

Federal Perspectives

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CMS Releases HCBS Final Rule Defining Community Settings

The Centers for Medicare and Medicaid Services (CMS) has issued the final rule on home and community-based services (HCBS) that includes the definition of community settings. The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for HCBS. In materials accompanying the rule, CMS stated its "intent to ensure that individuals receiving services and supports through Medicaid's HCBS programs have full access to the benefits of community living and are able to receive services in the most integrated setting."

The broad-ranging rule finalizes several proposed rules and addresses several areas of HCBS policy. Among its provisions, the rule:

- Defines and describes the requirements for home and community-based settings appropriate for the provision of HCBS under section 1915(c) HCBS waivers, section 1915(i) State Plan HCBS and section 1915(k) (Community First Choice) authorities;
- Defines person-centered planning requirements across the section 1915(c) and 1915(i) HCBS authorities;
- Provides states with the option to combine coverage for multiple target populations into one waiver under section 1915(c), to facilitate streamlined administration of HCBS waivers and to facilitate use of waiver design that focuses on functional needs;
- Provides new implementing regulations for section 1915(i) State Plan HCBS, revised to include new flexibilities enacted under the Affordable Care Act (ACA) to offer expanded HCBS and to target services to specific populations;
- Allows states to use a five-year renewal cycle to align concurrent waivers and state plan amendments that serve individuals eligible for both Medicaid and Medicare, such as 1915(b) and 1915(c);

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- Provides CMS with additional compliance options beyond waiver termination for 1915(c) HCBS waiver programs;
- Clarifies the timing of amendments and public input requirements when states propose modifications to HCBS waiver programs and service rates.

HCBS Settings The final rule requires that all home and community-based settings meet certain qualifications. These include:

- The setting is integrated in and supports full access to the greater community;
- Is selected by the individual from among setting options;
- Ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint;
- Optimizes autonomy and independence in making life choices; and
- Facilitates choice regarding services and who provides them.

The final rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections;
- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

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In addition to excluding statutorily defined institutional settings, the final rule identifies other settings that are presumed to have institutional qualities, and do not meet the threshold for Medicaid HCBS. These settings, according to a CMS fact sheet, "include those in a publicly or privately owned facility that provides inpatient treatment; on the grounds of, or immediately adjacent to, a public institution; or that have the effect of isolating individuals receiving Medicaid-funded HCBS from the broader community of individuals not receiving Medicaid-funded HCBS." If states seek to include such settings in Medicaid HCBS programs, the fact sheet indicates "a determination will be made through heightened scrutiny, based on information presented by the state demonstrating that the setting is home and community-based and does not have the qualities of an institution."

The fact sheet also points out that the final rule "clarifies that when an individual chooses to receive home and community-based services in a provider owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the individual is choosing that provider, and cannot choose an alternative provider, to deliver all services that are included in the bundled rate." For any services that are not included in the bundled rate, however, "the individual may choose any qualified provider, including the provider who controls or owns the setting if the provider offers the service separate from the bundle."

The final rule also clarifies that, according to the fact sheet, "states, as opposed to individual providers, have the responsibility for ensuring that individuals have options available for both private and shared residential units within HCBS programs." Provider owned or operated residential settings "will be responsible to facilitate individuals having choice regarding roommate selection within a residential setting."

The same fact sheet offers the important note that "CMS has clarified that the rule applies to all settings where HCBS are delivered, not just to residential settings," and indicates that CMS "will be providing additional information about how states should apply the standards to non-residential settings, such as day program and pre-vocational training settings."

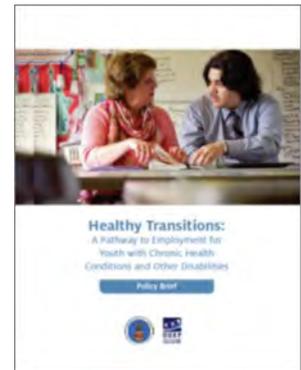
The final rule includes a provision requiring states offering HCBS under existing state plans or waivers to develop transition plans to ensure that HCBS settings will meet final rule's requirements. For currently approved 1915(c) waivers and 1915(i) state plans, states will need to evaluate the settings currently in their 1915(c) waivers and 1915(i) state plan programs and, if there are settings that do not meet the final regulation's home and community-based settings requirements, work with CMS to develop a plan to bring their program into compliance. CMS will afford states a maximum of a one year period to submit a transition plan, and CMS may approve plans for a period of up to five years, as supported by an individual state's circumstances, although material accompanying the rule emphasizes that "CMS expects states to transition to compliance in as brief a period as possible and to demonstrate substantial progress toward compliance during any transition period." States submitting a 1915(c) waiver renewal or waiver amendment within the first year after the effective date of the rule need to submit a plan that lays out timeframes and benchmarks for developing a transition plan for all the state's approved 1915(c) waiver and 1915(i) HCBS state plan programs within 120 days of the submission of the renewal or amendment. New waivers or state plans must meet the new requirements to be approved. CMS indicates it will be issuing future guidance to provide the details regarding requirements for transition plans.

Person-Centered Planning In the final rule, CMS specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed "through a

(HCBS Final Rule continues on page 4)

ODEP Study Examines Intersection of Health Care and Employment

The Office of Disability Employment Policy (ODEP) has released a new study on health care, transition and employment. ODEP commissioned the study in 2012 to "better understand the relationship between disability (including chronic health conditions); health and wellness; and transition and employment outcomes for youth with disabilities." In addition, the study examines the role health care providers play in establishing employment expectations.



The study indicates that youth with chronic health conditions and other disabilities face a number of challenges in accessing health care transition services. Included among these are "low expectations, lack of time, and inadequate payment and training related to employment among providers; systems with distinct and disparate outcomes and goals, and the application of a biological/physiological versus bio-psychosocial treatment approach."

The study team offers recommendations, including highlighting the need to:

- underscore the interdependence between health and wellness, and employment through education and outreach to youth and their parents and other caring adults; and
- provide health-care providers and other youth service professionals with professional development opportunities to gain the knowledge, skills and abilities needed to guide youth through a coordinated self-determined, cross-discipline transition planning process.

FMI view the full policy brief at www.dol.gov/odep/pdf/2013ODEPHealthyReport.pdf.

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person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals." The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative whom the individual has freely chosen and others chosen by the individual to contribute to the process.

The rule has an effective date of 60 days from publication, meaning the one year states have to develop a transition plan is expected to begin in March.

FMI CMS has placed links to several important items regarding the new rule defining HCBS settings at www.medicaid.gov/hcbs, including:

- The text of the Final Rule
- An Information Bulletin on the Final Rule
- A press release announcing the Final Rule
- Four factsheets:
 - An overview of the regulation
 - Changes to 1915(c)
 - Changes to 1915(i)
 - Summary of Key Provisions 

CMS Delays Approval of Kansas Managed Care Amendment; NCD Voices Concerns About Amendment

The Centers for Medicare and Medicaid Services (CMS) last month delayed the approval of a proposed 1115 Waiver Amendment by the state of Kansas to incorporate long-term services and supports (LTSS) for persons with intellectual/developmental disabilities into the state's managed care program, known as KanCare (the amendment has since been approved). In a letter to Kansas informing the state of the delay, CMS asked for additional information regarding developing and assessing service plans, needs assessment tools, and provider capacity. In addition, CMS asked Kansas to develop a stakeholder engagement plan regarding the state's proposed process to address its "underserved" waiting list, and provide a process for assessing the needs of those currently on the underserved waiting list and ensuring they are met.

NCD Issues Recommendations for KanCare

The National Council on Disability (NCD) sent a letter to the Centers for Medicare and Medicaid Services (CMS) expressing appreciation for the agency's recent decision to delay the approval of Kansas' proposed amendment to the State's KanCare Section 1115 demonstration project, and offering "recommendations on appropriate safeguards ... CMS should incorporate into the KanCare demonstration prior to approval of Kansas' 1115 amendment." CMS has delayed approval of the proposed 1115 Waiver Amendment, which would incorporate long-term services and supports (LTSS) for persons with intellectual/developmental disabilities into the state's managed care program, and asked for additional information regarding developing and assessing service plans, needs assessment tools, and provider capacity.

In the letter, NCD says it "believes that Medicaid managed care can be a positive force for controlling costs and improving outcomes, if it is implemented with good program design and the necessary safeguards to ensure beneficiary rights." NCD goes on to outline "a number of recommended program design changes and benchmarks for Kansas to undertake prior to the approval of their proposed 1115 amendment." While the proposed 1115 amendment relates specifically to people with intellectual and developmental disabilities (I/DD), many of these recommendations apply across all populations who utilize Managed Long-Term Services and Supports (MLTSS). These include:

1. Kansas should "demonstrate statewide stakeholder engagement and assistance in the construction of its revised waiver application."
2. Kansas should "commit and demonstrate success in bringing itself into compliance with its obligations under its current 1915(c) waiver, including serving the full number of people Kansas committed to serving in its 1915(c) waiver application and all people on its 'underserved' waiting list."

(NCD Recommendations continues on page 6)

The National Council on Disability (NCD) recently weighed in on the KanCare Section 1115 Amendment, recommending in a public letter that CMS not approve the portion of the Amendment that would transfer the state's Intellectual Disabilities/Developmental Disabilities (I/DD) Waiver into managed care, and instead should "delay its consideration of Kansas' proposed 1115 Waiver amendment for 12 months, pending the completion of an extended review by CMS of the concerns raised by both Kansas stakeholders and NCD." Additionally, NCD recommended that CMS "require specific changes to the structure of KanCare's application to people with intellectual or developmental disabilities, such as an end to the institutional carve-out, and providing for a more robust and independent Ombudsman's program."

NCD raised caution about the process for review and consideration of stakeholder concerns by both Kansas and CMS, the exclusion of public Intermediate Care Facility (ICF) institutional services and supports into the proposed waiver, and reported payment delays to providers. Further, NCD called on CMS to require Kansas to eliminate

(Kansas continues on page 6)

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the "'underserved' waiting list and [provide] all necessary services to the upwards of 1,700 Kansans on it." NCD expressed the opinion that "approval of Kansas' managed care demonstration for people with I/DD should be predicated on successful compliance with Kansas' existing commitments under the 1915(c) waiver."

NCD offered specific recommendations with regard to KanCare, including:

- The development of a "successful regional pilot project that tests, documents, and evaluates what the State is proposing with the shift of the I/DD Waiver into its 1115 Amendment Demonstration" before such a shift is approved;
- Requirement by CMS that Kansas "include all institutional services within the 1115 Demonstration should it desire to shift HCBS services for people with I/DD into KanCare;"
- A "12-month delay of further consideration of the proposed amendment pending the completion of an extended review by CMS of the concerns raised by both Kansas stakeholders and NCD;"
- Creation by CMS of a definition of medical necessity that includes long-term supports and services (LTSS);
- Careful review by CMS of Kansas' medical loss ratio requirement, as well as the "issuance of technical assistance to other states regarding the applicability of this tool to managed care demonstrations involving complex populations, such as people with disabilities."

The specifics of the request for information from CMS, along with the letter from NCD, also a federal agency, may offer some sense of the types of requirements the federal government will likely expect from states seeking to incorporate I/DD services into their Medicaid managed care systems in the future. The CMS letter indicates that the 90-day waiver request review period, scheduled to end December 29, 2013, has been stopped as a result of the agency's request for information, and will a new 90-day clock will begin when CMS has received Kansas' response.

FMI The CMS letter is available at www.nasdds.org/pdf/CMSletterdelay.pdf. The NCD letter can be found at www.ncd.gov/publications/2013/12132013/. 

(NCD Recommendations continued from page 5)

3. Kansas should "operate during the next 12 months a regional... I/DD pilot project consistent with the managed care model proposed in its 1115 amendment request for the state I/DD system" and create "a robust Demonstration Implementation Council to monitor, oversee, and amend, as needed the 1115 DD Waiver for statewide application based upon the successes or limitations of the regional pilot."
4. Kansas should "amend its proposed 1115 amendment to remove carving out of public Intermediate Care Facilities from the managed care framework."
5. Kansas should "establish a robust and independent Ombudsman's office... located outside of any agency that administers or manages Medicaid services."
6. CMS should require Kansas "to ensure that MCOs maintain a maximum ratio of care coordinators to beneficiaries of no more than 1:40 for people with I/DD."
7. CMS should require Kansas "to submit a plan and documentation showing how implementation of such a plan will ensure that all consumers receiving MLTSS that are subject to changes or reductions in service will receive written notice along with information on their due process rights, with documentation to demonstrate that consumers will not be subjected to a more cumbersome or time-consuming process."

NCD suggests that "implementation of the recommendations noted above would help ensure the successful implementation of KanCare and protect people with disabilities from adverse unintended consequences." 

IRS Says it Will Treat Difficulty of Care Payments to Family Members as Tax Exempt

The Internal Revenue Service (IRS) has issued a notice providing that the Service will treat qualified Medicaid waiver payments for care provided to any individual who is living in a "foster family home" in which the individual was "placed" by an agency of a state or a political subdivision thereof, or a qualified foster care placement agency, as difficulty of care payments, which excludable income under §131 of the Internal Revenue Code even if the care provider is related to the eligible individual. Previously, the IRS held the position that a caregiver of a biological relative receiving qualified Medicaid waiver payments may not qualify as a foster care provider under section 131; this notice reverses that position, meaning that stipends to family members to meet the cost of supports provided to their adult family members who live with them can now be treated as tax-exempt.



Section 131 does not explicitly address whether payments under Medicaid waiver programs are qualified foster care payments. Medicaid waiver programs and state foster care programs, however, share similar oversight and purposes, according to the IRS notice, and therefore the IRS considers them qualified foster care payments as long as they meet all other requirements. Similarly, the term "placed" is not defined in § 131. However, the notice points out, "under state foster care programs, a state or political subdivision thereof, or a qualified foster care placement agency, may assist in locating a home that meets the qualified foster individual's needs, negotiate or approve the foster care payment rates, and contract with the foster care providers for the provision of foster care," and "the Tax Court has determined that these activities constitute 'placement' for purposes of § 131(b)(2)."

Section 131(d)(2) provides that a provider may not exclude payments for the care of more than 10 eligible individuals under age 19 or more than five eligible individuals who are age 19 or over. Because qualified Medicaid waiver payments are difficulty of care payments, they are subject to these limits. The notice does not address whether qualified Medicaid waiver payments excluded from income under this notice may be subject to tax under the Federal Insurance Contributions Act (FICA) or the Federal Unemployment Tax Act (FUTA) in certain circumstances. This notice is effective for payments received on or after January 3, 2014.

FMI The bulletin is available at www.irs.gov/irb/2014-4_IRB/ar06.html. 

Issue Brief Addresses State Policy Issues Related to ACA Essential Health Benefit Standards

Sara Rosenbaum, the Harold and Jane Hirsh Professor of Health Law and Policy at the George Washington University School of Public Health and Health Services, has published an issue brief analyzing "how habilitative services may be covered under the Essential Health Benefits [EHB] Provisions of the Affordable Care Act [ACA]." Rosenbaum notes that "states will play a primary role in determining Essential Health Benefits," and that "establishing state standards for health insurance plans sold in the individual and small group markets will be key to health policy for children with disabilities."

The ACA establishes coverage standards for the individual and small group health insurance markets, and defines EHB to include and habilitative services and devices. Rosenbaum suggests that the

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NCD Continues to Signal Support for Eliminating Subminimum Wage

The National Council on Disability (NCD) recently wrote to the United States Department of Justice (DOJ) Civil Rights Division in support of their "efforts against segregated day and employment activities, including sheltered workshops and facility-based day programs," and specifically to applaud the recent investigation of Rhode Island's Birch Vocational School.

In the letter, the latest example of NCD's continuing activity around subminimum wage issues, NCD commends DOJ for "consistently taking constructive action using all enforcement tools available, working in tandem with other federal partners such as the Department of Labor and the Centers for Medicare and Medicaid Services." According to NCD, the work of the DOJ "has accelerated the transition away from sheltered workshops and towards integrated employment at competitive wages in states across the country." The advisory group urges DOJ to "work closely with partners across the federal government to hold states to their commitment to end the use of sheltered workshop settings and support people with disabilities in real jobs for real pay." NCD has met with DOJ several times recently in support of its actions.



NCD Urges White House to Include Subminimum Wage Workers in Minimum Wage Hike for Federal Contractors

The National Council on Disability (NCD), an independent federal agency that advises Congress and the administration regarding laws, policies, practices, and procedures that affect people with disabilities, recently sent a letter to the White House regarding the impending executive order to raise the minimum wage for employees of federal contractors, urging the administration to apply the full increase to individuals with disabilities currently working for federal contractors at subminimum wage.

The letter calls on the White House to "explicitly state in the executive order that the increase in minimum wage for employees of federal contractors applies to all employees of federal contractors, including the thousands of Americans with disabilities who are currently being paid less than the minimum wage under the Section 14(c) program." Additionally, NCD urges the administration "to publicly state its support for congressional action to phase out and eliminate the 14(c) program for all workers."

FMI The letter is available at www.ncd.gov/publications/2014/01232014/. ↗

FMI The letter is available at www.ncd.gov/publications/2014/01302014/. ↗

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"implementation approach taken by the Obama Administration makes state law the primary source of regulatory policy in defining EHBs," and points out that the Administration has "elected to give broad deference to the health insurance industry to define the level of habilitative services coverage." Under federal regulations issued in February 2013, "insurers will be permitted not only to define the benefit but also to engage in 'substitution' of greater rehabilitative services for adults in favor of lesser habilitative services for children." Key regulatory issues for states, Rosenbaum says, "encompass coverage definition, permissible limitations and exclusions, medical necessity evaluation, the permissibility of substitution, and the interaction between habilitative services and mental health parity."

FMI The issue brief is available at cshcn.wpengine.netdna-cdn.com/wp-content/uploads/2013/05/Habilitative-Services-Issue-Brief-6-20-13.pdf. ↗

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Knowing Our History...

The Turning Point in Federal I/DD Aid to States

By Bob Gettings
Founding Executive Director of NASDDDS

As part of NASDDDS' 50th anniversary celebration, this is the third in a year-long series of articles on the history of federal financial support for developmental disabilities services and the role the association has played in shaping such policies.

The era of the New Frontier and the Great Society had passed by the time the National Association of Coordinators of State Programs for the Mentally Retarded (NACSPMR) opened a headquarters office in the Washington, D.C. area in the fall of 1970. Richard Milhous Nixon had been elected the 37th president of the United States in November 1968, running on a platform that promised a far more conservative social agenda than those pursued by President Kennedy and President Johnson. Advocates of social reforms expected to encounter strong executive branch resistance to further expansions in federal health and human service programs; and, on many fronts, these expectations were realized. Yet, to the surprise of most political prognosticators, the early-to-mid 1970s ended up being a period in which the entire face of disability policy in the United States changed and, along with it, the balance of power between the federal government and the states.

When the Nixon administration assumed office in January 1969, the federal government provided very little financial aid to state and local agencies responsible for assisting children and adults with severe disabilities. The U.S. Department of Health, Education, and Welfare estimated that in fiscal year 1969 total departmental expenditures for research, training, income maintenance and services on behalf of children and adults with mental retardation amounted to less than half a billion dollars (\$496.9 million); and, of this total, only about 40 percent (\$201.8 million) was devoted to direct services to persons with intellectual disabilities.¹ Furthermore, any statutory rights afforded to individuals with disabilities were established under state, not federal, law.

The situation changed markedly, however, during President Nixon's first term. By the mid-1970s, the historic restrictions on the role of the federal government in the disability arena had been removed and a solid statutory foundation had been laid for assisting persons with disabilities. Between 1970 and 1975, Congress approved and the president signed into law the following statutes:

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- The Developmental Disabilities Services and Facilities Construction Act of 1970, which expanded the qualifying categories of disability beyond mental retardation and established an ongoing infrastructure to support planning, program development and training within each state;
- The Social Security Amendments of 1972, which federalized income maintenance benefits for elderly, blind and disabled individuals by creating the Supplemental Security Income program. Henceforth, the eligibility of all low income elders and non-elderly persons with disabilities was to be judged against uniform national income and disability criteria and all beneficiaries were to be guaranteed minimum monthly federal payments (which states were free to supplement if they elected to do so);
- The Rehabilitation Act of 1973, which: (a) established specific non-discrimination rights in federal law for individuals with disabilities participating in any federally assisted program or activity; and (b) directed state vocational rehabilitation agencies to assign priority to serving individuals with "the most severe handicaps;"
- 1971 amendments to Title XIX of the Social Security Act allowing states to offer "intermediate care facilities for the mentally retarded" as an optional coverage under their Medicaid state plans. The passage of this legislation introduced federal cost sharing into, initially, institutional services and, later, community-based long-term services for persons with intellectual and developmental disabilities; and
- The Education for All Handicapped Children Act of 1975, which established a separate federal grant-in-aid program for educating children with disabilities and committed the federal government to assuming a set percent of the overall cost of furnishing educational services to such children. But, more importantly, the legislation embedded in federal law a zero reject policy, guaranteeing all children access to a free and appropriate public education regardless of the nature or the severity of their disabilities.

By the end of 1975, the basic planks of the federal disability edifice were in place. Responsibility for assisting individuals with chronic disabilities no longer was vested exclusively in state and local governments. The federal government had assumed a broad, pro-active role in assuring that Americans with disabilities are treated as first class citizens and gain access to the services and supports they needed.

Many important federal policy changes would occur in subsequent years. Pressed by disability advocates, Congress and succeeding administrations would build upon the foundation that had been laid by 1975. Programs established during this period would be fleshed out through a lengthy series of appropriation and substantive legislative actions. For example, the passage of the Americans with Disabilities Act in 1990 extended the concept of federal civil rights for people with disabilities, first articulated in Title V of the Rehabilitation Act of 1973, to privately funded endeavors as well as activities sponsored by state and local governments. Similarly, the addition of the home and community-based waiver authority in 1981 provided the basis for a vast expansion and re-direction of long-term supports for low income individuals with developmental disabilities; this expansion, however, would not have been possible without the establishment of the ICF/MR state plan coverage option in 1971 (see forthcoming article in this series).

FMI For additional information on the changing role of the federal government in supporting I/DD service, see, *Forging a Federal-State Partnership: A History of Federal Developmental Disabilities Policy* by Robert M. Gettings, 2011. Copies of the book can be ordered via the [NASDDDS](#) website. 

ⁱ U.S. Department of Health, Education, and Welfare, Secretary's Committee on Mental Retardation, *Mental Retardation Activities of the Department of Health, Education and Welfare*, January 1970. U.S. Government Printing Office: Washington, D.C.

OAA Reauthorization Would Expand Family Caregiver Program



Bernie Sanders

Bernie Sanders (VT-I) introduced The Older Americans Reauthorization Act, S. 1562, several months ago, and the Senate Health, Education, Labor and Pensions (HELP) Committee approved the bill by voice vote in October, but the bill has stalled until a funding formula issue regarding the number of elderly persons in a state is resolved. While the bipartisan bill is a fairly simple reauthorization of most of the Older Americans Act (OAA), it makes changes to National Family Caregiver Support Program that will be significant to people with disabilities.

Language in the reauthorization bill would ensure that older adults caring for adult children with disabilities and older adults raising children under 18 are eligible to participate in the Family Caregiver Support Program. Current language suggests that while other relatives may participate, parents are prohibited from receiving funding or services through the program. The changes would increase the availability of resources for family caregivers of individuals with I/DD.

FMI To read the bill or track it's progress, go to beta.congress.gov/bill/113th/senate-bill/1562. ↗



! MARK YOUR CALENDAR !
 NASDDDS Mid-Year Conference
 June 4-6, 2014 ♦ New Orleans, Louisiana
 ~ REGISTRATION OPENS SOON ~



The conference will focus on supports and services for people with co-occurring intellectual/developmental disabilities and mental health support needs and provide practical solutions and examples of community living, treatment, and support.
 Stay tuned for conference details and registration.

CMS Updates Medicaid Expenditure Reports

One updated report and two new reports on Medicaid long-term services and supports (LTSS) are now available on the Centers for Medicare and Medicaid Services' (CMS') website. The updated report is the annual Medicaid LTSS expenditure report for FY 2011. The first new report is a companion to the LTSS Expenditures report that highlights spending from 1915(c) home and community-based services waivers. The second new report summarizes data about 1915(c) waiver programs submitted by states on the CMS 372 report.

The updated report corrects double-counting of managed care expenditures for 1915(c) waivers in five states. The impact on national data is small:

The increase in total LTSS spending in 2011 was 0.8 percent, not 0.7 percent
 The increase in total non-institutional LTSS spending in 2011 was 1.9 percent, not 1.8 percent
 LTSS accounted for 33.1 percent of total Medicaid spending in 2011, not 33.2 percent
 LTSS accounted for 34.6 percent of total Medicaid spending in 2010, not 34.7 percent

The CMS 372 includes both expenditures and participant information. Because the data source is different, the expenditures reported in that report are not exactly the same as those reported in the CMS-64 reports.

FMI The reports are available at www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Long-Term-Services-and-Support.html. ↗