STATEMENT OF

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ON

THE ADA AND *OLMSTEAD* ENFORCEMENT: ENSURING COMMUNITY OPPORTUNITIES FOR INDIVIDUALS WITH DISABILITIES

BEFORE THE

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Hearing on "The ADA and *Olmstead* Enforcement: Ensuring Community Opportunities for Individuals with Disabilities"

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Chairman Harkin, Ranking Member Enzi, and Members of the Committee, thank you for the invitation to discuss the Centers for Medicare and Medicaid Services' (CMS) role in encouraging and supporting community-based services and supports for individuals in need of long-term care. The Medicaid program plays a critical role in assuring that these services and supports are available and in promoting State efforts to comply with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's decision in *Olmstead v. L.C.* Working with the disability and aging communities, as well as States, CMS is currently building upon several current initiatives and looks forward to expanding State options that will ensure that Medicaid beneficiaries living with disabilities have the opportunity to receive the care they need in the community.

I would like to begin by commending the work of Chairman Harkin and this Committee on the improvements in this area that are part of the recently enacted Affordable Care Act (ACA). Your tireless commitment to improving the lives of Americans with disabilities, as demonstrated by your instrumental contributions to passage of the ADA, manifested itself again in the inclusion of the Community First Choice Option program and other notable improvements to the Medicaid program within this important legislation.

Since the passage of the ADA and the *Olmstead* decision, the nation has made great progress toward improving and expanding community living opportunities for people living with

disabilities. Over the past 10 years, funding for long-term care services has grown at an average annual rate of 6.3 percent, while spending on community-based long-term services and supports has increased by an average of 11.8 percent per year from $17 billion in 1999 to $52 billion in 2009.[1] Annual Medicaid expenditures for community-based services have increased from a national average of only 27 percent of total Medicaid long-term care expenditures to almost 45 percent of long term care expenditures over the period.[2] More than half of all Medicaid LTC beneficiaries now receive services in community settings.[3] However, the demand for community services continues to grow, and many individuals in need of these services struggle without them. And while the number of people served in community settings has grown, there are still over 1.6 million Americans receiving services in institutions, many of whom would prefer to receive services at home; and many more individuals are at risk of institutionalization, waiting for access to community based services. In addition, on-going State budget constraints threaten the progress that has been achieved, raising concerns about compliance with the ADA and *Olmstead*. In response to State budget constraints, however, the Administration has requested $25.5 billion in its FY 2011 budget submission to Congress for a six month extension of the Recovery Act's temporary FMAP increase.

In this context, we are very committed to moving forward with existing and new initiatives. Our commitment at CMS is, of course, shared Administration-wide. In June 2009, President Obama announced the "Year of Community Living" to mark the 10th anniversary of the *Olmstead v. L.C.* decision. In that decision, the U.S. Supreme Court affirmed that States are obligated to serve individuals in the most integrated setting appropriate to their needs, and held that the unjustified

[1] Thomson Reuters analysis of CMS Form 64 Reports, 2010
[2] Thomson Reuters analysis of CMS Form 64 Reports, 2010
[3] Thomson Medstat, Medicaid Long Term Care Data Chartbook, CMS, 2003

institutional isolation of people with disabilities is a form of unlawful discrimination under the ADA.

Following the President's announcement, Secretary Sebelius established the Community Living Initiative, led by the Department of Health and Human Services (HHS), but designed to coordinate the efforts of several Federal agencies, including CMS, to implement comprehensive solutions that address barriers to community living for individuals with disabilities and older Americans. Under this initiative, HHS is partnering with the Department of Housing and Urban Development (HUD) to improve access and affordability of housing for people with disabilities and older Americans with long-term care needs. In addition to the work of the Community Living Initiative to remove barriers and provide better options for community integration, the HHS Office for Civil Rights is collaborating with the U.S. Department of Justice (DOJ) to advance enforcement of the ADA under the directive of the *Olmstead* decision.

As you also know, Congress included several mechanisms in the Affordable Care Act to address gaps in the availability of community services for individuals with disabilities. The passage of the ACA provides new and expanded opportunities to serve more individuals in home and community-based settings and adds to the tools already available so States can implement the integration mandate of the ADA as required by the *Olmstead* decision.

As we work within the broad scope of the Community Living initiative and the new authorities provided under the ACA, CMS is also deepening its efforts in this area. On May 20, 2010, CMS issued a letter to all State Medicaid Directors (SMD) to underscore the importance of continuing

to make progress consistent with the *Olmstead* decision and to provide States with information on both new and existing tools for community integration and to reiterate our support for community living options for Medicaid beneficiaries living with disabilities. I would like to take this opportunity to discuss several of these existing approaches in more detail and also to touch on exciting new opportunities under the ACA.

Waiver and State Plan Options

The core mechanism that States have used to promote access to community-based services and supports for Medicaid beneficiaries is through the Home and Community-Based Services (HCBS) waiver. We are continuously reviewing and assessing our policies and practices to identify ways in which the Medicaid program can assist States in achieving the requirements of the ADA, including assisting States in efforts to serve more individuals in community settings. Forty-eight States are operating over 300 HCBS waivers that serve over a million individuals with disabilities. In 2009, HCBS services under both State plans and waiver programs comprised 45 percent of Medicaid spending on long-term care. This demonstrates impressive growth in community-based options of approximately 13 percent since 2008 alone, while overall spending on community options has tripled since 1999.[4]

We must acknowledge, however, that there are significant disparities across States in the level of investment in community services. The percent of Medicaid long-term care funding directed toward HCBS varies among States from 14 to 75 percent. In addition, the HCBS investment varies significantly among different target populations. The opportunities afforded under the

[4] Thomson Reuters analysis of CMS Form 64 Reports, 2010

ACA hold great promise for all States to move forward in expanding HCBS options for all individuals with long-term care needs.

The State plan options under Sections 1915(i) and 1915(j) of the Social Security Act (the Act) provide States with opportunities to serve individuals in the most integrated setting without the requirement of a waiver. Section 1915(i), which permits States to provide HCBS as a State plan option, allows States to serve individuals in the community without linking the benefit to either a current or future need for institutional care. As of today, five States have taken up the 1915(i) State plan option: Iowa, Wisconsin, Washington, Nevada, and Colorado. States have found the section 1915(i) option to have particular promise for improving access to community-based services for individuals with mental and substance use disorders, a group which has been an underrepresented element of previous waiver populations. With the reforms enacted by the ACA, the State plan option offers even greater promise as a tool to prevent institutionalization and to meet mental health service needs in additional States. The ACA has also provided for broader financial eligibility rules and a more expansive array of services.

Section 1915(j) allows States to design self-directed personal assistance or other HCBS for individuals who would otherwise receive State plan personal care or HCBS waiver services. While not changing the services available to individuals, 1915(j) gives States flexibility in offering individuals the opportunity to exercise maximum choice and control over their services. States offering services under 1915(j) authority include Arkansas, Florida, New Jersey, California, Oregon, Alabama and Texas.

Money Follows the Person (MFP) Grants

CMS also operates the Medicaid Money Follows the Person (MFP) grant program, which was authorized in the Deficit Reduction Act of 2005. MFP assists States in their efforts to reduce reliance on institutional care, develop community-based long-term care opportunities, and transition individuals living in institutions to community living. MFP provides enhanced federal matching funds to serve individuals who move from institutional care to community integrated LTC settings. Originally set to expire next year, the MFP program was extended through September 30, 2016 under Section 2403 of the ACA, with an additional appropriation of more than $2 billion. The ACA also modified the time Medicaid beneficiaries must reside in institutions so those individuals who do not reside in a facility for a long-term stay will qualify for MFP at three months rather than six months. Now in its third year, the MFP program has made it possible for almost 6,000 people to live more independent lives by providing necessary supports and services in the community. Currently, twenty-nine states and the District of Columbia have MFP programs. The extension and expansion of MFP under the ACA will allow current MFP states to assist more individuals to move to community settings and allow additional states to initiate MFP programs.

We recognize that much more can be done through this demonstration authority to expand its reach to more beneficiaries who could benefit from this approach. The extension and expansion of MFP under the ACA will allow current MFP states to assist more individuals to move to community settings and allow additional states to initiate MFP programs. CMS is finalizing a letter to State Medicaid Directors providing guidance on the MFP extension and expects to announce a new MFP grant solicitation this summer.]

Aging and Disability Resource Centers (ADRC)

The Aging and Disability Resource Centers (ADRC) program, a collaborative effort of the Administration on Aging (AoA) and CMS, is designed to streamline access to long-term care services and supports. ADRCs play a critical role in supporting health and long-term care reform by improving the ability of State and local governments to effectively manage the system, monitor program quality, and measure the responsiveness of State and local systems of care. ADRCs now operate in at least one community in each of the 50 States and in four Territories. There are currently more than 200 ADRC sites across the nation. A growing number of ADRCs have Medicaid applications available on the Internet with seven of these allowing consumers to complete and submit the application online. The ACA provides the opportunity for CMS, in collaboration with its HHS partners, to expand the ADRC program and similar models to ensure streamlined access to information and service supports.

The Person-Centered Hospital Discharge Planning Model Grants, created under the ADRC program, provides another avenue to strengthen person-centered planning and community-based long-term care. CMS awarded 10 of these grants between 2008 and 2009, totaling approximately $12 million. These grants are designed to assist States in developing hospital discharge planning structures and processes that will place greater emphasis on involving consumers and their families in after-care plans, including community-based alternatives to institutional care. Grantee efforts to date include: development of discharge planning checklists; patient and caregiver information kits and hospital staff training webinars; enhancing online resource directories; developing electronic referral, application, and tracking systems; and

employing transition coaches to follow-up with individuals once they are discharged from the hospital back into the community.

CMS looks forward to continuing to work closely with the AoA on the expansion of the ADRC program under the provisions of the ACA. Improving the hospital discharge planning process and enhancing community-based long-term care options are essential elements of an effective community based long-term care system.

New Infrastructure Reforms

In addition to the initiatives described above, the ACA created new grant funds and enhanced Medicaid financing to support State efforts to create more balanced long-term care services and support systems. The new authorities provided by Congress under the ACA will allow CMS to sustain and expand Federal support for States to provide long-term care services in a community setting.

One provision in the ACA, known as the Community First Choice Option, establishes a new Medicaid State Plan option, effective October 1, 2011, to allow States to cover home and community-based attendant services and supports for individuals with incomes not exceeding 150 percent of the Federal poverty level (FPL) or, if greater, the income level for an individual who has been determined to require an institutional level of care. It also requires States to make such services and supports available to individuals under a person-centered plan of care for purposes of assisting them in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing. States

are provided an additional six percentage point increase in Federal Medicaid matching funds for services and supports provided to such individuals. This increased match rate is a strong incentive for States to reorient spending to sustain these programs. Thank you, Mr. Chairman, for your leadership on the Community First Choice Option.

Moreover, we hope that in this time of State budgetary constraints, there will be great interest in the provisions that offer States additional resources to effectuate widespread changes to their long-term care support systems to better serve people with disabilities and chronic conditions. The increased Federal match offered under the Balancing Incentive Program and the Health Home Initiative will not only expand access to key home and community-based services, but also provide incentives for States to build lasting infrastructure to integrate behavioral and physical health, improve care coordination, and offer health promotion services for people with chronic conditions.

Availability of Technical Assistance

CMS also currently offers a variety of resources for technical assistance to States regarding the design and operation of their Medicaid programs. While we understand that States face unprecedented budget shortfalls, we also recognize that the Medicaid program provides strong partnership opportunities between CMS and States to support community integration for people with disabilities. As part of this partnership, CMS is committed to providing targeted technical assistance to States to help them meet their obligations under the ADA. Specifically, CMS will, at the request of a State, work with the State to identify the Medicaid coverage, reimbursement and service delivery options available to increase a State's system capacity to serve individuals

in the community. Technical assistance also can help identify and support development of the strategies States can employ to ensure that services meet the needs and preferences of each individual.

CMS offers technical assistance through a number of vehicles. The National Quality Enterprise (NQE) is designed to assist States in developing and improving the structures to ensure the health and welfare of individuals served through HCBS waivers and State plan options. The NQE, which provides assistance at no cost to States, is a valuable resource that States can use to design and improve their quality improvement systems.

Another source of technical assistance is provided through the MFP Rebalancing Demonstration. This aspect of the MFP demo provides direct technical assistance to participating States to reduce reliance on institutional care while developing community-based long-term care opportunities, enabling the elderly and people with disabilities to fully participate in their communities. In addition, CMS supports the ongoing operation of the National Direct Service Workforce (DSW) Resource Center. The DSW Resource Center supports efforts to improve recruitment and retention of direct service workers who help people with disabilities and older adults to live independently and with dignity. This Resource Center brings together the nation's premier resources on the topic of Direct Support Workforce and provides State Medicaid agencies, researchers, policymakers, employers, consumers, direct service professionals, and other state-level government agencies and organizations easy access to information and resources they may need about the direct service workforce. These resources, which include

web-based clearinghouses, technical experts, training tools and more, are designed to address the full range of DSW consumer populations.

Additionally, CMS has published a technical assistance guide, entitled *Long Term Services and Supports in a Managed Care Delivery System*, which describes the various Medicaid authorities and structures that States can use to enhance the availability of HCBS within managed care delivery systems. These managed care delivery systems allow for the use of capitation payments with both institutional and HCBS services in a global budget, where the resources available to support an individual can follow the individual wherever they choose to receive their services. CMS is working to ensure that managed care arrangements encompassing long-term services and support include all necessary safeguards and protections to ensure the health and welfare of individuals served.

Implementation of Preadmission Screening and Resident Review (PASRR)

Another mechanism currently available to States is the Preadmission Screening and Resident Review (PASRR) process. Congress developed the PASRR program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities. Under Federal requirements, States must assure that individuals with mental disabilities or developmental disabilities being considered for admission to a nursing facility are evaluated through the PASRR process to determine the most integrated setting that can meet their needs. CMS has established the new National PASRR Technical Assistance Center, which provides technical assistance to States, at no cost, to facilitate this reform activity. PASRR is a powerful tool for diversion from

institutions, and the resident review elements of PASRR are important tools to help encourage transitions to the community.

Access to Affordable Housing as a Means to Maximize Opportunities for Community Living

The lack of accessible and affordable housing continues to be an obstacle to serving individuals in the most integrated setting. As part of the Community Living Initiative, HHS has partnered with HUD to improve access to affordable housing for people with disabilities. HHS and HUD collaborated to provide housing support for non-elderly persons living with disabilities to live productive, independent lives in their communities rather than in institutional settings. HUD is offering approximately $40 million to public housing authorities across the U.S. to fund approximately 5,300 Housing Choice Vouchers for non-elderly persons with disabilities, allowing them to live independently. HHS will use its network of State Medicaid agencies and local human service organizations to link eligible families to local housing agencies who will administer voucher distribution.

Of the 5,300 vouchers set aside as part of this program, up to 1,000 will be specifically targeted for non-elderly individuals with disabilities currently living in institutions but who could move into the community with assistance. The remaining 4,300 may be used for this purpose also, but are targeted for use by non-elderly disabled families in the community to allow them to access affordable housing that adequately meets their needs. HUD expects to have funding awards ready before the end of 2010.

Looking Forward

July 26 will mark the 20th anniversary of the enactment of the ADA. Much progress has been made over the past 20 years to improve the quality of life for individuals with disabilities in the United States, but the work remains unfinished. CMS recognizes the significant progress made since the passage of the ADA and the *Olmstead* decision, but we strongly believe that more can be done with the tools provided to us, despite the challenges that Medicaid beneficiaries who live with disabilities, as well as States, face in the current uncertain economic and fiscal climate. I assure you that CMS will be taking on a leadership role both in implementing the new opportunities provided by the Affordable Care Act, and also in assisting all States in meeting their obligations under the ADA and the *Olmstead* decision. We intend to capitalize on this opportunity by maximizing existing resources and we look forward to working with States and the Congress in the future to continue the vital work of improving the quality of life for individuals living with disabilities in this country.