NOTE: There will be no update, February 9, 2007
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Plan to Join Us!! VOR 2006 Annual Meeting and Washington Initiative. See - http://www.vor.net/VORAnnualMeeting2007.htm for complete details, including a registration form.
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VOR is the only national organization advocating for a full range of residential and support options for people with mental retardation, including Medicaid-certified Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) and home and community-based care. VOR supports choice.
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VOR Weekly E-Mail Update February 2, 2007

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1. "Waiver without a Waiver": Congress approves major changes to Medicaid Home and Community Based Services (VOR reprint)
2. States Now Have More Flexibility to Adopt Personal Care Programs Without Waivers
3. Tax Legislation Makes Technical Corrections to DRA
4. Bipartisan Group in House, Senate Pushes Grants for States to Expand Health Insurance Access
5. Please contribute to VOR! Use form at the end of this update to support our effective advocacy.

Coming Up: There will be no update on Friday, February 9, 2007. The next update will be distributed on February 16.
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1. "Waiver without a Waiver": Congress approves major changes to Medicaid Home and Community Based Services (VOR reprint).

Summary: The following article first appeared in VOR's newsletter, The Voice, in Spring 2006. The referenced provision of the Deficit Reduction Act (DRA), Section 6086, became effective January 1, 2007. This article shares VOR's perspective, including cautionary notes, regarding the new Medicaid community benefit. The next article gives background information about Section 6087, "Cash and Counseling", to which some of VOR's concerns also apply.

Source: The Voice, Spring 2006.

Section 6086 of the Federal Budget Deficit Reduction Act of 2005 establishes major changes to how states can implement home and community-based services (HCBS). States now can provide any of the services covered under the HCBS waiver without going through the waiver process.

What's good about the waiver process?

For a waiver to be approved, states historically have had to submit their proposals to the Centers for Medicare and Medicaid Services (CMS) for approval based primarily on the following state assurances: health and welfare of waiver participants; plans of care responsive to waiver participant needs; only qualified waiver providers; State eligibility assessment includes need for institutionalization; State Medicaid Agency retains administrative authority; and the State provides financial accountability (the waiver must cost less than the institutional program).

HCBS waivers are reviewed every 3-5 years. In 2005, CMS refined its method of quality oversight, initiated with the release of The Protocol in 2000. In January 2004, CMS made mandatory the use of the Interim Procedural Guidance as the method for federal waiver review. The Guidance requires CMS staff to solicit evidence from the states as to their quality management strategy and implementation, including evidence that the statutory and regulatory assurance have been met. CMS also revised the voluntary waiver application template and the annual report form ("372 form") to gather additional information about how states assure and improve quality (Source: The Voice, Winter 2004).

Although HCBS waivers did not afford the same level of quality assurance and oversight as the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) program, the process afforded beneficiaries some protection.

What States gain with the new Section 6086 State Plan Option benefit

The new HCBS State Plan Option provides states with even more flexibility than is available under the waiver, but with virtually no federal oversight. States are only required to submit to CMS quarterly reports (Form 64), showing the number of people served and the cost to serve them. Furthermore, States do not have to establish budget neutrality, unlike the waiver, which requires the HCBS benefit cost less than institutional care. States will also now be required to establish stricter eligibility (level of care) criteria for institutional services than for community-based services.

Like the waiver, States can restrict what, to whom and where a covered services are provided.

The new HCBS State Plan Option also expressly allows states to cap enrollment and maintain waiting lists for services now covered under the state Medicaid plan, such as personal care services and rehabilitation services, by moving them into the new HCBS State Plan Option. This provision is aimed at curbing the many waiting list lawsuits that have been filed against states 25 as of May 2005. Waiting list lawsuits assert that federal Medicaid law obliges a state to furnish home and community services to eligible individuals when needed.

What about people currently receiving HCBS waiver services

The only requirement in the new benefit is that an individual's current HCBS waiver benefit expire. There is no requirement that states continue to provide the same or any benefits. In other words, as states begin to exercise their new found flexibility, a great many people could find themselves without services, or with reduced services, and with virtually no legal recourse to challenge these changes.

Conclusion

Despite strong opposition by disability organizations, including VOR, Section 6086 passed. Its passage represents perhaps the most significant reform to Medicaid law since the passage of the HCBS waiver. Seriously negative ramifications are predicted upon implement. It is predicted that the "waiver without a waiver" benefit will undermine the availability and quality of Medicaid home and community-based services. Although States can still opt to provide HCBS waiver services, overtime there seems to be little incentive for a state to pursue this more "restrictive" process. V

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2. States Now Have More Flexibility to Adopt Personal Care Programs Without Waivers
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Source: BNA, 2007

States will now be able to more easily provide Medicaid beneficiaries in need of personal care services with a new "self-directed" personal assistance service option, a private group said Jan. 29.

Prior to Jan. 1, any state interested in introducing a so-called Cash & Counseling option was required to obtain a Section 1115 or 1915c waiver from the Centers for Medicare & Medicaid Services, according to an announcement from the Cash & Counseling National Program Office at the Boston College Graduate School of Social Work. However, Section 6087 of the Deficit Reduction Act of 2005, which took effect Jan. 1, now allows states to offer a Cash & Counseling option within their regular Medicaid states plans without first obtaining a waiver.

Known as "Cash & Counseling," the program gives beneficiaries eligible for personal care services--frail elderly people and those with disabilities--the option to manage a flexible budget and decide for themselves what mix of goods and services will best meet their care needs. Cash & Counseling was created to help address the serious barriers these individuals can meet when seeking personal assistance through the traditional route, state-contracted home care agencies.

Typically, services chosen involve help at home with daily activities such as bathing, dressing, grooming, and meal preparation. Cash & Counseling participants may use their budget to hire their own personal care aides, including family members and friends, as well as buy items or make home modifications that help them live independently.

The Cash & Counseling program is jointly funded by the Robert Wood Johnson Foundation and the Department of Health and Human Services.

"The new law will make it possible for Cash & Counseling to become an option in more states--giving thousands more elderly adults and people with disabilities choice and control over their Medicaid personal assistance services," said Kevin J. Mahoney, director of the Cash & Counseling National Program Office at Boston College.

Mahoney added that the federal waiver process is long, cumbersome, and difficult for states, and the new option will address many of the issues that currently hinder states that want to offer the self-directed option.

The release said that based on the results, 12 more states are now implementing Cash & Counseling programs: Alabama, Illinois, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia.

More information on Cash & Counseling programs is at http://www.cashandcounseling.org.

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3. Tax Legislation Makes Technical Corrections to DRA

Note: VOR 2006 Washington Initiative participants called on Congress to pass a Deficit Reduction Act (DRA) technical correction relating to cost sharing. The article below relays that such a bill passed late in December, 2006.

According to the National Association of State Directors of DD Services (NASDDDS, Jan. 19, 2007; http://www.nasddds.org/publications), the Tax Relief and Healthcare Act of 2006 (TRHA), passed shortly before the close of the 109th Congress, contains two technical corrections to last year's Deficit Reduction Act (DRA) important to advocates for people with disabilities:

* Medicaid recipients below 100 percent of the federal poverty line are not subject to most of the new cost sharing requirements of the DRA-a protection that most legislators agreed was part of the intent of Congress, but which did not appear in the DRA due to a drafting error [NOTE: VOR called on Congress to make this technical correction during the June 2006 Washington Initiative]. Congress also clarified that the total cap on cost sharing applies to the family, not on a per person basis within a family.

* The TRHA codifies a CMS clarification that Medicare and Supplemental Security Income (SSI) recipients are exempt from the citizenship documentation requirements. TRHA extends citizenship documentation exemptions to recipients of Social Security disability benefits.

One technical correction sought by advocates was not included. The DRA, which allows states to restructure their Medicaid programs for certain beneficiaries into "Benchmark Plans," does not specify that those benchmark plans must provide Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services to enrolled children. Although it has generally been conceded that this was an error of omission, and a technical correction was included in the Senate version of the legislation, the law as passed does not address this issue.

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4. Bipartisan Group in House, Senate Pushes Grants for States to Expand Health Insurance Access

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Source: BNA ISSN 1091-4021 Volume 12 Number 11 Thursday, January 18, 2007

A bipartisan, bicameral group of lawmakers Jan. 17 introduced bills to provide federal grants to states to carry out reforms to reduce the number of individuals without health insurance coverage.

The introduction of the legislation is an indication that states have become laboratories for health care reform efforts and that Congress is unlikely to consider sweeping reforms in the next two years, sponsors of the measures said at a press briefing.

The bills would establish a "State Health Innovation Commission" that would review state health reform proposals. The proposals then would be subject to approval by Congress. The review process would take about six months, bill supporters said.

Proposals spanning the political spectrum likely will be spawned by the bills, from single-payer types plans to those using the tax code to provide coverage to the uninsured, to expansion of Medicaid or State Children's Health Insurance Program plans, they said. The number of Americans without health insurance reached 46.6 million in 2005, according to the Census Bureau.

Congressional Approval Needed

The bill would provide as much as $4 million for the operation of the commission, but the amount of money available to states would depend on the type and scope of plans submitted by states, they said.

The commission would act in much the same way as the Base Realignment and Closure Commission does, as votes would be taken on numerous state health reform plans as part of a package, they added.

After five years, the commission would report to Congress about state efforts and recommend possible additional congressional action.

The Senate bill, the proposed Health Partnership Act (bill number unavailable), was introduced by Sens. Jeff Bingaman (D-N.M.) and George Voinovich (R-Ohio). The House bill, the proposed Health Partnership Through Creative Federalism Act (H.R. 506), was introduced by Reps. Tammy Baldwin (D-Wis.), John Tierney (D-Mass.), and Tom Price (R-Ga.). Both bills also were introduced in the 109th Congress.

Health care lobbyists and policy analysts have said helping reduce the number of uninsured Americans may be a topic on which Democrats and Republicans could work together in the 110th Congress, although the federal budget deficit likely would prevent major proposals from becoming law.

State Initiatives

A report issued Jan. 17 by the Robert Wood Johnson Foundation said states are motivated to provide coverage for the uninsured for a variety of reasons, including declines in employer-sponsored health insurance, improved state economies with increased state revenues, and the lack of national action.

The report, State of the States 2007, Building Hope, Raising Expectations, found that more than a dozen states have enacted innovative policies to expand coverage; they include comprehensive health care reform (Massachusetts, Vermont, Maine) , public-private partnerships (Arkansas, Montana, New Mexico, Oklahoma, Rhode Island, Tennessee, Utah), and initiatives to cover all children (Illinois, Pennsylvania).

California Gov. Arnold Schwarzenegger (R) Jan. 8 unveiled a health care reform plan that would require every one of the state's 6.5 million uninsured residents to have health insurance, and use a combination of funds from individuals, employers, providers, hospitals, and state and federal government to pay the $12 billion price tag.

"States are facing a 'perfect storm' with health care," said State Coverage Initiatives Acting Director Enrique Martinez-Vidal, "and that has provided governors and state legislators with the political will necessary to tackle the problem. States have been fertile testing grounds for new reforms and have proven that bipartisan compromise is possible." The state coverage initiatives program is a national program of the Robert Wood Johnson Foundation.

Valuable Information

Lawmakers said while individually they may disagree with the best way to expand health insurance, funding state initiatives will provide valuable information about covering the uninsured.

"The truth is, dealing with this problem between now and the [2008] election is not realistic," Bingaman said of a comprehensive solution being considered by Congress.

"While there are many health reform bills on the table, including my own preference for a single payer plan, it's clear to me, and has been for some time, that no single approach has enough support to become law," Baldwin told reporters.

Price said he favored the bill because "one-size fits all doesn't work in health care . . . and it's not politically feasible. What is right for one state may not be right for another."

"For too many years, I have listened to my colleagues on both sides of the aisle talk about the rising cost of health care and the growing number of uninsured. And for too many years, I've seen little progress here at the federal level," Voinovich said.

The bill "aims to break the logjam and allow states to experiment with health care reform options," he added. "Our hope is the bill will provide a platform from which we can have a thoughtful conversation about comprehensive health care reform here in Washington."

The Robert Wood Johnson report is available on the Web at
http://www.statecoverage.net/pdf/stateofstates2007.pdf

Tamie Hopp

REFERRAL/MEMBERSHIP/CONTRIBUTION FORM

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Mail the completed form (if joining or contributing) with payment to: Voice of the Retarded 5005 Newport Drive, Suite 108 Rolling Meadows, IL 60008 847-253-6054 fax (for referrals or credit card payments) vor@compuserve.com (for referrals or credit card payments)

FOR REFERRALS: ____ The contact information provided is for someone I think would consider membership with VOR.

FOR REFERRALS: _____ You may use my name in any correspondence with this individual.

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