href="mailto:Donna.Grgurich@iowalifechanging.com">Donna.Grgurich@iowalifechanging.com</a>	515-242-4766	200 E. Grand Ave. Des Moines, IA 50309
Department of Education (DE)	Kiersten Hensley, Consultant	<a href="mailto:kiersten.hensley@iowa.gov">kiersten.hensley@iowa.gov</a>	515-281-4123	Bureau of Student and Family Support Services Grimes State Office Bldg. 400 E. 14 <sup>th</sup> Street Des Moines, IA 50319  Fax: 515-242-6019

Iowa Finance Authority (IFA)	Terri Rosonke	<a href="mailto:Terri.rosonke@iowa.gov">Terri.rosonke@iowa.gov</a>	515.725.4956	2015 Grand Avenue Des Moines, IA 50312
Governor's DD Council	Rik Shannon	<a href="mailto:Rshanno1@dhs.state.ia.us">Rshanno1@dhs.state.ia.us</a>	515-281-9086	617 E. 2 <sup>nd</sup> Street Des Moines, IA 50309
Department of Human Rights	Jill Avery	<a href="mailto:Jill.avery@iowa.gov">Jill.avery@iowa.gov</a>	515-281-6334	Lucas Building 321 E. 12 <sup>th</sup> Street Des Moines, IA 50319
Department of Human Services, Mental Health and Disability Services (MHDS)	Bill Gardam	<a href="mailto:Bgardam@dhs.state.ia.us">Bgardam@dhs.state.ia.us</a>	515-281-4593	1305 E. Walnut 5 <sup>th</sup> Floor Des Moines, IA 50319
Department of Inspections and Appeals (DIA)	Ronda Bennett	<a href="mailto:ronda.bennett@dia.iowa.gov">ronda.bennett@dia.iowa.gov</a>	515-281-7624 Fax: 515-244-5022	Lucas Building 321 E. 12 <sup>th</sup> Street Des Moines, IA 50319
Iowa Medicaid Enterprise (IME)	Deb Johnson	<a href="mailto:Djohns06@dhs.state.ia.us">Djohns06@dhs.state.ia.us</a>	515-725-1012 Fax: 515-725-1360	100 Army Post Road Des Moines, IA 50315
Iowa Work Force Development (IWD)	Doug Keast	<a href="mailto:Douglas.keast@iwd.iowa.gov">Douglas.keast@iwd.iowa.gov</a>	515-281-9045	150 Des Moines Street Des Moines, IA 50309
Department of Public Health (DPH)	Dean Austin or Binnie Lehew or Karin Ford	<a href="mailto:daustin@idph.state.ia.us">daustin@idph.state.ia.us</a> <a href="mailto:blehew@idph.state.ia.us">blehew@idph.state.ia.us</a> <a href="mailto:kford@idph.state.ia.us">kford@idph.state.ia.us</a>	515-242-6514 515-281-5032 515-242-6336	321 E. 12 <sup>th</sup> Street Des Moines, IA 50319
Department of Public Safety (DPS)	Ljerka Vasiljevic	<a href="mailto:vasiljev@dps.state.ia.us">vasiljev@dps.state.ia.us</a>	515-725-6155	900 E. Grand Des Moines, IA 50319
Board of Regents	Patrick Clancy	<a href="mailto:pclancy@iowa-braille.k12.ia.us">pclancy@iowa-braille.k12.ia.us</a>	319-472-5221 X 1132	Iowa Braille School 1002 G Avenue Vinton, IA 52349
Department of	Phil Mescher	<a href="mailto:Phil.mescher@iowa.gov">Phil.mescher@iowa.gov</a>	515-239-1629	800 Lincoln Way

Transportation (DOT)				Ames, IA 50010
Department of Veterans Affairs (VA)	Patrick Palmersheim	<a href="mailto:Patrick.Palmersheim@icva.state.ia.us">Patrick.Palmersheim@icva.state.ia.us</a>	515-242-5331 800-838-4692	Director, Veteran's Affairs 7105 NW 70 <sup>th</sup> Avenue Camp Dodge, Bldg. A6A Johnston, IA 50131-1824
Iowa Veterans Home	Diane Blackburn	<a href="mailto:Diane.Blackburn@ivh.state.ia.us">Diane.Blackburn@ivh.state.ia.us</a>	641-753-4284	1301 Summit Street Marshalltown, IA 50158

**Informational Mailing List**

NAME	AGENCY	E-MAIL	PHONE	ADDRESS
Bacon, Robert	Center for Disability & Development	<a href="mailto:Robert-bacon@uiowa.edu">Robert-bacon@uiowa.edu</a>	319-356-1335	Center for Disabilities and Development 100 Hawkins Drive Iowa City, IA 52242-1016
Clark, Cherie		<a href="mailto:empoweria@mchsi.com">empoweria@mchsi.com</a>	319-364-0037	3105 Ridgemore Drive SE Cedar Rapids, IA 52403-9025
Cunningham, Terry	Center for Disability & Development	<a href="mailto:Terry-Cunningham@uiowa.edu">Terry-Cunningham@uiowa.edu</a>	319-338-7481	554 West Side Drive, Iowa City, 52246
Fanselow, Connie	DHS/MHDS	<a href="mailto:cfansel@dhs.state.ia.us">cfansel@dhs.state.ia.us</a>	515-281-5338	DHS/MHDS 1305 East Walnut Des Moines 50319
Flores, Becky	DHS/MHDS	<a href="mailto:Bflores1@dhs.state.ia.us">Bflores1@dhs.state.ia.us</a>	515-281-4593 Fax: 515-242-6036	DHS/MHDS Hoover Bldg, 5 <sup>th</sup> Floor 1305 East Walnut Des Moines IA 50319

Updated 5/07/2010

Ehlers, Connie	For Jeanne Nesbit DHS/MHDS	<a href="mailto:cehlers@dhs.state.ia.us">cehlers@dhs.state.ia.us</a>	515-281-4764	DHS/MHDS
Funke, Barbara Jean	For Bill Gardam DHS/MHDS	<a href="mailto:bfunke@dhs.state.ia.us">bfunke@dhs.state.ia.us</a>	515-281-7277	
Hiatt, Kay	DHS/MHDS	<a href="mailto:khiatt@dhs.state.ia.us">khiatt@dhs.state.ia.us</a>	515-242-5994 Fax: 515-242-6036	DHS/MHDS Hoover Bldg 5 <sup>th</sup> Fl. 1305 East Walnut Des Moines IA 50319
Miller, Linda Sue	For Director Charles J. Krogmeier, DHS/MHDS	<a href="mailto:Lmiller2@dhs.state.ia.us">Lmiller2@dhs.state.ia.us</a>	515-281-5452	
Reynolds, Jule	Staff to Senator Tom Harkin	<a href="mailto:Jule_Reynolds@harkin.senate.gov">Jule_Reynolds@harkin.senate.gov</a>	515-263-9247	2119 E. 9 <sup>th</sup> Street Des Moines IA
Riley, Ann	Center for Disability & Development	<a href="mailto:Ann-L-Riley@uiowa.edu">Ann-L-Riley@uiowa.edu</a>	319-353-6523	Center for Disabilities and Development 100 Hawkins Drive Iowa City, IA 52242-1016
Rickels, Amy		<a href="mailto:Mongolbaby2005@yahoo.com">Mongolbaby2005@yahoo.com</a>	641-673-1411	
Jack Willey	MHDS Commission Chair	<a href="mailto:Jjw_eddyplace@hotmail.com">Jjw_eddyplace@hotmail.com</a>		

Updated 5.5.2010

## [DRAFT] OLMSTEAD CONSUMER TASKFORCE COMMITTEES

### STANDING COMMITTEES

#### EXECUTIVE

Jerry Mayes, Chair  
Ben Brandenburg, Vice Chair  
Janie Woodhouse, Secretary  
Dawn Francis  
Casey Westhoff  
Jerri Sloan

#### NOMINATIONS

Janie Woodhouse, Chair  
Alice Holdiman  
Rik Shannon  
Ray Gerke  
Jim Paprocki

#### LEGISLATIVE

Dawn Frances Co-Chair  
Casey Westhoff Co-Chair  
Randy Davis  
Doug Sample  
Rik Shannon  
Jim Paprocki  
Patrick Clancy

#### PUBLIC INFORMATION

Jerri Sloan, Chair  
Doug Sample

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## AD HOC COMMITTEES

### OLMSTEAD STATE PLAN

Alice Holdiman, Chair  
Janie Woodhouse  
Doug Sample

### HONORING LT. GOVERNOR PEDERSON

Dawn Francis, Chair  
Raymond Gerke

### BY-LAWS

Jim Paprocki, Chair  
Jerri Sloan  
Connie Smith

### Notes to Taskforce:

- The Taskforce would like every member and every state agency representative to become a member of at least one committee. Just notify Nominations Committee Chair Janie Woodhouse [jw5257771@yahoo.com](mailto:jw5257771@yahoo.com) 641-660-4847.
- All Taskforce members and state agency representatives are welcome to participate in all committee meetings, but you will not receive e-mail meeting notices unless you have indicated you are a committee member.
- Committee Chairs are responsible for setting phone conference meetings for their committee and chairing committee meetings. They are responsible for notifying committee members plus Jerry Mayes, Becky Flores, and Terry Cunningham of committee meetings. Becky Flores will arrange DHS teleconferencing numbers upon request. Chairs are responsible for reporting Committee activity at every meeting of the Taskforce as a whole.

--- On **Thu, 5/6/10, O'Hara, Elizabeth A <elizabeth-ohara@uiowa.edu>** wrote:

From: O'Hara, Elizabeth A <elizabeth-ohara@uiowa.edu>

Subject: FW: (SCL: 7) 2010 Patient Protection and Affordable Care Act and Olmstead Implementation for

To: "Dawn Francis" <dawn@iowasilc.org>, "Casey Westhoff" <westhoff@arceci.org>, "Alice Holdiman" <holdimal@yahoo.com>, "JERRY MAYS" <jrmays63@msn.com>, "Sample Doug" <d.sample.gov@gmail.com>, "Paula Connolly" <paula@askresource.org>, "Jim Paprocki E-mail" <jpaprocki@mchsi.com>, "Ingrid Wensel" <iwensel@kirkwood.edu>

Date: Thursday, May 6, 2010, 12:10 PM

-----Original Message-----

From: [owner-stevegoldada@SteveGoldADA.com](mailto:owner-stevegoldada@SteveGoldADA.com)

[mailto:[owner-stevegoldada@SteveGoldADA.com](mailto:owner-stevegoldada@SteveGoldADA.com)] On Behalf Of [SteveGoldADA@cs.com](mailto:SteveGoldADA@cs.com)

Sent: Wednesday, May 05, 2010 3:28 PM

To: [stevegoldada@SteveGoldADA.com](mailto:stevegoldada@SteveGoldADA.com)

Subject: (SCL: 7) 2010 Patient Protection and Affordable Care Act and Olmstead Implementation for

2010 Patient Protection and Affordable Care Act and Olmstead Implementation for Disabled and Elderly. Information Bulletin #311 (5/10).

With the recent enactment of the 2010 Patient Protection and Affordable Care Act in March, there are a number of critical long-term services supports (LTSS) provisions that your States can implement that will dramatically improve community services opportunities. States may not act

if not pushed by advocates!!! These new statutory provisions make the ADA

and the Olmstead decision more powerful than at anytime since 1999.

Some background information: the Supreme Court in Olmstead rejected the

States' argument that Medicaid "reflected a Congressional policy preference for treatment in the institution over treatment in the community." The Court also emphasized that "since 1981, Medicaid has provided funding for state-run home and community-based care through a waiver program."

It was this existence and availability of Medicaid Waivers which moved the

Court in Olmstead to hold that unnecessary institutionalization was discrimination under the ADA. Since then, Congress has offered States additional Medicaid opportunities to end discrimination. For example, States were offered Real System Choice Grants and Money Follows the Person

Grants to reform their systems and get people out of institutions.

With the 2010 new health care reform statute, States will have many more Medicaid community-based program opportunities to end discrimination - IF they take advantage of these new LTSS opportunities and apply.

Four provisions of the 2010 Act will allow states to offer more home and community services. States will no longer have excuses to continue their discriminatory funding practices. Advocates should work with your State to implement these LTSS opportunities. These programs become effective October 2011 or before, so advocates should begin now to make sure your State and your Medicaid officials take advantage of these provisions. Here they are:

1. Community First Choice Option (Section 2401).

For persons with disabilities regardless of age, who meet your State's institutional level of need criteria (nursing home, ICF-MR, IMD) the Federal Medical Assistance Percentages (FMAP) - the federal reimbursement to your state for community-based attendant services and supports in the community - will be increased by six percent.

Since community-based attendant services and supports are the critical need to live in the community, your State will be able to focus on this service.

When this option is selected, these services will be mandatory and not a

"waiver." Cost caps, cost neutrality and waiting list restrictions are not part of this program. Therefore, States can provide community-based services and supports to persons with the most severe disabilities and receive enhanced federal funds. Transition costs from nursing homes and other institutions are also permissible and will receive the increased FMAP. These transition costs can now include first month's rent and utilities, deposits, and household supplies.

2. Removal of Barriers to Providing Home and Community Based Services. (Section 2402).

This provision broadens the scope of permissible Medicaid home and community-based services under the current optional State Plan 1915 (i) program. For persons with disabilities regardless of age, who meet your State's institutional level of need criteria and for whom services do not

exceed the institutional costs, States can now include services which could not in the past be approved under section 1915 (i).

States cannot cap the number of people who receive these services but can target the benefits to people with specific conditions as well as based on functional need. Services must be provided statewide. They also raised financial eligibility from 150% of poverty to 300% of SSI.

Simply stated, the improved optional 1915 (i) when selected by your state will act as mandatory community services.

### 3. Money Follows the Person Rebalancing Demonstration. (Section 2403).

This provision extends the federal support for MFP from 2011 to 2016 by adding more than \$2 billion to provide enhanced FMAP so that States which did not sign up for MFP in the past can now have the opportunity. One use of these funds is to reimburse states persons with disabilities regardless of age, whom your State moves from the institution to the community and their own homes and apartments. Also, Congress reduced the eligibility requirement that a person be in nursing home from 6 months to 90 days.

### 4. "Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes," a Rebalancing Incentive Payment Program. (Section 10202).

This provision provides for enhanced FMAP from 2011 through 2015 for States that "rebalance" their long-term expenditures so that more Medicaid funds are expended on community-based services rather than to nursing homes and ICF-MR facilities.

For those most unbalanced States (i.e., States that spent less than 25% of Medicaid LTC funds in the community), their Federal Medical Assistance Percentages - the federal reimbursement - will be increased by five percent for increased services in the community until they reach at least 25% spending on community services.

States that spent between 25% and 50% of their Medicaid LTC in the community will receive an enhanced two percent increase in federal match until they reach at least 50% spending on community services.

States receiving this funding have till 2015 to reach these goals.

To receive this funding, states must make "structural changes" in their Medicaid program. States must develop a "single entry point" so that before a person goes into a nursing home they will be offered real community-based services; States must use a standardized assessment instrument to assess what services a person needs to stay in the community; and States must provide real case management services for eligible persons.

Congress appropriated \$3 billion for these rebalancing. States must apply and submit a plan to HHS/CMS. All funds must be used for new or expanded home and community-based services.

#### DISABILITY AND ELDERLY ADVOCATES:

The 2010 health reform act presents many opportunities, however as you all are very aware, your States and Medicaid officials will implement these changes only if they are pushed by you.

Get to your Medicaid officials now. Make sure they know about and are planning to take advantage of these new provisions. If they do not take

advantage, they will have no defenses against Olmstead lawsuits in the future. Congress has given them the tools to provide home and community services and to stop discriminating. We must work with the States to make

them implement these opportunities. If they don't - using Olmstead as a powerful advocacy/legal strategy is a resource we have.

#### DON'T MOURN&ORGANIZE!

Steve Gold, The Disability Odyssey continues

Back issues of other Information Bulletins are available online at <http://www.stevegoldada.com> with a searchable Archive at this site divided into different subjects.

To contact Steve Gold directly, write to [stevegoldada@cs.com](mailto:stevegoldada@cs.com) or call 215-627-7100.

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## ADA PLANNING COMMITTEE Update Report. May 3, 2010

- The Americans with Disabilities Act (ADA) protects Americans with mental and physical disabilities against discrimination. The act is a landmark piece of legislation signed into law in July, 1990. Twenty years later, an informal group of Iowans are assisting on a campaign to recognize the impact of the ADA in Iowa. We are reaching out to groups across Iowa to create a year-long celebration that focuses on the triumphs we have had and highlight the hurdles we still have to overcome.
  - **Our** informal planning group has been working together to facilitate or create events in celebration of the ADA.
  - Please visit our website ([www.adaiowa.webs.com](http://www.adaiowa.webs.com)) for additional background on the ADA.
  
- State agencies, local, state and national organizations and providers already have a number of projects, events and outreach efforts that are going on throughout the state. These projects can be borrowed and used for local efforts.
  - We have partnered with **minor and developmental league baseball teams** to produce “ADA nights” at the ballparks, emulating the excellent work done in Cedar Rapids where they have held an annual “ADA Night” .
    - Cedar Rapids: July 17
    - Sioux City: July 20
    - Des Moines: July 21
    - Davenport: July 28
    - Contacts have been made with other ballparks, but no dates have been set.
  - We will be at the **Des Moines Farmer’s market** this year in partnership with **VSA Iowa**, doing crafts and projects to raise awareness about the anniversary of the ADA.
  - **PSAs are** being produced through a collaboration of agencies; PSAs will focus on issues relevant to the disability community. IDPH’s Karin Ford was instrumental in securing pro bono PSA assistance, in development and production.
  - **Sharing personal stories.** We are reaching out to media outlets and submitting personal stories behind the ADA, based on interviews with Iowans with disabilities, their friends, their caregivers and their families.
    - **An initial story was posted in the Des Moines Register on line edition.**
  - **Habitat for Humanity and day of service.** A day of service is being planned in partnership with Habitat for Humanity to construct a house for a woman who is legally blind. In honor of the ADA, we plan to help Habitat display what they have done for persons with disabilities over the past 20 years and hopefully interview one of the families who lives in one of the houses built by Habitat.
  - **A sticker campaign** to raise awareness about universal design and highlighting the hidden aspects of the ADA is being worked on and should be launched in just a few short weeks.
  - There are also **non-traditional ideas** being pursued, such an alternative reality game where players join a fictional “secret grass roots think tank” and use online tools mixed with real-world problems to confront the issues faced by people with disabilities in Iowa.
  - **A festival is planned for July 24<sup>th</sup> at the Capitol complex** where we hope to invite groups from around Iowa to participate in a day long celebration. The event would welcome organizations to have booths and activities, bring in entertainment from around the state, and invite speakers who will address the issues of the day. Senator Harkin, the author of the ADA, has tentatively agreed to speak.
  - **“Following the July 24<sup>th</sup> festival, we are planning a day of workshops and guest speakers on Monday, July 26<sup>th</sup>—the actual date of the ADA anniversary.** Rooms in the Capitol have been reserved as tentative locations. We are hoping to get Gov. Chet Culver and other officials to speak,

including notable members or leaders of the disability community.”

- We are planning a “**Celebrate 20 Years of Ability in Iowa**” **photo campaign** to begin in Des Moines. We will be asking friends, family, coworkers, local celebrities, and random people around town—with and without disabilities—to pose with our sign, which will read: “Celebrate 20 Years of ABILITY in Iowa. Celebrate the ADA.” Depending upon funding, these images will be used in two ways. First, we are considering making digital versions available on our websites as downloadable desktop backgrounds, e-mail attachment images, and/or e-cards (similar to the Think Beyond the Label e-cards). Second, depending upon availability of funding, we intend to purchase postcards these images and send them out as “Save the Date” postcards for the ADA festival in July. They will also be distributed at outreach events throughout the year.”
- If you are looking to join our efforts there are hundreds of ways to get involved all throughout the year. For more information visit our website at **[www.adaiowa.webs.com](http://www.adaiowa.webs.com)** for toolkits, resources, event ideas and more.
- You can also call us for more information call 515-281-0337 or 281.0367 where you can reach a VISTA member of the Iowa Civil Rights AmeriCorps VISTA Project and be connected with all of the groups involved in the planning of our celebration.

The logo features a stylized sunburst or starburst design in shades of blue and white. In the center, the number '20' is prominently displayed in white with a blue outline, with the word 'years' written in a smaller, blue, sans-serif font directly below it. Underneath the '20 years' graphic, the words 'Americans with Disabilities Act' are written in a large, bold, blue, sans-serif font, stacked in three lines: 'Americans', 'with', and 'Disabilities Act'. The background of the logo is white with a light blue curved border at the top and bottom.

**20**  
years  
**Americans  
with  
Disabilities  
Act**

Olmstead Taskforce:

Thank you for having me at your meeting on March 5th and for letting me speak about the ADA celebration. I am very grateful for everyone who gave me suggestions and feed back.

As you know, the ADA is a landmark piece of legislation in its 20th year and we're hoping to create a year-long, state-wide celebration to recognize that fact. In the meeting I offered to come up with a packet of some of the projects that we are working on and the funding amounts that we are looking for on each one. This is that packet.

Inside you will find a brief description of what we are working on, and the estimated total cost of each project. As well as those specific examples that anyone can support in part or in full, we are also looking for smaller donations for operational costs, printing costs, and other needs as wells as in-kind donations of any type to use as contest prizes or other items to incorporate into our efforts. All money for this effort should be donated to the Iowa Friends of Civil Rights, a 501(c)(3) organization.

I would like to thank you again and if there any questions or comments, please let me know by email [Elizabeth.debruin@iowa.gov](mailto:Elizabeth.debruin@iowa.gov) or by phone at 515-281-0337.

Sincerely,  
E.B. DeBruin

# Join the Celebration

## Projects to Support

### Farmer's Market

A booth at the “Community Corner” would give us the chance to reach out to the general population and put information directly into their hands. Our booth would have not only information about the ADA, but also collected brochures of groups across the disability spectrum. Our goal is to put this information into bags to be given out to members of the community. Also, there will be quizzes and an interactive youth project to engage people passing the booth

Cost: \$45 per weekend over 5 weekends plus printing costs.

\$250

### State Wide Art Contest

K-12 students will take a word or phrase relating to the ADA, such as “ability” and interpret that concept in whatever art medium they chose; paint, photograph, written word, the sky’s the limit.

Costs: Cash prizes, prizes and operational costs. Example: Blank Park Zoo has donated a pack of tickets to be used as a prize.

\$400

and In-kind donations

### ADA: Faces and Voices

Through interviews, collage, and artist generated images we’re working to represent what the ADA means after twenty years. We hope this effort culminates in a large art work to be unveiled at the ADA celebration. The work will also create images to be connected with the larger statewide celebration, such as physical and virtual postcards to spread information about the ADA at 20 years. Cost: art supplies, printing costs

\$1000

### Sticker Campaign

By creating stickers or stencils to be distributed to volunteers, organizations and individuals we will create a campaign to raise awareness of accessible design in Iowa. The stickers would be placed around the state in areas where ADA regulations are being followed but may not be “visible” to the general public; i.e. curb cuts, automatic doors, etc. Costs: Distributable stickers or stencils, printing costs on information packets distributed with the stickers or stencils.

\$2000



## Ongoing Efforts

### Website

Our website is already out there at [ada-iowa.webs.com](http://ada-iowa.webs.com), but we have to keep Google Ads up on the site in order to keep it running. These ads can make the site more difficult to access for those with screen readers and other adaptive technology. A small donation would help us get rid of those ads and make our site completely accessible.

\$50

# Join the Celebration

## Continued...

### The Festival

In Des Moines we're commemorating the date of the 20th Anniversary with a festival to bring together figures and groups who have made the ADA possible in the past, the present, and those working together to make sure that our future is brighter than ever before.

By welcoming organizations to have booths and activities, having entertainment from around the state, speakers who will address the issues of the day and presenting key figures of the ADA's past with awards, we're working to make sure this day is one that is a true celebration of everything that has been achieved, and everything we are working to make happen. We are working to find sponsorship from many sources, but no matter what we end up raising we have plans set to do whatever we can for that day. You can help us bring everyone of those plans into action!

Example costs: T-shirts for guests and volunteers, table and tent rental for "vendors", permit fees, law enforcement fees, traffic signs and blockades, waste management, lunch for volunteers, printing costs, sound system rental, entertainers fees, and more. If you wish to discuss the festival in more detail or discuss what you could support please email [Elizabeth.debruin@iowa.gov](mailto:Elizabeth.debruin@iowa.gov) or call 515-281-0337.

Goal total:\$17000

### State-wide Outreach

Through the Iowa Civil and Human Rights Commission's Americorps VISTA Project we have VISTAs across the state working on their own projects to celebrate the ADA through education and outreach. In cities like Ames, Fort Dodge, Iowa City, Cedar Rapids and Waterloo VISTAs are working within their communities to create events throughout the year. Costs: though the need would vary from project to project even a small amount could help create something big.

Per Project:\$200

For more information on anything you've read here visit [ada.iowa.webs.com](http://ada.iowa.webs.com) or email [Elizabeth.debruin@iowa.gov](mailto:Elizabeth.debruin@iowa.gov)

This Document was created on 03/08/10 for the Olmstead Taskforce.



**United Spinal  
Association**



1660 L Street NW, Suite 510 510, Washington D.C. 20036, (202) 556-2076 (V), (202) 223-2380 (F)

## **Impact of Health Care Reform on People with Disabilities**

The disability community has worked together tirelessly for more than a year to achieve health care reform. After health care reform nearly died several times, Congress revived it and it became law in March 2010.<sup>1</sup>

From any perspective, the final legislation is not perfect, but it will bring important improvements in health care coverage for people with spinal cord injuries and disorders and people with disabilities in general. The insurance market reforms alone are clearly beneficial. Once the permanent provisions go into effect, no longer will health insurers be able to deny coverage, charge outrageous premiums, offer less coverage to people with pre-existing conditions or impose annual or lifetime caps on benefits. In addition, the bill enacts several provisions that encourage home and community based services so that people with disabilities do not have to choose between living at home and getting the services they need.

As of 2014, when many permanent provisions go into effect, states must have health insurance exchanges (or alternatives) through which people and some employers may purchase health insurance. In addition, most people will be required to have health insurance unless they are eligible for health care through government programs such as Medicare, Medicaid, Department of Veterans Affairs and military service. Multistate plans are allowed but individual states can require additional benefits to be covered by health insurance in their states. There will be refundable tax credits for some people based on income and tax credits for some small businesses that provide health insurance to their employees.

Summarized below are major final health care reform provisions that particularly impact people with disabilities. This list is by no means exhaustive. The final legislation not only reforms health insurance but also addresses many health care issues including prevention and wellness and improving the health care workforce.

With enactment of the law, reform is only beginning. The disability community must stay involved and present as implementing regulations are drafted, proposed, promulgated, and implemented. For the foreseeable future, we will need to be vigilant in making our voices heard

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<sup>1</sup> The Patient Protection and Affordable Care Act (HR 3590, Public Law 111-148, signed into law 3/23/10) as modified by the Health Care and Education Reconciliation Act (HR 4872, Public Law 111-152, signed into law 3/30/10).

with regard to the countless rules and regulations to be issued, advisory boards and commissions to be established, and many other steps to be taken to implement health care reform.

Find more information on our public policy website [www.spinalcordadvocates.org](http://www.spinalcordadvocates.org) or contact our Washington, DC public policy staff Peggy Hathaway and Andrew Morris at 202-556-2076, [phathaway@unitedspinal.org](mailto:phathaway@unitedspinal.org) or [amorris@unitedspinal.org](mailto:amorris@unitedspinal.org).

This summary was prepared by Peggy Hathaway, Vice-President for Public Policy, and Andrew Morris, Director of Legislation, for Spinal Cord Advocates, a public policy collaborative of United Spinal Association and the National Spinal Cord Injury Association, and Barbara L. Kornblau, JD, OTR, Dean, University of Michigan - Flint, School of Health Professions and Studies, on behalf of the American Association of People with Disabilities (AAPD).

April 27, 2010

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## **Insurance Market Reforms**

Generally, health care reform legislation includes many provisions that make private market health insurance far more available and affordable to people with disabilities and other chronic conditions.

### **No Discrimination Based on Pre-Existing Conditions**

As of 2014 health insurers will no longer be able to discriminate against people due to disabilities or other pre-existing conditions. Health insurers will no longer be allowed to deny coverage, charge higher premiums, exclude benefits relating to pre-existing conditions, rescind coverage after someone is injured or acquires a new condition, or impose annual caps on benefits. Most of these provisions go into effect for children in September 2010.

### **Lifetime and Annual Benefits Caps**

Lifetime caps on benefits are prohibited immediately. This will end the common insurance practice of imposing lifetime caps such as \$1 million. Between now and 2014, the Secretary of Health and Human Services (HHS) may restrict annual caps on benefits. As of 2014, both lifetime and annual caps on benefits are prohibited.

### **Temporary High-Risk Pools**

Between now and 2014, many people with pre-existing conditions are eligible to purchase coverage through high risk pools.

Unfortunately, to be eligible to purchase this insurance, people must have been without any health coverage whatsoever for at least six months. Also, the insurance could be unaffordable for many people. Premiums are subject to restrictions, but even so, the law allows insurers to charge older people four times as much as younger people. Limits on

out-of-pocket expenses must be consistent with high-deductible health savings account plans—currently \$5,950 for an individual and \$11,900 for a family.

It is currently uncertain when the temporary high risk pools will become available or where people will apply for insurance in these pools. If a state does not offer the required insurance, HHS will either help establish a pool in that state or residents of that state will be eligible for a national high risk pool. This decision-making process is now underway.

## **Mandatory Health Plan Coverage Provisions**

### **Essential Benefits**

For most health insurance plans (including plans offered in the exchanges and individual and small group plans but excluding grand-fathered individual and employer-sponsored plans) the law mandates coverage of at least the following essential benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.

HHS has the authority to further define essential benefits consistent with these required elements and is expected to do so. If HHS adds essential benefits, the law requires HHS to take into account the health care needs of people with disabilities and other diverse groups. We will continue to make our voices heard as HHS goes through the process of defining essential benefits.

For people with disabilities, it is a substantial improvement that rehabilitation and habilitation services are essential services. Many people with disabilities depend on them (e.g. to maintain muscle bulk and minimize spasticity) but pre-health care reform insurance policies did not cover them or severely limited the number of treatments.

As we understand it, the term “devices” is meant to include all durable medical equipment (including wheelchairs), prosthetics, orthotics and supplies (DMEPOS). This provision would be stronger if it made this point more explicitly. Because DMEPOS are critically important to many people with disabilities, we are advocating that anticipated HHS regulations defining essential benefits will explicitly provide that all DMEPOS are included in the meaning of “devices” as essential medical benefits.

It is important that mental health and substance abuse services are included as essential benefits.

### **Limits on Cost Sharing**

The amount that people will have to pay out-of-pocket cannot be greater than the limits for health savings accounts. Small group market plans are prohibited from deductibles greater than \$2,000 for individuals and \$4,000 for families. These maximums may

increase only in accordance with increases in average per person health insurance premiums.

## **Home & Community-Based Services**

Health care reform has enacted or enhanced several provisions to expand home and community based services to help make it easier for people with disabilities and chronic conditions to live at home and participate in their communities, rather than having to live in a nursing home or other institution in order to receive needed services. No one should have to choose between living at home and receiving the services they need.

### **Community Living Assistance Services and Supports -CLASS**

The CLASS provisions establish a national voluntary, insurance program whereby people with functional limitations receive benefits of not less than an average of \$50 per day to pay for services and supports of their choice that help them with activities of daily living. To qualify, people will have had to pay premiums, by means of a voluntary payroll deduction plan, for at least five years. These services can enable them to remain independent, employed and participate in their communities. Unlike Medicaid, CLASS does not require people to be impoverished to qualify for this program. HHS is required to develop an actuarially sound benefit plan so that the program is self-sustaining.

### **Community First Choice Option**

Creates the Community First Choice Option. This allows state Medicaid plans to choose home and community-based services and supports as the rule, rather than the exception, for Medicaid-eligible individuals with disabilities with incomes up to 150% of the Federal Poverty Level, who would otherwise require institutional care. To encourage states to choose this option, states that opt in will receive an additional six percent to the federal government's share of Medicaid costs (referred to as the Federal Matching Assistance Percentage or FMAP) for five years. Effective October 1, 2011.

### **Money Follows the Person**

Extends the popular Money Follows the Person demonstration grants until September 2016. These grants help state Medicaid programs defray the cost of moving eligible Medicaid recipients who have resided in an in-patient facility for a minimum number of consecutive days into community-based settings for eligible Medicaid recipients.

### **Home and Community Based Services in Medicaid**

Makes it easier for state Medicaid programs to offer home and community based services by allowing states to do so by amending their state plan, rather than having to apply for a Medicaid waiver, which can be a lengthy process.

## **ADDITIONAL IMPORTANT CHANGES**

### **Substantial Expansion of People Eligible for Medicaid**

Health care reform substantially increases the number of people who are eligible for Medicaid. Since many people with disabilities have low or very modest incomes, this Medicaid expansion will give many more people with disabilities the right to health care coverage

As of 2014, health care reform expands Medicaid to cover non-elderly, childless adults for the first time and adults with incomes up to 133% of the Federal Poverty Level. It also expands Medicaid to cover children in families with incomes up to 133% of the Federal Poverty level, and it extends Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) mandates to all children on Medicaid including those in managed care. EPSDT services address developmental disabilities and delays. States will receive an increased Federal matching share for the first few years. In 2009, 133% of the Federal Poverty Level for individuals was \$14,404 and for families of four was \$29,327.

Between now and 2014, states have the option of extending Medicaid coverage to these groups.

In addition, states are required to maintain their current services under Medicaid and have incentives to cover preventive services and immunizations without cost-sharing to adults under Medicaid.

Note regarding Medicare 2-year waiting period. Under existing law, people found eligible to receive disability benefits under Social Security's SSDI and other Title II programs must wait two years before they can receive Medicare benefits. In the meantime, many people with disabilities go without needed health care, which often causes dire consequences, including exacerbation of existing conditions and death.

While health care reform does not directly address this problem, it mitigates it for some people in the two-year waiting period. They may be able to obtain health coverage through the temporary high risk pool or through the health insurance exchanges once they go into effect (which cannot discriminate on the basis of pre-existing conditions) or they may qualify for Medicaid under its extended eligibility standards.

### **Medicare Part D Donut Hole Gap in Prescription Drug Coverage**

Phases out the famous "donut hole" in prescription drug coverage under Medicare by 2020. Currently, when Medicare enrollees are in the donut hole (after they reach a certain limit on prescription drug coverage and before additional coverage kicks in), they must pay for prescription drugs at full price.

Provides a one-time \$250 rebate for prescription drugs after enrollees enter the donut hole in 2010. Beginning January 1, 2011, it provides a 50 percent discount on brand name drugs and other discounts for generic drugs for enrollees in the donut hole.

### **Substantial Increased Funding for Community Health Centers**

Provides an additional \$11 billion of funding from the Public Health Trust fund for Community Health Centers located across all 50 states and territories (over 1200 facilities). Community Health Centers are major providers of health care to people who are uninsured or are underinsured

### **Medicare Outpatient Therapy Caps**

Health care reform extends until December 31, 2010 some exceptions to caps on Medicare Outpatient Part B Therapy Services, thus allowing Medicare enrollees to get medically necessary therapy services beyond the \$1,860 cap for occupational therapy, and \$1,860 cap for physical therapy and speech-language pathology services.

### **Accessible Medical Diagnostic Equipment**

Requires the U.S. Access Board, in consultation with the Food and Drug Administration, to establish regulatory standards setting the minimum technical criteria for medical diagnostic equipment for people with disabilities. While existing law requires medical equipment to be accessible, these standards are intended to clarify how to comply with this requirement.

These standards, to be completed in two years, will clarify minimum technical criteria for medical equipment in doctors' offices and other medical facilities to be considered accessible for people with disabilities including people who use wheelchairs. The standards shall ensure the equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible. At a minimum medical diagnostic equipment covered by the new standards will include: examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other radiological equipment commonly used for diagnostic purposes by health professionals.

### **Elimination of Medicare First-Month Purchase Option for Power Wheelchairs**

Under existing law, Medicare beneficiaries have the option to purchase their power wheelchairs, rather than rent them. This enables the person with long-term need of a wheelchair to have it adjusted to his or her size and unique needs. Under health care reform, Medicare will only pay for rental, rather than purchase, of certain power wheelchairs for the first thirteen months of use (with exceptions for certain classes of complex rehab power wheelchairs). During the 13-month rental period Medicare will pay 80 percent and the beneficiary will pay 20 percent of the rental cost.

We are concerned because wheelchairs, like people, are not fungible. They require many adjustments to meet the individual user's size and needs. With purchased wheelchairs, suppliers are likely to bear the cost of individualization, but they are not likely to do so for a rental that can be so easily returned. Without individualization, users frequently suffer exacerbated or secondary conditions that require treatment and often hospitalization, thus offsetting any cost savings to Medicare.

### **Durable Medical Equipment Excise Tax**

A new excise tax (\$20 billion over 10 years) on medical devices will be imposed on manufacturers of medical equipment. It is intended to help offset the costs of health reform. Although the tax is imposed on manufacturers, the consumer will ultimately bear the cost because manufacturers are likely to pass these costs on to consumers through increased prices.

### **Medicare Durable Medical Equipment Competitive Bidding Program**

Existing law requires HHS to implement a competitive bidding program for suppliers of wheelchairs and other durable medical equipment, under Medicare, as a cost-savings measure. Wherever competitive bidding goes into effect, Medicare will only pay suppliers selected by HHS. It is likely that there will be far fewer suppliers to choose from for both purchase and repairs of wheelchairs and other durable medical equipment and that the quality of products and repairs may go down. People who use wheelchairs may well have to give up their existing suppliers and find it difficult to get to the new suppliers for repairs.

Health care reform speeds up the pace of expanding competitive bidding to additional Standard Metropolitan Statistical Areas and requires coverage of all areas by 2016.

### **Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan**

Provides Medicare Part B coverage, with no co-payment or deductible, for personalized prevention plan services. Personalized prevention plan services means the creation of a plan for an individual that includes a health risk assessment and may include other elements, such as updating family history, listing providers that regularly provide medical care to the individuals, body-mass index measurement, and other screenings and risk factors.

### **Comparative Effectiveness Research**

Creates a federal coordinating council for comparative effectiveness that will be responsible for the annual funding of research to compare the effectiveness of various treatments on specific conditions. Comparative effectiveness research compares available treatments to see which works best based on research findings.

The law also creates a patient-centered outcomes research institute responsible for the development of national comparative effectiveness research priorities and the conduct of clinical outcomes research. Research must take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, and quality of life preferences.

### **Training of Future Health Practitioners**

Requires that medical professionals receive disability awareness training to help reduce the health disparities that exist for people with disabilities. Grants and other incentives are available to develop programs and model curricula to train health professionals and

increase the number of health professionals (including dentists) trained to meet the health care needs of individuals with disabilities.

### **Nondiscrimination**

Except as provided elsewhere in the law, prohibits discrimination based on disability under any health program or activity which receives federal assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments) and provides Section 504 of the Rehabilitation Act as the enforcement mechanism for violations. The Secretary of HHS may promulgate regulations to implement this.

### **Comprehensive Workplace Wellness Programs**

Authorizes an appropriation for grants to eligible small businesses for the purpose of giving their employees access to comprehensive workplace wellness programs that meet criteria to be developed by HHS. Employee wellness programs can be a good way to encourage better health. However, this provision could inadvertently have a negative impact on people with disabilities. For example, a person with a disability may be unable to participate in an exercise program or another benchmark of the wellness program. If employees who do participate receive a reduced deductible under the employer-sponsored health plan (or another financial incentive), the person with a disability who is unable to participate would end up paying a higher deductible (or would not be eligible for other financial incentive). To avoid inadvertent negative impacts on people with disabilities and chronic conditions, it will be important to work with HHS in designing the programs.

### **Coverage of Anti-seizure, Anti-spasm, and Smoking Cessation Medications**

Mandates coverage of barbiturates, benzodiazepines, and tobacco cessation agents under Medicare Part D. Barbiturates include phenobarbital and other medications that treat seizures. Benzodiazepines include sedatives, anti-anxiety medications, and anti-spasm medications. Both of these categories of medications were previously specifically excluded from coverage under Medicare Part D.

### **Data Collection and Analysis to Understand and Address Health Disparities**

Requires the federal government to collect health survey data from people with disabilities to enable better understanding of the health of people with disabilities compared to other minority groups.

Also requires the government to collect survey data from health care providers in order to learn where people with disabilities receive their care, the number of providers with accessible facilities and equipment, and the number of health care professionals trained in meeting the health care needs of patients with disabilities.

Requires the development of recommendations for quality measures to improve the quality of health care for individuals with disabilities.

## Report for Iowa Olmstead Real Choices Task Force May 14, 2010

### Ingrid Wensel

On May 6<sup>th</sup> Heritage Area Agency on Aging's hosted a meeting with aging and disability home and community based services advocates to share their desire to coordinate an advocacy event to educate current elected officials and candidates in east central Iowa running in November 2010 about home and community-based services, Iowa's over-reliance on institutional-based care, and the Olmstead Decision. At the meeting a number of individuals and organizations made the commitment to support the development of this forum that will be held in late summer/early fall by committing to support a broad advocacy message about the need to support home and community based services for older adults and people with disabilities, marketing the forum and recruiting constituents to participant in the forum, and contacting elected officials and candidates to attend the forum. As was discussed at the meeting on May 6<sup>th</sup> it is not the intent of the forum to replace individual or organization's current advocacy efforts, but rather compliment them by creating a venue for a united voice for home and community based service advocates. **Our next forum planning meeting will be on Monday, June 7<sup>th</sup> from 10:30 a.m. – 11:30 a.m. at the Heritage Area Agency on Aging conference room 32A.** Please consider joining us. Free teleconferencing is also available for those who are not able to attend in person. If you want more information or have any questions please call Ingrid at 319-398-5559/800-332-5934 or e-mail [iwensel@kirkwood.edu](mailto:iwensel@kirkwood.edu) . Thank you for your continued efforts toward the development of a system that supports the independence and dignity of older adults and individuals with disabilities

# Direct Care Alliance Policy Brief No. 3

## The Best and Worst State Practices in Medicaid Long-Term Care

By Candace Howes, Connecticut College

Medicaid—the federal-state program that provides health care for the poor—pays for about half of public long-term care, including nursing home care and home- and community-based services such as home health care, adult day care, adult residential homes, and personal care services for the homebound. Thanks in part to the U.S. Supreme Court’s Olmstead decision of 1999,<sup>1</sup> and states’ own desire to slow growth in the cost of Medicaid programs, states are starting to catch up with consumer preference for home- and community-based care.

But much of that growth is fueled by the private market. A change that profound in Medicaid policy takes time to implement—longer in some places than in others. Nationwide, Medicaid still pays for more nursing home care than home- and community-based care, but a few states have reversed that formula. States share the cost of the Medicaid program with the federal government and are free to design their own mix of long-term care services within broad guidelines set by federal statutes, so there is tremendous variation from state to state in the range and access to services.

This brief explains why Medicaid policies lead to so much variation in current state Medicaid long-term care programs, and how those policies have been used in some states to expand the range and availability of services. It also draws lessons

from innovative states to suggest reforms in national Medicaid policies that would make home- and community-based services accessible to more program participants.<sup>2</sup> A second brief, to follow, will examine state policies to expand the direct care workforce. Home health aide is the third-fastest growing job category in the U.S. and personal and home care jobs the fourth-fastest.<sup>3</sup> The number of home- and community-based direct care workers recently surpassed the number of nursing assistants in nursing homes. But the growing need for long-term care workers is expected to outpace supply growth in the next decade and states will not be able to move more recipients into home- and

### Long-term care by the numbers

**Number of Americans needing long-term care services:**  
nearly 13 million

**Number of nursing home residents:**  
1.8 million

**Number receiving home- and community-based services (HCBS):**  
10.9 million

**Number of people receiving unpaid help from family and friends:**  
9.8 million

**Number of people receiving HCBS who get paid help:** 1.4 million<sup>4</sup>

### April 2010

- This is the third in a series of policy briefs about the direct care workforce in long-term care issued by the Direct Care Alliance (DCA). This series was conceived at a meeting of labor economists, lawyers, long-term care researchers, and other experts convened by the DCA and funded by the Russell Sage Foundation.
- Editorial committee: Nancy Folbre, Elise Nakhnikian, Vera Salter, Leonila Vega.

### The Direct Care Alliance

The Direct Care Alliance is the national advocacy voice of direct care workers. We empower workers to speak out for better wages, benefits, respect, and working conditions, so more people can commit to direct care as a career. We also convene powerful allies nationwide to build consensus for change.

community-based services without an adequate high quality workforce.

## Growing Old Across the States

Suppose when you next visit your 80-year-old mother, who has been living independently for 20 years in Tennessee, you find that she can barely get out of bed or go to the toilet without assistance. You conclude that it is no longer safe for her to live on her own.

Her monthly income is less than \$2,000, and while she has some assets other than her house, they would not support her in a nursing home for more than a month. Because she is poor, she is eligible for Medicaid-financed long-term care in a nursing home. However, if she goes into a nursing home, she will be required to sell her home and contribute the proceeds of the sale, along with her monthly income, toward the \$70,000-a-year cost of the nursing home.

Your mother is horrified by the idea of living in a nursing home. She wants to hire someone she knows to take care of her at home, but private pay home care would cost about \$36,000 per year. You find that she is eligible for a state-funded program, but there is a waiting list of 4,000 for the 2,000 slots. In contrast, there are 37,000 beds in nursing facilities.

You consider moving her to your state of residence, Connecticut, which spends almost twice the per capita national average on long-term care services for the elderly. But most of that is spent on nursing facilities. Here too, there is a long waiting list for home care services, and even if your mother did get a spot, she would not be able to hire someone she knows.

Too bad your mother doesn't live in Washington or Oregon, where about three out of every four people receiving Medicaid long-term care services live in the community. If she did, she would be eligible for a huge array of home and community-based services, including a "consumer-directed" home care program in which she could choose her own provider, and there would be no waiting list.

Spending on Medicaid long-term care costs makes up as much as 10% of states' budgets, making the program highly visible and politically vulnerable to state and federal fiscal crises.<sup>6</sup> Even in the best of times, long-term care services must compete for funding at the state level. It's a political process that pits stakeholders against schools and other social services—and that often pits

nursing homes against home care providers.<sup>7</sup>

Within broad guidelines established by federal statutes, regulations, and policies, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services to be offered; sets the rate of payment for services; and administers its own program. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services one state provides may differ considerably in amount, duration, or scope from services provided in another state. Services don't even remain stable within states, since the legislatures may change Medicaid eligibility, services, and/or reimbursement at any time.<sup>8</sup>

In many states, Medicaid does not fund enough home- and community-based services to meet its recipients' needs, so people who are eligible for Medicaid long-term care make do with unpaid family care instead. The large unmet need for home- and community-based services has been well documented in national surveys, and is made manifest in the waiting lists many states maintain for these services.<sup>9</sup> Several states have been sued for this lapse, charged with failing to comply with the Olmstead ruling.

The table on the next page reveals huge state variations in the coverage, generosity per recipient, balance between institutional and home- and community-based services, and per capita cost of long-term care programs. It compares state programs along these four dimensions. First, it measures "coverage" as the number of people per 1,000 in the population who are receiving long-term care (LTC) services for the elderly and disabled, who are receiving those services in the form of home- and community-based services (HCBS), and who are receiving them in nursing homes. Within this dimension, states are categorized mainly by whether they provide above average (highlighted in green), average (yellow) or below the national average (red) coverage for HCBS. Generosity is measured by per recipient spending on HCBS, again highlighted in green, yellow and red. As a measure of balance, the table lists the percentage of the total Medicaid long-term care recipients who are receiving HCBS and the share of total LTC spending that is on HCBS. Finally, it shows how much the Medicaid long-term care program spends per capita in each state as a measure of the cost per person in the population. States are then placed in seven groups, based on their overall performance along the three dimensions of coverage,

**State Medicaid Long-Term Care Coverage for Aging & Disabled 2006** (2008 share of spending)<sup>10</sup>

For all except the last column, green indicates that the state's performance is at least 20 percent above the national average, red indicates that the state is at least 20 percent below the national average and states within plus or minus 20 percent of the national average are colored yellow. In the last column (Cost), green indicates that per capita spending is at least 20 percent *below* average and red indicates that spending is 20 percent *above* average, in keeping with the principle that green indicates better than average performance while red is less than average performance. The states are listed in alphabetical order within each performance group. Except for expenditure data used to measure HCBS spending as a share of total LTC spending, which is from 2008, all data are from 2006, the most recent year for which both usage and expenditure data are available, so the numbers may have improved since then, but the ranking of the states remains accurate. Arizona is excluded from the table because comparable data is not available.

	COVERAGE			GENEROSITY			BALANCE		COST
	No. of recipients 2006			Spending per recipient			% of HCBS in LTC		LTC \$
	LTC	HCBS	NH	LTC	HCBS	NH	Recipients 2006	Spending 2008	Per capita
	<b>HCBS ABOVE AVERAGE</b>			<b>AVERAGE &amp; ABOVE</b>			<b>ABOVE AVERAGE</b>		
Alaska	13.1	11.2	1.9	\$28,718	\$17,245	\$97,044	86%	63%	\$293
California	13.8	9.6	4.2	\$15,242	\$10,802	\$25,297	69%	51%	\$210
Minnesota	14.4	8.3	6.0	\$19,177	\$13,217	\$27,404	58%	51%	\$313
New Mexico	10.4	6.7	3.7	\$20,907	\$17,548	\$26,882	64%	64%	\$242
North Carolina	12.5	7.6	4.8	\$16,537	\$10,570	\$25,986	61%	41%	\$201
Oregon	11.4	8.7	2.7	\$14,316	\$9,973	\$28,390	76%	53%	\$184
Washington	12.1	8.7	3.4	\$15,577	\$11,666	\$25,490	72%	59%	\$213
	<b>HCBS AVERAGE</b>			<b>AVERAGE &amp; ABOVE</b>			<b>AVERAGE &amp; BELOW</b>		
Kansas	11.7	5.6	6.1	\$15,123	\$10,630	\$19,228	48%	36%	\$200
Montana	10.6	5.3	5.4	\$19,495	\$9,953	\$28,808	49%	28%	\$220
New York	16.1	5.4	10.7	\$30,399	\$23,880	\$33,705	34%	29%	\$525
Washington DC	13.0	5.8	7.2	\$29,419	\$14,815	\$41,052	44%	40%	\$513
West Virginia	11.8	5.5	6.3	\$23,188	\$9,289	\$35,394	47%	19%	\$302
Wisconsin	12.4	6.2	6.3	\$18,985	\$10,112	\$27,709	50%	28%	\$218
	<b>AVERAGE &amp; ABOVE</b>			<b>BELOW AVERAGE</b>			<b>AVERAGE &amp; ABOVE</b>		
Arkansas	18.9	8.8	10.1	\$12,286	\$5,289	\$18,352	46%	21%	\$250
Idaho	11.6	8.2	3.4	\$12,999	\$7,072	\$27,147	70%	39%	\$169
Illinois	9.8	4.1	5.7	\$14,058	\$6,866	\$19,199	42%	24%	\$151
Maine	14.1	7.4	6.7	\$17,565	\$7,968	\$28,266	53%	24%	\$249
Michigan	11.8	6.5	5.3	\$14,562	\$4,281	\$27,248	55%	19%	\$183
Missouri	18.8	12.1	6.6	\$9,838	\$4,493	\$19,635	65%	30%	\$205
Oklahoma	12.7	6.6	6.0	\$13,407	\$6,413	\$21,058	52%	29%	\$205
Texas	11.6	7.4	4.2	\$10,361	\$5,661	\$18,568	64%	33%	\$118
Vermont	15.5	6.4	9.1	\$14,070	\$8,465	\$18,047	41%	32%	\$268
	<b>HCBS BELOW AVERAGE</b>			<b>AVERAGE &amp; ABOVE</b>			<b>BELOW AVERAGE</b>		
Connecticut	15.0	3.7	11.2	\$25,640	\$8,556	\$31,342	25%	9%	\$392
Massachusetts	12.3	3.6	8.7	\$26,977	\$20,594	\$29,578	29%	21%	\$314
Nebraska	10.2	3.8	6.5	\$22,982	\$10,060	\$30,522	37%	19%	\$231
Ohio	11.9	3.4	8.5	\$23,240	\$13,490	\$27,131	29%	18%	\$269
Rhode Island	13.0	2.8	10.2	\$24,193	\$11,854	\$27,597	22%	13%	\$323
	<b>HCBS BELOW AVERAGE</b>			<b>BELOW AVERAGE</b>			<b>BELOW AVERAGE</b>		
Iowa	10.5	3.5	7.0	\$16,376	\$6,170	\$21,534	34%	16%	\$186
Kentucky	9.5	2.8	6.7	\$19,874	\$5,217	\$25,994	29%	8%	\$205
Louisiana	10.3	2.8	7.4	\$16,902	\$8,061	\$20,296	28%	27%	\$222
Mississippi	11.9	4.0	7.9	\$18,945	\$314	\$28,400	34%	1%	\$244
North Dakota	12.5	3.5	9.0	\$21,968	\$3,813	\$29,064	28%	9%	\$287
South Dakota	9.7	2.5	7.2	\$18,585	\$4,631	\$23,405	26%	8%	\$187

(cont'd on page 4)

State Medicaid Long-Term Care Coverage for Aging & Disabled 2006—2008 share of spending (cont'd from page 1)

	COVERAGE			GENEROSITY			BALANCE		COST
	No. of recipients 2006			Spending per recipient			% of HCBS in LTC		LTC \$
	LTC	HCBS	NH	LTC	HCBS	NH	Recipients 2006	Spending 2008	Per capita
	<b>BELOW AVERAGE</b>			<b>ABOVE AVERAGE</b>			<b>BELOW AVERAGE</b>		
Delaware	5.8	1.6	4.3	\$35,467	\$12,516	\$43,861	27%	9%	\$221
Georgia	5.9	1.6	4.3	\$24,784	\$10,531	\$29,927	27%	19%	\$170
Hawaii	5.6	1.8	3.9	\$33,321	\$17,569	\$40,497	31%	19%	\$212
Maryland	6.1	1.5	4.6	\$30,970	\$14,736	\$36,074	24%	12%	\$201
New Hampshire	7.7	2.2	5.5	\$32,777	\$13,497	\$40,314	28%	15%	\$268
New Jersey	8.7	3.3	5.4	\$30,164	\$15,204	\$39,211	38%	20%	\$267
Pennsylvania	8.8	2.1	6.7	\$39,988	\$17,213	\$46,926	23%	11%	\$349
Virginia	5.4	1.7	3.7	\$21,985	\$15,546	\$25,025	32%	30%	\$136
	<b>BELOW AVERAGE</b>			<b>BELOW AVERAGE</b>			<b>AVERAGE &amp; BELOW</b>		
Alabama	7.7	2.0	5.7	\$25,355	\$6,607	\$31,842	26%	11%	\$201
Colorado	7.0	3.4	3.6	\$17,577	\$7,177	\$27,339	48%	23%	\$132
Florida	8.7	2.3	6.4	\$16,426	\$4,539	\$20,760	27%	12%	\$149
Indiana	8.3	0.6	7.6	\$19,719	\$7,760	\$20,730	8%	5%	\$206
Nevada	5.4	3.4	2.0	\$16,277	\$8,110	\$30,527	64%	35%	\$96
South Carolina	6.7	3.0	3.7	\$19,522	\$8,122	\$28,564	44%	23%	\$145
Tennessee	5.8	0.3	5.6	\$30,028	\$6,131	\$31,185	5%	4%	\$174
Utah	3.3	1.0	2.3	\$17,521	\$2,487	\$23,867	30%	12%	\$68
Wyoming	8.5	3.1	5.5	\$16,724	\$6,083	\$22,745	36%	16%	\$155
<b>United States</b>	<b>10.8</b>	<b>5.0</b>	<b>5.8</b>	<b>\$19,598</b>	<b>\$10,295</b>	<b>\$27,698</b>			<b>\$220</b>

generosity and balance. States within each grouping are listed in alphabetical order.

We learn from this table that the seven states in group 1—Alaska, California, Minnesota, New Mexico, North Carolina, Oregon, and Washington—perform above the national average on coverage and balance, and at or above the average in generosity. These states provide useful lessons about how to construct a cost-effective long-term care system that better meets the needs of the elderly and disabled. Each of these seven states serves at least as many persons per capita as the national average, but most maintain far fewer nursing home beds and all provide far more home- and community-based services, giving consumers the home-based services they want. Despite the high level of coverage and generosity, except for Alaska and Minnesota, good balance between institutional and home- and community-based care means these states are paying no more than the per capita national average for long-term care services.

In the two bottom groups are the seventeen worst-performing states, which provide almost exclusively nursing home care services to below average numbers of people. Half of these states spend above the national per

participant average on HCBS and half spend less than the national average. All have high overall per-participant cost for long-term care because they make so little use of HCBS. Per capita costs for the bottom group of 10 are low only because they cover so few people and spend so little on HCBS per participant. Oregon, in the top group, covers more than twice the number of people per 1,000 in LTC and about 30 times more people per 1,000 in HCBS than does Tennessee, which is in the bottom group. Oregon also spends 35 percent more per HCBS participant, yet its overall cost per capita is comparable to Tennessee.

### Why are People’s Options for Long-term Care so Varied Across States?

Under the federal Medicaid statutes, states must provide Medicaid long-term care to all aged, blind and disabled persons over the age of 21 who require an institutional level of care and are eligible for Supplemental Security Income.<sup>11</sup>

Medicaid statutes have historically required states to provide institutional care (beginning in 1965) and home health care (1970) to anyone who meets the physical, income and asset criteria. Home health care services must be deemed medically necessary, authorized by a doctor,

and supervised by a nurse. In 1975, states were given the option to include personal care services in the home (the PCS option) as part of the state plan.<sup>12</sup>

Because nursing home care was required and PCS was not, many people have been placed in nursing homes simply because they need regular assistance with activities of daily living (ADLs), such as bathing, eating, assistance with mobility, or with instrumental activities of daily living (IADLs) such as cooking, shopping, telephoning, although

those needs could easily be met in their own homes.

In states where Medicaid long-term care services have been limited primarily to institutions, Medicaid participants are likely to prefer unpaid family care in their homes. This leads to the fear of what is sometimes called “the woodwork effect,” a concern that if the state expands its Medicaid long-term care services to include home and community services, people who currently cost the state nothing because they are receiving unpaid care in their homes will pour out of the woodwork to demand services.

In part to address this concern, Congress allowed states to waive the statewideness and categorical eligibility rules beginning in 1981, so they could target certain home- and community-based programs only to people who would otherwise be in nursing homes.<sup>13</sup> Under these 1915(c) waivers, states can target services to specific groups, set fixed expenditure caps, limit the scope of services, set hourly service caps, and geographic limits, limit the number of slots in a program and maintain waiting lists.

Many states have opted to use Medicaid waiver programs instead of the PCS option, since the waivers allow them more flexibility in defining eligibility. As a consequence, we have a system that provides no services for almost three-quarters of the individuals who need them,<sup>14</sup> distributes inadequate paid long-term care services inequitably among the rest, and imposes a huge burden on many families.

In 1999, the U.S. Supreme Court handed down its landmark *Olmstead vs. L.C.* decision, the first serious challenge to the funding priorities of the Medicaid long-term care system. The court ruled that the Americans

### State Medicaid LTC Requirements and Options

#### FUNCTIONAL AND INCOME ELIGIBILITY CRITERIA

- Blind, aged and disabled people are functionally eligible if they require health-related care and services above the level of room and board
- States must cover functionally eligible blind, aged or disabled individuals who are eligible for SSI (categorically needy)
- States have the option to cover blind, aged or disabled individuals (categorically related) who...
  - are institutionalized and have incomes of 300% of the cutoff for SSI or less
  - would be eligible for Medicaid if they were in an institution, but are in home- and community-based services instead
  - are receiving only state supplementary income payments
  - have income greater than the SSI benefit, but less than the federal poverty level (FPL)
  - are working and disabled with family income of less than 250% of FPL and would be eligible for SSI if they weren't working
- States have the option to cover people who would be eligible if income was measured after deducting medical costs (medically needy)

#### MANDATORY SERVICES

- All states must offer institutional care to the categorically needy

- All states must offer home health care (medical services) to those eligible for Medicaid institutional care
- States are permitted to offer institutional and home health care to the categorically related and medically needy
- States can determine amount, scope and duration of benefits

#### OPTIONAL MEDICAID PERSONAL CARE SERVICES (PCS) (ADOPTED IN 30 STATES)

- States are permitted to offer personal care services (PCS)
- If PCS is part of the state Medicaid plan, it must be offered statewide (statewideness requirement) to all age and population groups (comparability requirement) who are defined as categorically needy
- States may also expand PCS to categorically related and/or medically needy
- States may define scope and level of all PCS

#### OPTIONAL 1915(C) HOME- AND COMMUNITY-BASED SERVICES WAIVERS (ADOPTED IN ALL STATES)

- Programs are limited to people who meet requirements for institutional care
- States are allowed to waive the comparability and statewideness requirements, as well as income and resource eligibility requirements for the medically needy
- The average per capita cost of the program must not exceed per capita cost of nursing home care

with Disabilities Act requires states to provide care for people with disabilities in the most integrated (i.e. community) setting when appropriate—which meant that, for the first time, states were expected to offer some home and community-based alternatives to institutional long-term care.

The Court indicated that states should make “reasonable accommodations” to their long-term care systems, but were not required to make “fundamental alterations.” It suggested that compliance might be demonstrated by “comprehensive, effectively working plans” to increase community-based services and reduce institutionalization, and by ensuring that waiting lists for services move at a “reasonable pace.”<sup>15</sup> Those comprehensive plans for rebalancing state long-term care systems so they are no longer unduly weighted toward providing nursing home care are known as Olmstead Plans.

The full potential of the Olmstead ruling has yet to be realized, as states create and execute their Olmstead Plans. Meanwhile, the interpretation of “reasonable accommodations,” “fundamental alterations,” and “reasonable pace” is being clarified through class action suits in various states.<sup>16</sup>

### Best Practices Among the States

Bits of a better long-term care system are already in place in some states. Some have used waivers to expand access rather than to limit it, and both waivers and the PCS option have been used not only to keep consumers from being placed in nursing homes but also to relocate nursing home residents back to their homes, notably without increasing overall costs.

In a few states, thanks to a philosophical commitment to independent living and legislative action to provide more options—frequently in response to political pressure from advocates—the state long-term care system has been transformed to increase access to home- and community-based care. Best practices concentrate on policies that make home- and community-based care a viable option to nursing home care by:

- Increasing access to HCBS by raising income and asset caps and at least equalizing eligibility criteria for nursing home and community-based care;
- Consolidating the state’s long-term care budgets and oversight entities into a single administrative agency whose mandate is to address recipients needs and

preferences cost effectively by providing the optimal mix of long-term care services, including increasing long-term care options in the community, and;

- Establishing practices that effectively divert or relocate recipients from nursing homes to home- and community based settings of their choice.

### Successful Rebalancing: Washington and Oregon

Both Washington and Oregon launched major initiatives in the 1980s and 1990s to transition people out of nursing homes and into the community, and to divert new program participants to home- and community-based services. As a result, 70 percent or more of the Medicaid long-term care recipients in these states receive HCBS at a reduced overall cost to the states.<sup>17</sup>

In 1981, Oregon received the country’s first HCBS waiver. Since then, it has led the country in maintaining a low institutionalization rate. Language in the original legislation to promote HCBS laid out a vision of a long-term care system in which people were entitled to freedom and independence. A state program called the Oregon Project Independence, launched in 1975 and paid for out of the state’s general fund, also helped lay the groundwork by providing in-home services to people aged 60 and above who might otherwise be in nursing homes. Between 1982 and 1996, approximately 10,000 people were moved out of Oregon’s nursing facilities.<sup>18</sup>

Washington reduced the number of people living in its nursing homes (on a given day) from 17,500 in 1990 to 12,300 in 2005. The enabling legislation, HB 1908, overcame nursing homes’ reluctance to relocate residents by requiring the state to reduce nursing home Medicaid census rates by 1,600 beds within two years.

In order to use their Medicaid funding more efficiently, both states consolidated their budgets and administrative functions for nursing facilities and HCBS, creating a single agency to manage both. This practice is known as “global budgeting.”

Both states also use their own funds to employ case workers whose goal is transitioning suitable nursing home residents—especially those recently discharged from hospitals—back into the community. Medicaid does not cover case management services for nursing home residents, so newly admitted residents who would prefer to be in a community setting probably wouldn’t know about the

community option unless a state-supported case manager were there to tell them.

Washington has expanded community living options and funded the cost of transitioning from a nursing home in several notable ways. For example, it has extended medically-needy eligibility to residents of adult family homes and assisted living facilities, making those programs eligible for Medicaid funding. Like Oregon, Washington has set its asset limit much higher for people who choose community living than for those admitted to nursing homes, in recognition of the fact that people who remain in the community need more financial resources.

Washington is also one of few states that provide “spousal impoverishment” protections for people whose spouses are in community-based programs. These protections, which always apply to people whose spouses are in nursing homes, allow couples to set aside some of their assets to support the spouse who remains in the community, rather than requiring them to spend down to almost nothing before their spouse can be eligible for Medicaid.<sup>19</sup> Extending spousal impoverishment protections to people using HCBS is an important part of removing the state’s thumb from the nursing home side of the scale. Without that protection, Medicaid recipients might agree to go into a nursing home for the sake of their spouses, though they would rather receive care at home or in the community.

Another innovation that makes Washington’s program work is that the state permits new nursing home residents to avail themselves of the home maintenance allowance. This exemption—which is permitted but not required under federal regulations—allows new nursing home residents who have a good chance of returning to the community to keep part of their income (up to 100 percent of the federal poverty level) for the first six months after admission, as long as those funds are used to maintain a home. In addition, although Medicaid recipients who enter nursing homes are usually required to liquidate their assets to pay for their care, Washington does not require them to do so for the first six months.

In addition, since only limited Medicaid funds are available to pay for the costs of transitioning to the community, Washington uses state funds to supplement that amount, permitting up to \$800 to cover costs related to the transition.

Washington also guarantees community providers that they will receive payment for services provided to recipients who are “presumptively eligible” for up to 90 days,

while the Medicaid application is completed and reviewed. And like many other states, Washington uses a single assessment tool to determine what level of care a recipient needs, prior to making any decision about the setting. Studies show that consumer choice is more likely to occur in states which use uniform assessment tools and single-points-of-entry.<sup>20</sup>

As a result, there are no long waiting lists for community-based services in Washington.

Both Washington and Oregon are also encouraging the use of home- and community-based services by redirecting some of the funding that used to automatically flow to nursing homes. Both won five-year (2007–2011) Money-Follows-the-Person (MFP) Demonstration grants to simultaneously transition individuals from nursing homes to community settings and to change state policies so that Medicaid dollars for long-term care can follow the person to the most integrated setting of their choice.<sup>21</sup> Oregon will use its grant to move 780 individuals or 16.5 percent of its institutionalized Medicaid population into the community. Washington plans to transition 660 people, or about 6 percent of its institutionalized Medicaid population. In addition, Oregon’s Independent Choices Program offers Medicaid recipients the option of receiving cash in lieu of authorized in-home services. They may use that cash to hire family, friends, or spouses as caregivers.<sup>22</sup>

Oregon and Washington are among the states including California, Massachusetts, Michigan and Missouri (soon) that are working to ensure that they can find and keep enough qualified personal care workers for their Medicaid-funded consumer-directed care programs. These states have adopted a public authority model for these programs, setting up governmental entities called public authorities to serve as the employer of record for the workers. These public authorities assume responsibility for paying the workers, though they are hired and managed directly by the consumers they serve. Public authorities can also negotiate with unions to set wages and benefits (with approval of the state).<sup>23</sup>

The advent of public authorities has given workers, who would otherwise be without any, legal collective bargaining mechanism, the bargaining power to negotiate higher wages and benefits making their jobs more stable and desirable. Wages for personal care assistants in Washington, Oregon, and California have increased much faster than the national average increase since 1999. Workers

covered under collective bargaining contracts have also gotten health care coverage and other benefits that are often unavailable to personal care workers.<sup>24</sup>

Public authorities help consumers as well, often handling the paperwork involved in hiring and paying workers, providing training, and sometimes helping consumers find workers. The public authorities in California, Oregon and Michigan maintain registries of available workers.

### Expanding HCBS Access—Vermont

Vermont provides far less Medicaid HCBS per capita than most states, but a relatively new program is working to change that.

Although it has had a small state-funded attendant services program since 1983 and a Medicaid PCS option since 2001, only 21 percent of the 3,300 Vermont residents receiving Medicaid long-term care services received them through HCBS as of 1999. To increase that percentage and expand access to consumer-directed home care while containing growth in program costs, Vermont introduced Choices for Care in October 2005, using an 1115 waiver.

Under Choices for Care, the state can combine HCBS funds with nursing home funds in a single capitated global budget.<sup>25</sup> The program also allows the state to offer different levels of service to people with different levels of need. These features help Vermont expand access while slowing the rate of growth of costs, by shifting participants from nursing homes to less expensive community settings while limiting the overall growth of long-term care services to a fiscally sustainable rate.<sup>26</sup> Like Oregon's Independent Choices program, Choices for Care makes it easier to find home-based caregivers by waiving the Medicaid prohibition against paying people to provide home care to their spouses.

Under Choices for Care, the state broadened eligibility criteria to include the medically needy, increased the maximum income eligibility criteria for home- and community-based services to match the criteria for nursing home care, and created a new category of eligible people who were at risk of nursing home placement without some level of service.

People categorized as "highest need" were entitled to either nursing home or HCBS if they met the following criteria:

- Have severe cognitive limitations or require extensive or total assistance with toileting, bed mobility, eating, or transferring;
- Have a monthly income of less than about \$2,000 and

assets worth less than \$2,000 (for nursing home care) or \$5,000 (for HCBS).

The next most severely impaired group, the "high need group," had been eligible only for nursing home care and was made similarly eligible for either nursing home or HCBS services. However, the waiver stipulates that the state can maintain a waiting list for applicants in this group when projected expenditures would exceed the budget, making the high need group a financial safety valve for Vermont's long-term care budget.

Those in the "moderate need" group, people considered at risk of needing nursing home care but not yet eligible, are eligible for homemaking services, case management, and adult day services—though, again, only as long as funds are available. The state made these services available to this group because it calculated that they would help keep people out of costlier hospitals and nursing homes.

By 2009, Vermont's Medicaid long-term care program was serving about 50 percent more people, from 3,450 in 2005 to 5,145 participants, without any additional expenditure. What's more, about 60 percent of its Medicaid long-term care recipients were receiving home- and community-based services. The state reduced its nursing home resident population of 2,200 by 10 percent over that period while increasing the number of participants in home- and community-based services by 50 percent—from 1,161 to 1,815. In addition, it provided homemaker services for an additional 1,262 people in the "moderate need" group.<sup>27</sup> In a further indication that the state was providing its residents with the kind of care they preferred, more than 60 percent of its personal care services hours were provided under consumer direction in 2006.<sup>28</sup>

But financial constraints may keep Vermont from being able to provide all the long-term care services its Medicaid recipients need. In November 2009, its financial cap led Vermont to freeze enrollment in HCBS for the moderate need group.

### Lessons From the States

The innovative actions described in this brief offer important lessons for other states—and, importantly, for the Centers for Medicare and Medicaid Services (CMS), which could change Medicaid rules at the national level, essentially requiring all states to adopt these best practices. A federal directive would de-politicize the process of expanding access to HCBS by equalizing eligibility criteria

and mandated services across states.

To accelerate the process of rebalancing state long-term care budgets and providing a range of care options for consumers, CMS could require states to adopt eligibility requirements and more effective nursing home diversion practices that make HCBS a viable alternative to nursing homes:

- Set the standard income and asset eligibility requirements for Medicaid-funded home- and community-based services at 300 percent or less of the Federal SSI benefit for income and well above \$2000 for assets;
- Implement better spousal protection rules for home- and community-based services;
- Reduce Medicaid-funded nursing home beds to roughly 25 percent of the number of persons expected to need Medicaid long-term care services each year over the next decade;
- Integrate long-term care budgets and administration, so one agency oversees both nursing homes and all home- and community-based services;
- Implement single-points-of-entry for persons seeking

long-term care services, whether in nursing homes or community settings and regardless of age and disability, where case managers, using uniform automated assessment tools and processes, will determine eligibility, assess need and help recipients develop a plan for care in the setting of their choice

- Establish policies to expand and stabilize the workforce, including mechanisms for collective bargaining, in all LTC settings.

Especially since the *Olmstead* decision, states have been looking for effective, cost-efficient ways to rebalance their long-term care systems, and where better to learn what works than from other states? By adopting their best practices of the states near the top of our chart, those near the bottom could streamline a mandated process. Not only could they save themselves time and money, but they could better serve the thousands of their citizens who are in nursing homes when they would rather be at home, or who are simply doing without the long-term care services they need.

## End Notes

<sup>1</sup> In *Olmstead v. L.C.*, the Supreme Court ruled that under Title II of the Americans with Disabilities Act (ADA, 1990) the plaintiffs in the case had the right to receive care in the most integrated (i.e. community) setting appropriate and that their unnecessary institutionalization was discriminatory and violated the ADA. <http://www.law.cornell.edu/supct/html/98-536.ZS.html>. The Court indicated that states should make 'reasonable accommodations' to their long-term care systems, but should not be required to make 'fundamental alterations'. It suggested that compliance might be demonstrated by 'comprehensive, effectively working plans' (*Olmstead Plans*) to increase community-based services and reduce institutionalization, and by ensuring that waiting lists for services move at a 'reasonable pace' (Smith, J.D.E. and Calandrillo, S.P. (2001) *Forward to Fundamental Alteration: Addressing ADA Title II Integration Lawsuits After Olmstead v. L.C.* Harvard Journal of Law & Public Policy, vol.24, Summer, 695. At: [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=694002](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=694002)).

<sup>2</sup> This brief will cover only long-term care for the elderly and physically disabled. People who are intellectually or developmentally disabled are also eligible for Medicaid long-term care services and make up 32% of the participants in long-term care programs. Nationwide, Medicaid spends 66 percent of its long-term care resources on services for the developmentally disabled. The majority is spent on home and community-based care.

<sup>3</sup> <http://www.bls.gov/oco/ocos326.htm>

<sup>4</sup> Kaye, H. Stephen, Charlene Harrington, and Mitchell P. LaPlante. 2010. "Long-term Care: Who gets it, who provides it, who pays and how much?" *Health Affairs*, 29, 1, 11-21.

<sup>5</sup> Mollica, Robert L., Kristin Simms Kastelein, and Enid Kassner. 2009. "State-funded home and community based services programs for older adults," AARP Public Policy Institute, accessed November 8, 2009 at [http://hcbs.org/files/157/7830/State-Funded\\_HCBS\\_for\\_Older\\_Americans.pdf](http://hcbs.org/files/157/7830/State-Funded_HCBS_for_Older_Americans.pdf); Harrington, Charlene, Terence Ng, and Molly O'Malley Watts. 2009. "Medicaid Home and Community-Based Service Programs: Data Update," Issue Brief for Kaiser Commission on Medicaid and the Uninsured, Publication #7720-03, November, accessed January 18, 2010 at

<http://www.kff.org/medicaid/upload/7720-03.pdf>.

<sup>6</sup> In 2002, states spent 12 percent of their general funds on Medicaid. Including federal financing for state programs, states spent 21 percent of their total budgets on Medicaid (Boyd 2003). While Medicaid currently represents less than 1/3 of state general fund expenditures and long-term care is less than 1/3 of that, expenditures on long-term care, most notably home care, are the fastest-growing component of state Medicaid expenditures, which are in turn the fastest-growing component of state budgets. Many of the costs that underlie that growth are hard to control. (Boyd, Donald J. 2003. "Health Care within the Larger State Budget," in *Federalism Health & Policy*, 59-109. Washington, D.C.: Urban Institute Press).

<sup>7</sup> In contrast, acute care for the elderly is provided under Medicare which is funded from a social insurance fund. Because the scope of Medicare services is set at the national level there is no variation across states.

<sup>8</sup> CMS, Office of the Actuary. 2008, *ibid*.

<sup>9</sup> Komisar, Harriet L., J. Feder, and J.C. Kasper. 2005. "Unmet long-term care needs: an analysis of Medicare-Medicaid Dual Eligibles," *Inquiry* 42 (Summer):171-82; Mollica, Robert L., Enid Kassner, Lina Walder and Ari Houser. 2009. Taking the long view: investing in Medicaid home and community-based services is cost-effective. AARP PPI; Harrington, Charlene, Terence Ng, Stephen H. Kaye, and Robert Newcomer. 2009. Home and Community-Based Services: Public policies to improve access, costs, and quality. University of California, San Francisco: Center for Personal Assistance Services, January, Accessed at [http://www.pascenter.org/documents/PASCenter\\_HCBS\\_policy\\_brief.pdf](http://www.pascenter.org/documents/PASCenter_HCBS_policy_brief.pdf), February 3, 2010.

<sup>10</sup> Table sources: C. Harrington, H. Carrillo, and B. Blank. Table 4, "Nursing, Facilities, Staffing, Residents, and Facility Deficiencies; 2003 through 2008," University of California, San Francisco, accessed January 18, 2010 at <http://www.nccnhr.org/sites/default/files/OSCAR%20complete%202009.pdf>; Harrington, Ng, O'Malley Watts. 2009, *ibid* and data online at <http://www.statehealthfacts.org/compare.jsp>; Burwell, Brian, Kate Sredl, and Eiken, Steve. 2008. Medicaid Long Term Care Expenditures FY 2007. Thomson Reuters, October accessed at

- <http://www.hcbs.org/moreInfo.php/doc/2374>, November 2009.
- <sup>11</sup> Blind, aged or disabled persons whose “countable income” does not exceed the SSI benefit level (\$664 in 2010) and whose “countable assets” do not exceed a value of \$2,000 are eligible for SSI. (Green Book 2008 accessed at <http://www.socialsecurity.gov/OACT/COLA/SSIamts.html> accessed January 15, 2010).
- <sup>12</sup> Only 30 states have included the PCS Option in their State Medicaid Long-Term Care Plan. Of those, in only 17 are the “medically needy” eligible for Personal Care Services and in only 17 are there not limits on service hours (Harrington, Charlene, Terence Ng, and Molly O’Malley. 2008. Medicaid Home and Community-based service Programs: Data Update, Issue Paper for Kaiser Commission on Medicaid and the Uninsured #7720-20, December.)
- <sup>13</sup> U.S. Health and Human Services, Office of the Assistant Secretary for Policy Evaluation (ASPE). 2000. Understanding Medicaid Home and Community Services: A Primer. October, accessed at <http://aspe.hhs.gov/daltcp/reports/primer.pdf> January 12, 2010; Harrington, Ng, & O’Malley. 2008, *ibid*.
- <sup>14</sup> Of the 12.7 million Americans who need assistance, 9.5 million get only unpaid care. (Kaye et al.)
- <sup>15</sup> Smith and Calandrillo (2001).
- <sup>16</sup> An analysis of rulings in community integration lawsuits after *Olmstead* has shown that lower courts have generally decided that “evidence of active engagement and slow progress” toward more community-integrated long-term care satisfies the ADA. (Teitelbaum, Joel, Taylor Burke and Sara Rosenbaum, 2004. *OLMSTEAD V. L.C. and the Americans with Disabilities Act: Implications for Public Health Policy And Practice*. Public Health Reports, v. 119(3): 371–374. Accessed at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497630/pdf/15158117.pdf>, February 2, 2010; Ng, Terence Alice Wong and Charlene Harrington. 2009. Home and Community-Based Services: Introduction to *Olmstead* Lawsuits and *Olmstead* Plans, PAS Center, August. Accessed February 3, 2010 at [http://www.pascenter.org/olmstead/downloads/Olmstead8\\_4\\_09.pdf](http://www.pascenter.org/olmstead/downloads/Olmstead8_4_09.pdf)).
- <sup>17</sup> Alexih L., S. Lutzky and J. Corea, Estimated Savings from the Use of Home and Community Based Alternatives to Nursing Facility Care in Three States, (Washington, D.C.: AARP, 1996). More recently, Kaye, et al. (Kaye, H. Stephen, Mitchell P. LaPlante and Charlene Harrington. 2009. “Do noninstitutional long-term care services reduce Medicaid spending?” *Health Affairs*, V. 28, no. 1: 262 – 272) find that initially states costs may increase but after a few years, rebalancing saves states money. SEIU (SEIU Healthcare. 2010. “A Basic Element of Healthcare—Reform for Seniors: Improving Access to Long Term Care and Supports,” An SEIU Healthcare Report, January) reports a projected cost saving to the Federal government, under a scenario in which the federal government increases its share of payments for HCBS, states increase the share of HCBS in response, and using the assumption that states will experience a “woodwork effect” similar to that of Oregon and Washington.
- <sup>18</sup> Kane, Robert L., Richard C. Ladd, Rosalie A. Kane, Wendy J. Nielsen. 1996. Oregon’s LTC System: A Case Study By The National LTC Mentoring Program, accessed March 3, 2010 at <http://www.bcm.edu/ilru/html/publications/pas/ltc.htm>.
- <sup>19</sup> Federal law requires that a community-resident spouse of a nursing home resident retain a minimum amount of income per month (\$1,822 in July 2009) and assets (the greater of \$43,000 or half the couple’s assets up to a maximum of \$109,000), but there is no similar requirement for community-resident spouses of persons in assisted living or other residential care facilities.
- <sup>20</sup> Summer, Laura. 2007. “Community-based long term care services financed by Medicaid: managing resources to provide appropriate Medicaid services,” Georgetown Public Policy Institute, Long term Care Financing Project, Issue Brief, June. Accessed March 3, 2010 at <http://ltc.georgetown.edu/pdfs/summer0607.pdf>.
- <sup>21</sup> Centers for Medicare and Medicaid Services. 2007. Money Follows the Person (MFP) Rebalancing Demonstration, updated June 7, accessed March 3, 2010 at [http://www.cms.hhs.gov/CommunityServices/Downloads/MFP\\_AwardsSummary.pdf](http://www.cms.hhs.gov/CommunityServices/Downloads/MFP_AwardsSummary.pdf); Noelle Denny-Brown and Debra J. Lipson, 2009. Early Implementation Experiences of State MFP Programs, Reports from the Field, no. 3, November, accessed March 3, 2010 at <http://www.cms.hhs.gov/CommunityServices/Downloads/MFPReportNo3Nov09.pdf>.
- <sup>22</sup> Participants undergo the regular HCBS functional assessment and the value of the needed services is then converted into a cash equivalent that is sent to the participant’s bank account every month. Oregon uses a Medicaid 1115 demonstration waiver, which allows the state to circumvent the Medicaid prohibition against consumers hiring a custodial relative such as a spouse or parent. Section 1115 demonstrations are a broad Medicaid waiver authority that can be used by states to design innovative financing and delivery of medical and supportive services for Medicaid recipients. Both Arizona and Vermont now operate their long-term care systems as capitated managed care systems for the provision of long term care services. The Arizona Long Term Care System (ALTCS) provides all Medicaid services to Arizona Medicaid recipients in need of long-term care, including acute medical care services, institutional and HCBS long term care services and case management. (ASPE, *ibid*.; Harrington, Ng, O’Malley Watts. 2009,*ibid*; Kassner, Enid, Susan Reinhard, Wendy Fox-Grage, Ari Houser, and Jean Accius. 2008. “A balancing act: state long term care reform,” AARP Public Policy Institute accessed January 2, 2010 at [http://www.aarp.org/research/ppi/ltc/hcbs/articles/A\\_Balancing\\_Act\\_State\\_Long-Term\\_Care\\_Reform.html](http://www.aarp.org/research/ppi/ltc/hcbs/articles/A_Balancing_Act_State_Long-Term_Care_Reform.html)).
- <sup>23</sup> Illinois has another model for ensuring that the state negotiates with the designated representative of the workers.
- <sup>24</sup> Seavey & Salter, 2006, *ibid*.
- <sup>25</sup> There is no federal cap on funding for programs in a state’s Medicaid plan, including nursing home, home health and the personal care option. Unlike the global budgeting strategy used by Oregon and Washington, Vermont has agreed to contain overall costs—the maximum or capitated budget, regardless of the number of enrollees.
- <sup>26</sup> In contrast, under traditional Medicaid programs, states are entitled to the open-ended matching financing from the federal government through the Federal Medical Assistance Percentage (FMAP).
- <sup>27</sup> Vermont Department of Disabilities, Aging and Independent Living, Division of Disability and Aging Services. 2009. Choices for Care Quarterly Data Report, October. Accessed February 3, 2010 at <http://www.ddas.vermont.gov/ddas-publications/publications-cfc/cfc-qrtrly-data-rpts/cfc-quarterly-report-october-2009>; Crowley, J. and M. O’Malley. 2008. Vermont’s Choices for Care Medicaid Long-Term Services Waiver: Progress and Challenges as the Program Concluded its third Year, Kaiser Commission on Medicaid and the Uninsured, accessed at <http://www.kff.org/medicaid/upload/7838.pdf> November 23, 2009.
- <sup>28</sup> Seavey and Turnham, 2006, *ibid*.

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