



## **COUNCIL MEETING NOTICE/AGENDA**

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**March 16, 2011**

10 a.m. – 5 p.m.\*

*(\*ending time is approximate only and for the purpose of travel planning)*

### **Holiday Inn**

300 J Street

Sacramento, CA 95814

(916) 446-0100

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*\*Denotes action items*

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2. ESTABLISHMENT OF QUORUM	L. Shipp
3. WELCOME/INTRODUCTIONS	L. Shipp



**4. PUBLIC COMMENTS**

*This item is for members of the public only to provide comments and/or present information to the Council on matters **not** on the agenda. Each person will be afforded up to three minutes to speak. Written requests, if any, will be considered first. The Council will provide a public comment period, not to exceed a total of seven minutes, for public comment prior to action on each agenda item.*

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# DRAFT

## Council Meeting Minutes January 19, 2011

### Members Present

Jennifer Allen  
Michael Bailey  
Catherine Blakemore  
Lisa Cooley  
Ray Ceragioli  
Terri Delgadillo  
Shirley Dove  
Max Duley  
Denise Filz  
Robin Hansen  
Dean Lan  
Emily Matlack  
Bill Moore  
David Mulvaney  
Leroy Shipp  
Steve Silvius  
Jennifer Walsh  
Kerstin Williams

### Members Absent

Jorge Aguiar  
Lora Connolly  
Marcia Good  
Patty O'Brien-Petterson  
Oliva Raynor  
Tom Torlakson

### Others Attending

Alva Barquero  
Melissa Corral  
Susan Eastman  
Tammy Evrard  
Dena Hernandez  
Robin Keehn  
Molly Kennedy  
Cary Kreutzer  
Jane Lefferdink  
Angie Lewis  
Robin Maitino  
Heidi Matlack  
Dawn Morley  
Julia Mullen  
Roberta Newton  
Diana Ramirez  
Carol Risley  
Michael Rosenberg  
Margaret Shipp  
Rocio Smith  
Vicki Smith  
Mark Starford

## 1. **CALL TO ORDER/ESTABLISHMENT OF QUORUM**

Leroy Shipp, Chairperson called the meeting to order at 10:00 a.m. and established a quorum present at 10:05 a.m.

## 2. **WELCOME AND INTRODUCTIONS**

Council Members and others attending introduced themselves.

**3. PUBLIC COMMENT**

Molly Kennedy discussed the Consumer Advisory Committee meeting she attended on January 18, 2011. The training focused on how consumers can be more vocal.

Molly also reported that the 16<sup>th</sup> Annual Conference for Adults with Cerebral Palsy will be held June 10-12, 2011 in San Jose. Questions or further information may be obtained by contacting Molly directly.

**4. APPROVAL OF NOVEMBER 21, 2010 MEETING MINUTES**

It was moved/seconded (Ceragioli/Mulvaney) and carried to approve the November 21, 2010, Council meeting minutes as presented.

**5. PEOPLE FIRST OF CALIFORNIA UPDATE**

Joe Meadours was unavailable due to illness.

**6. CALIFORNIA SECTION 1115 COMPREHENSIVE DEMONSTRATION PROJECT WAIVER**

Gregory Franklin, Department of Health Care Service (DHCS), gave an overview on the Section 1115 Waiver, what it is, and how the Department is going about implementing it. The 1115 Waiver is a mechanism for allowing states to waive provisions of the Medicaid program to improve upon the program. DHCS plans on rolling out the mandatory enrollment of Medicaid eligibles into manage care by birth month. This equates to 1/12 of the population at a time. There were several key questions from the Council as follows:

**Question:** Is the State of California going to reduce payments to doctors and hospitals?

**Response:** That is in the proposed budget this year. If rate reductions or the payment reduction plan goes through, there are two parts; one is the payment reduction is on the fee for service side. The question really is, if fewer doctors accept the medical payment, there are fewer doctors providing services for the fee for service side. DHCS has given the

managed care plans a capitation amount and say you bear all of the risks for serving this population.

**Question:** What is the Department's plan in terms of the roll out and enrollment? I understand that if people do not enroll, they are assigned to a managed care plan?

**Response:** 1/12 of the population by birth month will be enrolled each month. In order to have the first day of enrollment be in June, the enrollment process will start in March. The first set of enrollment packets will go out in February. People will have a 90-day period from the time the packets go out to the time the beneficiary is enrolled. In that 90-day period, quite a bit will happen:

1. The enrollment package will go out and at the end of the first 30 days if we do not hear from the person, a second enrollment packet stating DHCS has not heard from you yet will be sent. In another 30 days a phone call will be made to the beneficiary stating that the enrollment package, along with a reminder, was sent out with no response.
2. In the next 30 days another notice will go out stating that DHCS has yet to hear from the person and if they do not hear back from them (by the date listed) DHCS will automatically enroll them into a health plan and assign a doctor.

**Question:** How are you going to ensure that the special conditions imposed on the state regarding accessibility to ensure that managed care providers provide the services in accessible ways are followed through with?

**Response:** The Department has been working with a group of individuals on a facility site review tool. This tool checks for the height of exam tables, ramps, and ensures there is work going on around culture competency in general.

**Question:** What interface is the Department planning with regional centers?

**Response:** We are going to require them to coordinate with the regional centers so that the incoming flux of beneficiaries can still avail themselves to the regional centers.

**Question:** Is there an adaptive packet for people with developmental disabilities?

**Response:** The enrollment packet was created at a certain grade level with lots of white space. It is not “adaptive” though.

**Question:** If you are doing it by birth month, obviously people with developmental disabilities all across the state will be one of the first 1/12, regardless of whether there is an available health plan that is passed the survey and assessed to be able to accommodate them. You may end up having people in some regions where you don’t have a managed care plan that is ready to cover them.

**Response:** In most regions there is a two-plan model. Say in Alameda they are not ready, then for Alameda County, we would turn them off for that month for that county because there is not a choice in that county. Those folks that reside in Alameda would not receive a packet. As soon as the other plan is ready, we turn them back on and start the enrollment process.

**Question:** Will the doctors involved in the waiver have any sort of knowledge of disability beyond the type of knowledge they get in medical school?

**Response:** That is not known at this time.

**Question:** Will this waiver improve MediCal and Medicare services for all who use it?

**Response:** This is a Medicaid waiver. This is geared and targeted toward that population. Is not meant to “improve” care, but it does improve access to care.

**Question:** What happens after the five years when the waiver is over?

**Response:** This is a two part answer: First of all, in three years we will have health care reform. People in the low income health program will transition from low income to Health Care Reform, the California Health Benefits Exchange or the Medical Program. The second thing that is going to happen is those low income health programs will go away. The seniors and persons with disabilities are already be enrolled in medical managed care and that process will continue.

**Question:** How are you going to be able to guarantee the medical access that people need in rural counties up north?

**Response:** The County Medical Services Program (CMSP) are going to come in and apply as one entity. The CMSP program will flip into a low income health program. You have a standard package for the CMSP program. Preventive care, outpatient, behavioral health, pharmaceutical, it will be a standard program for the CMSP counties.

**Question:** The tool that is going out to the providers to determine if they meet ADA requirements, is that self-administrated, like the provider has to do it?

**Response:** Yes.

**Question:** Are you doing educational forums for beneficiaries?

**Response:** We will not only educate the beneficiaries and the consumers, but we have conducted some provider education and health plan education as well.

Following the discussion, it was moved, seconded (Bailey/Dove) and carried to send letters to DHCS and DDS emphasizing the need for the departments to coordinate efforts to assure enrollees with developmental disabilities receive information in formats and methods that enhance their ability to make informed choices.

## 7. COMMITTEE REPORTS

### a. STRATEGIC PLANNING – Olivia Raynor

Olivia Raynor was not present.

b. EMPLOYMENT FIRST – Michael Bailey

Michael Bailey reported on the January 7, 2011, Employee First Committee meeting. The meeting objective was to review subcommittee reports to take community input, and review the draft policy.

c. LEGISLATIVE AND PUBLIC POLICY – Jorge Aguilar

Carol Risley reported that the Committee has not met since the last council meeting and is due to meet on January 27, 2011 in Sacramento. Items on the agenda include:

- The reauthorization of the federal developmental disabilities act. There is a lot of discussion on whether or not the State Developmental Disability agencies should become the fourth partner.
- The Governor's proposed budget will also be discussed.
- The sharing of Area Board 9's booklet, Advocating with Your Elected Officials which has an accompanying DVD illustrating how to use the booklet.

d. EXECUTIVE – Leroy Shipp

Leroy Shipp presented a draft executive director evaluation instrument reviewed by the Executive Committee on December 14, 2010. Leroy requested that Council members review the tool and provide input to the Committee by February 4, 2011. The Committee will incorporate those revisions and bring back for a vote at the March Council meeting.

e. CONSUMER ADVISORY – Jennifer Allen

Jennifer Allen gave a report on the first Consumer Advisory Committee meeting which was held on January 18, 2011. The Committee is made up of consumer's that sit on the Council. The objective of this new Committee is to teach the consumer's how to be leaders and advocates for themselves. Have their voices heard, ask questions, and participate at not only Council meetings

but in the community as a whole. The next Committee meeting will be held on March 15, 2011.

**8. PROJECT SEARCH**

Rocio Smith, Sarah Murphy, and Lori Kostonas presented. Project Search, an internationally recognized organization/movement. Their focus is to build a work force that includes people with developmental disabilities. They are a training and employment program that is business-led.

Project Search started with Children's Hospital Oakland and is now on its third year. Alameda County is the first government entity that actually has a Project Search and is hiring people with developmental disabilities as a regular part of the work force. The Consortium that was developed through this grant is still going even though they no longer have funding because it has been so successful.

The presentation focused on the outcomes for people with developmental disabilities, one of which was an opportunity to learn and be employed in complicated, complex, career-oriented positions that allows them to compete in the labor market.

**9. BRIEFING PAPER FOR GOVERNOR**

Leroy Shipp opened the draft Governor's Briefing Paper up for discussion and comment. After various questions and requests for revisions by Council members, it was moved/seconded (Dove/ Silvius) and carried to approve Governor's Briefing Paper as amended.

Carol Risley will amend as directed, prepare a cover letter on behalf of the Council for final review and approval by Leroy Shipp.

**10. COUNCIL MEMBER REPORTS/COMMENTS**

Terri Delgadillo, Department of Developmental Services (DDS), gave a budget overview on how the budget deficit in California has affected the department and what this could mean to their various services. Budget hearings for the Department will be on February 3 and February 10, 2011. One of the reasons the Department's hit may seem to be so large is that the Federal Stimulus money has ended.

DDS is anticipating the moving forward with the Lanterman Developmental Center closure.

DDS reported that they will be having increased auditing both of providers and regional centers. There is trailer bill language that is related to this issue.

Robin Hansen, University of California, Davis, M.I.N.D. Institute, reported that they are in the last half of their first five years of funding as a UCEED. They are in the final draft brochure that celebrates the accomplishments of the first five years. One item that they are especially proud of is developing a successful infrastructure and increasing array of activities that address all of the core functions that they are responsible for.

They are also currently going through a strategic planning process in which they have been getting input from the consumer advisory committee, broader community, and the partners.

They have also developed a new DVD that is strategies for teaching functional skills for parents with children with autism. The DVD is available in English and Spanish.

UCEED has completed a social marketing campaign as a result of doing a focus group in the South East Asian community which was developed to try and tackle obstacles in the screening and identifying of children as well as adults with developmental disabilities. Additionally, they have done two workshops for youth and young adults on transitioning into postsecondary education or employment.

Megan Juring, Health and Human Services Agency (CHHS), reported on the proposed budget stating that many programs and benefits are part of the proposed reductions in the 2011-12 budget. Within MediCal, each proposal assumes that state legislation would be enacted by March 1, 2011. This is on an expedited timeframe. Some specifics include a hard cap on the purchase of hearing aids; limits on prescriptions, except for those defined as life saving; and a limit of 10 doctor visits per year.

CHHS reported the multi-purpose senior program is targeted for elimination. In-home supportive services is also sharing in the reductions as is SSI/SSP.

Megan received an appointment as the Deputy Director of External Affairs at the Department of Rehabilitation. She started that job January 3, 2011. She will continue to represent CHHS at the Council meetings until her position is backfilled.

Bill Moore, Department of Rehabilitation (DOR), reported on their proposed budget which includes \$416 million. They have a total of 1,775 positions, 3 of which are limited term. DOR has lost approximately 300 positions over the several years. Additionally, some of the proposed cuts that are for other agencies will also impact DOR.

Shirley Dove reported on the Coalition to Preserve the Lanterman Act. There are 12 major entities as members. It is critical that this cause keep a united front. Art Bolton attended the last meeting; he was one of the people that helped Lanterman get the Act enacted. Wolton was most concerned that there was a lack of grassroots movement across the state to address the budget issues. There was discussion on what could be done to put a positive a spin in the face of all the cuts and also talk about other things that could be done.

Dove is excited that the Council has joined the Coalition.

## 11. CHAIRPERSON'S REPORT

Leroy Shipp, gave his first report as Chairperson stating that he appreciates all of the work that everyone does.

Leroy will be attending the National Disability Policy Seminar in Washington D.C., February 14-16, 2011 with Carol Risley and Marcia Good. They are also going to make congressional visits.

## 12. EXECUTIVE DIRECTOR'S UPDATE

Carol Risley reported that since the last meeting she attended a meeting at Area Board 9. She announced that if any Area Board would like her to come by for a site visit, she would be happy to do that.

Carol also met with Senator Steinberg's staff regarding legislation addressing employment. The Senator's office wants to take a look at recognizing agencies and businesses that hire people with developmental disabilities.

The Area Board Executive Directors' meeting is tomorrow. One of the things being focused on is the upcoming state plan process. Borrowed staff are helping to get something put together that illustrates the goals and objectives and reflects upon the strategic planning by the area boards that will be the focus of the upcoming plan hearings.

Carol participated in the California Collaborative, a group of aging, mental health, developmental disabilities advocates.

Staff appointment documents are still pending at the new Governor's office.

Carol also met with some non-profit housing corporations. They received a grant from the Council and were sharing some of the things they had done with the funding. They shared a handout on affordable homes at-risk of conversion by private owners that has been included in today's packet.

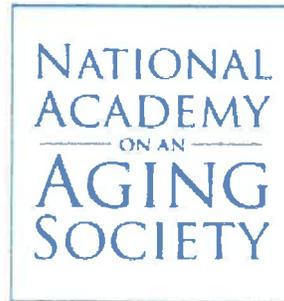
Carol did training for the Alta California Regional Center staff and providers on the history of the Lanterman Act.

### 13. **ADJOURNMENT**

Meeting was adjourned at 4:45 p.m.



# Public Policy & Aging Report



Spring/Summer 2010

Volume 20, Number 2



Bringing CLASS to Long-Term Care  
Through the Affordable Care Act



## Public Policy & Aging Report

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*Public Policy & Aging Report* is a quarterly publication of the National Academy on an Aging Society ([www.agingociety.org](http://www.agingociety.org)), a policy institute of The Gerontological Society of America.

Yearly subscription rate is \$39 (\$49 overseas). Address all subscription inquiries to: National Academy on an Aging Society, 1220 L Street, NW, Suite 901, Washington, DC 20005, (202) 587-2842. e-mail: [policy@agingociety.org](mailto:policy@agingociety.org)

Please address all editorial inquiries to Robert B. Hudson, Boston University, School of Social Work, 264 Bay State Road, Boston, MA 02215. e-mail: [rhudson@bu.edu](mailto:rhudson@bu.edu)

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ISSN 1055-3037

## Bringing CLASS to Long-Term Care

*Robert B. Hudson, Editor*

In an enormously important yet widely unrecognized development, passage of President Obama's health care reform legislation included major provisions centered on long-term care, including the Community Living Assistance Services and Supports program (the CLASS Act). To a world dominated by Medicaid payments to institutional providers, the CLASS Act introduces a publicly administered social insurance program for long-term care. Individuals enrolled in the program no longer will have to be demonstrably poor or spend themselves into penury to receive long-term care protection. They also will be free to elect the community-based care that the vast majority of long-term care recipients prefer. In theory, and hopefully in practice, the CLASS Act will provide meaningful protection against chronic and disabling conditions for middle-class Americans. There are significant limits to the program that may be seen as rendering the CLASS Act "social insurance light," but to see public long-term care insurance come into existence against all odds is a stunning occurrence in its own right.

With the generous support of The SCAN Foundation, *Public Policy & Aging Report* is pleased to publish the first detailed accounts of the CLASS Act and other long-term care initiatives that emerged from the Affordable Care Act (ACA). The following articles by Lisa Shugarman (from The SCAN Foundation), Joshua Wiener (RTI International), Walter Dawson (Oxford University), Barbara Manard (American Association of Homes and Services for the Aging), Anne Tumlinson and colleagues (Avalere Health), Rhonda Richards (AARP), and Kathryn Roberts (Ecumen) recount the laborious process that led to realization of the long-term care provisions found in ACA, analyze the key provisions of the legislation, and explore hurdles that are certain to be encountered during program implementation.

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**Disclaimer:** Statements of fact and opinion in these articles are those of the respective authors and contributors and not of the National Academy on an Aging Society or The Gerontological Society of America.

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# Health Care Reform and Long-Term Care: The Whole is Greater than the Sum of its Parts

*Lisa R. Shugarman*

Health care reform is about so much more than covering the uninsured. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148) lays the groundwork for wide-ranging continuum-of-care reform and establishes a framework for care coordination and a future where care is integrated across providers and settings. Currently, the continuum of care, composed of the entire realm of primary, acute, and rehabilitative medical services along with supportive long-term care services, is fragmented and unsustainable. The new health reform law presents many opportunities to improve long-term care, concurrently creating and strengthening linkages between medical care and supportive services.

This article will describe some of the key features in the ACA that will facilitate an improved continuum of care and bolster one element of the continuum, long-term care, that has been absent from previous legislative efforts. This new era of long-term care reform begins with the Community Living Assistance Services and Supports (CLASS) program, which, for the first time, provides the middle class with the opportunity to access supportive services in the settings of their choice without impoverishing themselves to Medicaid eligibility. CLASS fundamentally reframes the concept of long-term care from one of poverty, sickness, and loneliness to one of choice, community, and personal responsibility in the face of functional impairment.

Other critical reforms discussed here include: the establishment of the Center for Medicare and Medicaid Innovation and the Federal Coordinated Health Care Office (informally known as the “Office of the Duals”), both within the Centers for Medicare and Medicaid Services (CMS). These provisions create the space to test out ideas that can lead to improvements in care coordination, including mechanisms to break through regulatory barriers and integrate funding sources, a major contributor to the fragmentation of the current system. Efforts to transform payment and delivery system models of care such as accountable care organizations, medical/health homes, and pilots to bundle payment for acute and post-acute care services also offer the promise to expand beyond a narrow medicalized scope of practice toward connecting older adults in need of long-term care to supportive services in their communities. Finally, the ACA provides funding to expand both the provider base needed to deliver long-term care services through direct care workforce investments and resources needed to help people with

disabilities navigate the long-term care system through Aging and Disability Resource Centers (ADRCs), as well as offering states incentives to expand Medicaid-funded home and community-based services (HCBS).

## **A Fragmented System in Need of Repair**

A major challenge facing older people and adults with disabilities in the current health and long-term care systems is the fragmentation of financing, administration, and oversight of the myriad services available (Stone, 2000). The result of this division is significant. Consumers are challenged constantly to navigate the disparate medical and social care worlds, managing the different payors and providers with little or no help. The risk of poor outcomes from the quality-of-care and quality-of-life perspectives is high, with system inefficiencies leading to increased costs for the most vulnerable in our society.

Ultimately, the goal of the long-term care system is to enhance the well-being and quality of life of individuals who experience functional or cognitive limitations because of chronic illnesses, accidents, or other causes of disability. The vision of an integrated system across the continuum of care is one that is person-centered, efficient, high quality, and accessible. The ACA offers several opportunities to move toward integration across the continuum of care; the CLASS Act presents the first opportunity for the middle class to have reasonable access to long-term care services. This new offering and the other elements described below begin to move us toward the vision presented here of a well-integrated system.

## **CLASS – A Middle Class Opportunity**

One of the major long-term care system

challenges is access to a range of services for the near poor and middle class, as eligibility for most programs is restricted to those with the lowest income levels. There are few good choices for the non-poor who need services and few tools other than private long-term care insurance to help prepare them for long-term care needs. Currently, private long-term care insurance accounts for approximately seven percent of all long-term care expenditures (Avalere Health, LLC, 2008). Given the absence of comprehensive long-term care financing, low uptake of often costly, private long-term care insurance and low savings rates among those nearing retirement, many middle-class aging boomers likely will be unable to pay for their long-term care. The few middle class protections that exist currently are only available for those in nursing homes and not for those receiving services in the community, where individuals overwhelmingly prefer to remain as they age.

A common misperception is that Medicare will pay for long-term care costs, even though the government-funded health care program for seniors only covers short-term rehabilitative care. The only way to qualify for government assistance for nursing home care or community-based services for an extended period of time is to impoverish oneself by spending down one's personal assets to Medicaid eligibility levels. Currently, about 42 percent of people in the United States age 45 and over have saved less than \$25,000 for retirement (Helman, Copeland, & VanDerhei, 2010). Middle-class Americans generally are not capable of paying \$6,000 per month for nursing home care or \$1,700 per month for part-time in-home help (Administration on Aging, 2010a). With so little saved, the middle class is particularly vulnerable, yet the startling reality is that 70 percent of Americans over 65 will need long-term care support at some point in their lives (Administration on Aging, 2010a). Such a profound level of destitution can affect spouses along with family members who might otherwise have been able to provide a helping hand. To illustrate this point further, a March poll of California voters, commissioned by The SCAN Foundation and the UCLA Center for Health Policy Research, found that, regardless of party affiliation, people are worried about long-term care costs and are unprepared to pay for these services (Lake Research Partners & American Viewpoint, 2010).

The CLASS program represents the beginning of

a public long-term care safety net based on a risk pool concept. It is a voluntary public insurance program for employed individuals with no exclusion for pre-existing conditions and offers a lifetime benefit for people with significant difficulty performing daily living tasks. Premiums will be age-rated, with younger people paying considerably less and older adults more. A vesting period requires enrollees to pay premiums for at least five years prior to receiving benefits. Benefits will be cash payments averaging \$50 a day and can be used to purchase a variety of supports and services, including home care, adult day programs, assisted living, or institutional care.

Some may argue that a benefit of \$50 a day does not go very far. This benefit, however, equals approximately \$1,500 a month and perhaps \$18,000 or more additional income over a year's time, which can supplement other resources to purchase services and ease the burden that caregivers often bear when working and caring for a loved one at the same time. Daily premiums provided by CLASS will offer a stable source of funding, leading to the availability of more reliable HCBS that strengthen the continuum of care.

### Care Coordination in the ACA

An important part of the foundation created by the ACA for improving the continuum of care is the continued pursuit of alternate models for paying for services and organizing care through pilot testing. CMS has a rich history of testing different methods for arranging and paying for services through Medicare and Medicaid through demonstration programs. The new law builds on this approach through the Center for Medicare and Medicaid Innovation (CMI), which creates a more rapid-cycle testing environment to develop, test, and expand innovative payment and delivery models that improve quality while controlling costs. When considering in which demonstration projects to engage, the CMI will give greater weight to those projects that address the key elements of person-centered care coordination. This may include individualized assessment focusing on the needs and preferences of beneficiaries, engagement with the appropriate medical and community-based providers using a team-based approach, and centering beneficiaries and their families in the middle of the care team.

The ACA also requires the Secretary of Health and Human Services, Kathleen Sebelius, to establish

the Federal Coordinated Health Care Office. This department will bring together CMS officials to integrate more effectively Medicare and Medicaid policy structures in an effort to improve coordination between the federal and state governments for those who are dually eligible. The primary aims of this “Office of the Duals” will be to improve care continuity and support state efforts to coordinate and align acute and long-term care services for dual eligibles.

Three innovative payment models included in the ACA incentivize providers and provider organizations to improve service arrangements for vulnerable populations: Accountable Care Organizations (ACOs), Medical Homes, and post-acute payment bundling. ACOs are collaborations of providers (physician groups, hospitals, nurse practitioners, and other providers). Those that meet both quality of care targets and reduce patient care costs through better service coordination will be eligible to share in the savings accrued to the Medicare program. This shared savings approach challenges the inpatient and outpatient providers to work together instead of engaging in “cost-shifting” behavior. The ACA also establishes a medical home program for Medicare beneficiaries with chronic conditions and offers states the option to enroll Medicaid beneficiaries in health homes. Medical/health homes are models that include a “whole-person orientation” for coordination and responsibility of an individual’s full array of health care services using a team-based approach. In its most enlightened iteration, the medical/health home also includes direct connections to supportive services recognizing that even the most chronically ill individuals live in their homes and communities, not in their doctors’ offices. Finally, payment bundling across acute and post-acute care services will be implemented as a national, voluntary pilot program. The bundled payment approach pays a single payment to hospitals and post-acute care providers for care provided during a specified episode for selected conditions (in the ACA, there are 10 conditions that have been identified to be used in determining which episodes will be eligible for the bundled payment). This model obliges acute and post-acute care providers to work together and coordinate across care settings to improve patient outcomes (i.e., reducing preventable hospitalizations) and to control overall costs of care.

Rounding out care coordination efforts in the ACA are the Community-Based Care Transitions

and Independence at Home demonstrations. The Community-Based Care Transitions program provides grants to communities seeking to improve Medicare beneficiaries’ experiences of returning home following a hospital or rehabilitative stay. Successful applications for these grant dollars must include a consortium of community-based service providers working in collaboration with hospitals and/or nursing facilities to implement an evidence-based care transitions intervention. As gerontologists know all too well, social and environmental challenges at home following an acute care stay can lead to re-hospitalization just as easily as through poor medication reconciliation (Coleman, Smith, Raha, & Min, 2005; Fu, Liu, & Christensen, 2004). For individuals who are home bound and have great difficulty visiting their doctors’ offices, the Independence at Home demonstration will support physician-led interdisciplinary team care in the home environment.

### Expansion of HCBS

The ACA contains several provisions allowing states to expand HCBS offerings under Medicaid by offering new benefits under their Medicaid State Plans and creating financial incentives through increased Medicaid federal matching rates for these services.

**Community First Choice.** The ACA establishes a new Medicaid state plan option for states to offer community-based attendant services and supports to those beneficiaries meeting the state’s criteria for nursing facility eligibility. States that choose this option will receive a six percentage point increase in their Federal Medicaid Assistance Payments (FMAP – the federal government’s share of the Medicaid program). Not only will the Community First Choice option cover the costs of personal attendant services and supports, but it will allow states to use funds to cover the costs of community transition supports (e.g., rent/utility deposits, first month’s rent and utilities, bedding, basic kitchen supplies) for institutionalized individuals who meet the eligibility criteria and wish to return to the community.

**Medicaid Home and Community-Based Services State Plan Option.** The Deficit Reduction Act of 2005 allowed states to amend their Medicaid state plans to add HCBS as an optional benefit (authorized as section 1915(i)). Since its inception, few states have opted for the 1915(i) state plan option because of several programmatic limitations. Unlike the eligibility criteria

afforded 1915(c) waiver programs that allow states to enroll individuals with incomes up to 300 percent of SSI, the 1915(i) had more stringent income eligibility criteria and thus states could not expand this program in ways that were meaningful to their residents. The ACA revises the 1915(i) option by allowing states to enroll Medicaid beneficiaries into HCBS with incomes up to 300 percent of SSI and permits states to extend the full range of Medicaid benefits to those receiving services through the state plan option. Additionally, the law now requires “statewideness” of services under this state option, meaning all who are eligible for services must have access as well.

**Money Follows the Person (MFP).** Also established in the Deficit Reduction Act of 2005, the Money Follows the Person demonstration provided opportunities for Medicaid beneficiaries residing in nursing facilities for at least six months to return to the community if they so wished. For the year of the transition back into the community, the state’s FMAP increases to provide necessary services to the beneficiary. The ACA extends the MFP demonstration through September 2016, and shortens the requirement for residency in a nursing facility from six months to 90 days.

**State Balancing Incentive Payments Program.** The ACA offers new financial incentives for states to shift Medicaid beneficiaries out of nursing homes and into HCBS. Eligible states will be those that spend less than 50 percent of their total long-term care expenditures on HCBS. Qualifying states will receive an enhanced FMAP; those that spend less than 25 percent of their total long-term care budgets on HCBS will receive a five percentage point increase in their FMAPs for related services, and those that spend 25 percent to less than 50 percent of their total long-term care budgets on HCBS will receive a two percentage point FMAP increase. States are permitted to increase the income eligibility standards for those seeking HCBS. States choosing to participate in the Balancing Program will be required to establish a “single entry point – no wrong door” system to make it easier for beneficiaries to access services. These states also must have case management services for the eligible beneficiaries and their caregivers particularly to be used when developing care plans for those transitioning out of nursing facilities back into the community.

**Other Related Provisions.** Currently, states offer *spousal impoverishment protections* to the

spouses of individuals residing in nursing facilities so that the community-residing spouse does not him/herself become impoverished to meet Medicaid eligibility requirements. The ACA now extends this same protection to the spouses of those residing in the community and receiving Medicaid-funded HCBS. *Aging and Disability Resource Centers (ADRCs)* serve as a single point of entry into the array of services available in the long-term care system. The Administration on Aging (AoA) and CMS have funded one or more ADRCs in almost every state to support consumers’ efforts to navigate through the variety of long-term care services available (Administration on Aging, 2010b). The ACA appropriates additional funds and extends the ADRC program through 2014, which will enable the program to expand and be accessible to more people and help in improving care coordination for seniors and younger people with disabilities.

### Support for the Direct Care Workforce

An integrated system cannot exist without a workforce to care for the population in need. In particular, there is a clear demand for a labor force that is trained appropriately to address the concerns of older adults. Building on recommendations from the Institute of Medicine’s report *Retooling for an Aging America* (Institute of Medicine, 2008), ACA allows for grants to encourage a career path for the existing direct care workforce and calls for the establishment of improved training for the next generation of direct care workers. The grants will offer tuition support for individuals already working in long-term care settings (e.g., nursing homes, assisted living, and home and community-based settings) and will require as a condition of receipt of funds that participating individuals agree to work in geriatrics, disability services, long-term services and supports, or chronic care management for at least two years following completion of advanced training.

The ACA also requires Secretary Sebelius to establish demonstration programs in up to six states for the purposes of developing core competencies, pilot training curricula, and certification programs for personal and home care aides. The core competencies prescribed by the ACA that must be included in these demonstration programs include training to be sensitive to the needs of different populations—seniors, younger disabled populations, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs.

### Bringing it Back to CLASS

So what do all of these other health care reform components have to do with CLASS? These components represent the building blocks of a continuum of care that are necessary for those individuals who become eligible to draw down benefits under the CLASS program. Otherwise, disabled adults would be enriched with purchase power for needed long-term care services but would still have the same broken system to navigate. It is quite possible that the services they need and prefer would not be available without these accompanying elements that will help transform our current system into one that is better coordinated and integrated for tomorrow.

Through the implementation of the initiatives to improve care coordination, the support for efforts to grow the needed direct care workforce, and the expansion of home and community-based services under Medicaid, a new system can be created that is truly greater than the sum of its parts. It is a system that will better be able to absorb the new and likely substantial demand for long-term care services created by a population that will grow exponentially in the next 20 years as a result of the aging of the boomer population. Although it is far from perfect, the new health care reform law is an opportunity to transform care, and supports a vision that is person-centered, accessible, affordable to all, and offered in the most appropriate and preferred settings.

*Lisa R. Shugarman, PhD, is director of policy for The SCAN Foundation in Long Beach, CA.*

### References

- Administration on Aging. (2010a). *National clearinghouse for long-term care information*. Washington, DC: U.S. Department of Health and Human Services. Retrieved May 25, 2010, from [www.longtermcare.gov](http://www.longtermcare.gov)
- Administration on Aging. (2010b). *Aging and disability resource centers*. Washington, DC: U.S. Department of Health and Human Services. Retrieved May 13, 2010, from [http://www.aoa.gov/AoAroot/AoA\\_Programs/HCLTC/ADRC/index.aspx](http://www.aoa.gov/AoAroot/AoA_Programs/HCLTC/ADRC/index.aspx)
- Avalere Health, LLC. (2008). *Long-term care: An essential element of healthcare reform*. Retrieved May 13, 2010, from [http://www.thescanfoundation.org/sites/default/files/ChartBook\\_121808.pdf](http://www.thescanfoundation.org/sites/default/files/ChartBook_121808.pdf)
- Coleman, E. A., Smith, J. D., Raha, D., & Min, S. (2005). Post-hospital medication discrepancies: Prevalence, types, and contributing system-level and patient-level factors. *Archives of Internal Medicine, 165*, 1842-1847.
- Helman, R., Copeland, C., & VanDerhei, J. (2010). *The 2010 retirement confidence survey* [Research Brief]. Washington, DC: Employee Benefit Research Institute. Retrieved May 13, 2010, from [http://www.ebri.org/pdf/briefspdf/EBRI\\_IB\\_03-2010\\_No340\\_RCS.pdf](http://www.ebri.org/pdf/briefspdf/EBRI_IB_03-2010_No340_RCS.pdf)
- Fu, A. Z., Liu, G. G., & Christensen, D. B. (2004). Inappropriate medication use and health outcomes in the elderly. *Journal of the American Geriatrics Society, 52*, 1934-1939.
- Institute of Medicine, Committee on the Future Health Care Workforce for Older Americans. (2008). *Retooling for an aging America: Building the health care workforce*. Washington, DC: The National Academies Press.
- Lake Research Partners & AmericanViewpoint. (2010). *New poll shows California voters 40 and older largely unprepared for costs of long-term care services*. Retrieved April 21, 2010, from <http://www.thescanfoundation.org/sites/default/files/TSF-UCLA%20Poll%Results.pdf>
- Stone, R. (2000). *Long-term care for the elderly with disabilities: Current policy, emerging trends, and implications for the twenty-first century*. New York: Milbank Memorial Fund.

# What Does Health Reform Mean for Long-Term Care?

*Joshua M. Wiener*

The enactment of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) and the Health Care and Education Reconciliation Act (HCERA, P.L. 111-152) marks an historic moment in the reform of the American health care system. Although the two pieces of legislation focus on providing medical insurance to the uninsured and controlling acute care costs, PPACA addresses several major issues in long-term and post-acute care, including lack of health insurance among direct care workers, the inadequacy of the financing system, the lack of home and community-based services, the absence of care coordination, and poor-quality care. The inclusion of the Community Living Assistance Services and Supports (CLASS) Act in PPACA is especially notable, given the intractability of financing reform in long-term care.

## Health Insurance for Direct Care Workers and Low-Income People with Disabilities

The most overlooked impact of health reform on long-term care are provisions that will provide health insurance to direct care workers, such as certified nursing assistants, home health aides, and personal care attendants, and to low-income people with disabilities. In 2008, approximately 800,000 direct care workers did not have health coverage, including approximately one-fifth of certified nursing assistants and one-third of personal and home care aides (PHI, 2010). Only about half of direct care workers have employer-based coverage. About 12 percent of people with disabilities are uninsured.

Although the new health reform law does not include an employer mandate *per se*, employers with more than 50 workers will have to pay a penalty if any employee receives a premium tax credit; the fee is higher if the employer does not offer health insurance. No penalty is imposed on employers for employees who enroll in Medicaid; nor is a fee imposed for failure to offer health insurance to part-time employees. In 2008, 53 percent of personal and home care aides worked part time or full time for only part of the year.

With the exception of people for whom health insurance is too expensive relative to their income, individuals not receiving health insurance through their employers are required to obtain health coverage through Medicaid or the newly formed health insurance exchanges. Currently, although there is some variation by state, Medicaid generally excludes nondisabled adults with no children, people with income above the federal poverty line, and those with more than \$2,000 in financial assets. Under health reform, all people below age 65 with income below 133 percent of the federal

poverty level will be eligible for Medicaid. Even under current rules, almost one-quarter of certified nursing assistants working in nursing homes are enrolled in Medicaid (Squillace, Remsburg, Harris-Kojetin, Bercovitz, Rosenoff, & Han, 2009). Some low-income people with disabilities who continue to work or do not qualify for Supplemental Security Income also will become eligible for Medicaid through this new pathway. Older people are excluded from the new provisions because they are eligible for Medicare.

Workers not obtaining health insurance through their employer, Medicaid, or the health insurance exchanges must pay a penalty. To make policies affordable, tax credits will be available to people with incomes between 133 and 400 percent of the federal poverty level. In addition, cost-sharing subsidies will protect people below 400 percent of the federal poverty level from high out-of-pocket costs for deductibles and coinsurance.

## CLASS Act

Championed by Senator Ted Kennedy, the CLASS Act is a voluntary public insurance program for long-term care that was incorporated into PPACA. Medicare does not cover long-term care and Medicaid requires people to be poor or become poor paying for health and long-term care before it provides assistance. Only about 10 percent of the older population and less than one percent of the nonelderly adult population have private long-term care insurance. Although the CLASS Act has the potential to change radically long-term care financing over time, it received little attention during the health reform debate and few people outside of a handful of experts know about it.

The CLASS Act draws heavily on the German

and Japanese long-term care insurance programs. Unlike most private long-term care insurance policies, it does not require medical underwriting. In addition, benefits are provided on a lifetime basis rather than for a fixed number of years or expenditure level; this feature will be attractive to younger persons with disabilities who could receive benefits for decades. Only working people are eligible to enroll. After paying premiums for at least five years, enrollees who meet the disability benefit criteria will receive a regular cash payment to help meet their long-term care needs. The exact level of disability needed to obtain benefits is left to be determined by the Secretary of Health and Human Services. In order to receive benefits, however, the Secretary must set a standard that includes: (1) limitation in at least two or three activities of daily living (ADLs), (2) substantial cognitive impairment, or (3) an impairment equivalent to these two disability levels.

The initial average benefit will be no less than \$50 a day, but will vary by level of disability, with people with more severe disabilities receiving a higher payment and people with less severe disabilities receiving a lower payment. Although this payment level has been criticized as inadequate, it is about twice what Medicaid spends per year on beneficiaries in home and community-based services waivers. In addition, it provides an opportunity for private insurers to offer supplemental coverage for nursing home care. The legislation requires that there be between two and six benefit levels, but does not specify exactly how many nor what the cash benefits will be for each level. Germany established three basic benefit levels for its public long-term care insurance program and Japan has seven levels. Implementation of the CLASS Act also may draw on the experience of Medicaid programs, which routinely link disability levels to specific expenditure levels as part of the care planning process.

Unlike public insurance programs in countries such as Japan, Germany, and The Netherlands, CLASS does not require that everybody participate. Thus, the program is subject to adverse selection that could drive up the cost of premiums and potentially create an insurance death spiral. Without medical underwriting to exclude them, people with disabilities who need long-term care may enroll disproportionately in the program. To the extent that people who are not disabled do not enroll, the program's ability to spread

the costs of people using benefits across a broad population will be limited and premiums will rise, potentially causing nondisabled people to disenroll.

The CLASS Act attempts to lessen adverse selection through the following strategies:

- Enrollment is limited to people who work; retirees and people with disabilities who are not working cannot enroll. Using a definition of disability much broader than used to qualify for benefits in the CLASS program, only 19 percent of people with disabilities were working in April 2010 (U.S. Bureau of Labor Statistics, 2010). Thus, most people with disabilities are excluded from receiving benefits from the program.
- For employers who agree to administer payroll deductions, all workers will be enrolled automatically. Individuals who do not want to enroll may opt out, but they must decide actively to do so. This approach draws on behavioral economics research on participation in 401(k) retirement plans that found that enrollment rates were much higher when employees were required to opt out rather than opt in.
- To discourage people from waiting until they are disabled to enroll, enrollees must pay premiums for five years before they are eligible to receive benefits. In addition, premiums must continue to be paid after the five-year period. Thus, the requirement is more akin to a waiting period than a vesting period for a 401(k) plan.

Financing for the CLASS Act is entirely from premiums paid by enrollees, which may vary by age, as determined by the Secretary. There are subsidies to encourage enrollment for working full-time students and working people with incomes below the federal poverty level who initially will pay only \$5 per month. These subsidies are financed by other enrollees, not by federal general revenues. This subsidy by people who are enrolled in the insurance plan may raise substantially the premium for people who are not low-income or students.

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Setting the premiums is a classic “chicken-and-egg” problem. If actuaries assume that large numbers of people, including substantial numbers of people without disabilities, will enroll (or not disenroll), then premiums will be relatively low and large numbers of people, including those without disabilities, are likely to enroll. Advocates for the CLASS Act point to the near universal enrollment in Medicare Part B (largely physician services) and Part D (prescription drugs) as evidence that enrollment levels will be high for the CLASS Act. Conversely, if actuaries assume that relatively few nondisabled people will enroll and that most people with disabilities will enroll, then premiums will be high and few people, especially those without disabilities, will enroll. Premium estimators who argue this position note that voluntary enrollment in private long-term care insurance policies in employment settings is low, with generally only about five to seven percent of workers enrolling.

Premium estimates developed during the health reform debate assumed low levels of enrollment, resulting in high average premiums ranging from \$123 to \$240 per month (American Academy of Actuaries, 2009; Foster, 2009; U.S. Congressional Budget Office, 2009). The SCAN Foundation and Avalere Health’s (2010) premium simulator estimates average premiums for a voluntary long-term care social insurance program with some characteristics similar to the to the CLASS Act to be three times which the premiums would be for a mandatory program in which everyone participated. Active marketing of the CLASS insurance program will be critical to the program’s success, as will convincing actuaries that a high proportion of eligible workers will enroll. The initial premium might create a self-fulfilling prophecy that could determine the program’s success or failure.

The combination of the five-year minimum enrollment and the limitation of enrollment to the working population mean that the program will start off collecting far more in revenue than it pays out. As a result, the U.S. Congressional Budget Office scored the CLASS Act as reducing the deficit by \$70.2 billion over the period 2010 to 2019 (U.S. Congressional Budget Office, 2010a), including a modest level of Medicaid savings. CLASS would begin to add slightly to the deficit after 2029 because the benefit payments made in those years would exceed the premiums collected in those years. The law requires the program to be fully self-financing over 75 years.

### Promoting Medicaid Home and Community-Based Services

The most common critique of the long-term care delivery system is its institutional bias. Despite the strong preference of people to remain in their homes as they age, current spending for long-term care for older people and younger adults with physical disabilities is mostly for nursing home care. Only 32 percent of Medicaid long-term care expenditures for this population were for noninstitutional services in 2008 (Thomson Reuters, 2009).

States rely largely on Medicaid home and community-based services (HCBS) waivers to finance their expansion of noninstitutional services. These waivers allow Medicaid to cover a very broad range of services and to include people with slightly higher (although still low) income levels than are normally allowed. The waivers also give states strong fiscal control over expenditures by requiring that eligibility be limited to people who need nursing home care, mandating that average expenditures do not exceed the cost of nursing home care, and allowing states to limit the number of beneficiaries who receive services, a practice not permitted in the regular Medicaid program. The federal government exercises higher levels of administrative oversight on waivers than on regular Medicaid services, which some states view as burdensome.

The health reform law includes several additional options to cover Medicaid home and community-based services and, in some cases, provides states with a financial incentive to do so:

- *State Balancing Incentive Payments Program:* States planning to increase their percentage of long-term care expenditures for HCBS may apply to receive a time-limited (2011-2015) increase in their federal Medicaid match. The higher match is limited to states that spend less than 50 percent of their Medicaid long-term care expenditures on home and community-based services. In addition to specifying how they will increase their proportion of spending for HCBS, states must establish (1) a single point of entry to long-term care services, (2) “conflict-free” case management, and (3) standardized assessment instruments for determining

eligibility for HCBS. The legislation does not specify penalties for failure to meet the HCBS expenditure targets.

- *Community First Choice Option—Medicaid State Plan Option for Attendant Services and Supports:* This new state plan provision for attendant services and supports is an optional, less expensive version of the long proposed, but not enacted Medicaid Community Attendant Services Act. It covers a broad range of services, including those often needed to transition from the nursing home to the community (e.g., one month's rent deposit). Like Medicaid home and community-based waivers, eligibility is limited to people who need an institutional level of care with incomes up to 300 percent of the Supplemental Security Income payment level. Unlike Medicaid HCBS waivers, states are not required to limit average per person expenditures to less than or equal to what Medicaid spends on institutional care. Also unlike Medicaid HCBS waivers, states cannot set ceilings on the number of persons who can receive services nor can they limit benefits to subareas of the state. Services provided through this option receive a six percentage point increase in the federal Medicaid match.
- *Removal of Barriers to Providing Home and Community-Based Services:* The Deficit Reduction Act of 2005 established a new Medicaid state plan option for home and community-based services (Section 1915(i) of the Social Security Act). As enacted, the provision allows states to cover more than just personal care, but the range of services is less expansive than permitted under HCBS waivers. Unlike waivers, Section 1915(i) allows states to cover people needing less than institutional care. But, because this breaks the linkage to institutional care, states are not allowed to cover people up to 300 percent of the Supplemental Security Income payment level, the institutional financial eligibility

level in many states. The Deficit Reduction Act provision also does not allow waiver of "comparability," thus requiring states to offer the same benefit package to all eligibles. Like Medicaid home and community-based services waivers, states can limit the number of people served. While four states adopted this option, the rest did not, presumably because they did not believe that it offered enough advantages over the regular Medicaid personal care benefit or HCBS waivers to implement it. PPACA modifies Section 1915(i) to address some of the state and consumer concerns by broadening the scope of covered services, allowing states to reach the same groups financially and functionally as HCBS waivers do, and waiving comparability. PPACA reduces fiscal controls, however, by eliminating the ability to establish enrollment caps, and it also requires statewide coverage.

- PPACA also extends Medicaid institutional spousal impoverishment protections to community-based spouses of people receiving HCBS (for the period 2014 to 2019). In addition, it authorizes additional funds for Aging and Disability Resource Centers, which provide single points of entry to long-term care services. Finally, it authorizes additional funds for and slightly modifies the Money Follows the Person demonstration, which is experimenting with transitioning people from institutions to the community.

These provisions illustrate several issues related to creating a more balanced delivery system. First, although the most direct way to expand Medicaid HCBS would be simply to mandate coverage, PPACA relies instead on providing voluntary options for the states, some with financial sweeteners. This policy of offering options rather than mandates reflects overall Medicaid policy of the past 20 years. Second, the State Balancing Incentive Payments program and the Community First Choice option (and the Money Follows the Person demonstration) provide states with financial incentives, but only if they comply with

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certain requirements. From the federal perspective, the goal is to obtain behavioral change in exchange for the additional spending. Thus, the higher Medicaid match is provided only to states that commit to do more than they are doing now.

Third, the Community First Choice option and the modifications to the Section 1915(i) option showcase the tensions that exist between consumers and states on expanding home and community-based services. Consumers want statewide coverage of the widest possible range of services provided to the highest possible income group without the constraint of limiting average expenditures to nursing home levels and, especially, without the barrier of limitations on the number of beneficiaries and waiting lists. In contrast, states, while desirous of expanding home and community-based services, worry about runaway spending. In particular, given that less than a quarter of people with disabilities receive paid help (Kaye, Harrington, & LaPlante, 2010), states are concerned about large increases in use if they broadly offer services. States believe that they need the fiscal controls that consumers oppose and may not adopt options that do not provide them.

### Chronic Care Coordination

People with chronic conditions and disabilities receive care in a fragmented and uncoordinated financing and service delivery system, both within and between the health and long-term care systems. Financing for acute care is largely the responsibility of Medicare and the federal government, whereas long-term care is dominated by Medicaid and state governments. This division creates incentives for cost-shifting and disincentives for cooperation across programs. The high rate of unplanned rehospitalizations often is offered as evidence of the failure to coordinate care (Jencks, Williams, & Coleman, 2009). Coordinated care may improve outcomes and reduce costs.

Because relatively little is known about the effectiveness of care coordination, most PPACA provisions address this issue through administrative changes within the Centers for Medicare & Medicaid Services (CMS) or Medicare/Medicaid demonstration projects. These include the following:

- *The Federal Coordinated Health Care Office and the Center for Medicare and Medicaid Innovation within CMS:* To

focus attention on this high-need, high-cost population, the Federal Coordinated Health Care Office is charged with improving coordination between the Medicare and Medicaid programs for beneficiaries dually eligible for both programs. The Center for Medicare & Medicaid Innovation, although charged with more than care coordination, will test innovative payment and delivery arrangements. Importantly, successful models can be implemented nationally without additional legislation.

- *Medicare Special Needs Plans (SNPs):* A continuing frustration with standard managed care organizations is that they lack expertise on people with chronic conditions or disabilities. SNPs are Medicare Advantage plans that target enrollment of beneficiaries who are dual eligibles, nursing home residents, or have chronically disabling conditions. Some SNPs provide both acute and long-term care services. PPACA reauthorizes SNPs, requires them to have contracts with both Medicaid and Medicare, authorizes a new risk adjustment payment for fully integrated plans, and requires accreditation by the National Committee for Quality Assurance.
- *Medical Home and Related Demonstrations:* Medical homes are initiatives to reinvent primary care as the main mechanism for care coordination, especially among Medicare and Medicaid beneficiaries with chronic conditions and disabilities. One provision creates a state grant program to establish community health teams charged with developing patient-centered medical homes. The law also establishes medical homes services as an option in the Medicaid program. Another provision, the Medicare Independence at Home Demonstration Program, will test the use of medical practices consisting of primary care teams of physicians, nurse practitioners, and others to coordinate care and to deliver care to chronically ill

and disabled populations in their homes. Closely allied with the medical homes, the Community Care Transitions Program demonstration will provide transition services to Medicare beneficiaries at high risk of rehospitalization or poor transitions from hospital to post-acute care.

- *National Pilot Program on Payment Bundling and Related Provisions:* PPACA establishes a pilot program to change the way that care is reimbursed for 10 specific chronic conditions. Instead of each provider being paid separately, payments for acute hospital care, physician services, hospital outpatient services, and post-acute care will be combined (“bundled”) into a unified payment paid to a single provider, who will be responsible for managing all care for that episode. This all-inclusive payment will encourage the development of formal or informal integrated health systems, but it raises questions of whether hospitals (the most likely recipient of the bundled payment) will increase or decrease the use of post-acute and long-term care. If successful, the pilot may be expanded nationwide without additional legislation. In a related provision, PPACA also imposes financial penalties on hospitals with high rates of preventable rehospitalizations, a provision that may increase pressure on hospitals to find ways to work with long-term and post-acute care providers to reduce rehospitalizations.
- *Medicare Hospice Concurrent Care Demonstration:* Under existing law, Medicare or Medicaid beneficiaries who elect hospice care must forgo curative care for their terminal illness. This requirement is believed to deter people from enrolling in hospice care. PPACA establishes a three-year demonstration that will allow patients who are eligible for hospice care to receive all Medicare-covered services.

### Post-Acute Care Reimbursement

The health reform legislation finances expansion

of health insurance for the uninsured through new taxes mainly on higher-income people and through reductions in the Medicare payment rates. Post-acute care providers, including inpatient rehabilitation facilities, skilled nursing facilities, home health agencies, and hospices, are among the providers affected. In part, post-acute care providers are targets because of their high Medicare profit margins. For example, the Medicare Payment Advisory Commission estimated that the Medicare margin for skilled nursing facilities will be 10.3 percent in 2010 and, for home health agencies, was 17.4 percent in 2008 (Medicare Payment Advisory Commission, 2010). Skilled nursing facilities have argued that they need higher Medicare payments to offset the losses they incur on Medicaid residents. For post-acute care providers, the savings from the health reform legislation are achieved primarily by reducing the annual update for inflation. Through 2019, the estimated Medicare savings for skilled nursing facilities, home health agencies, and hospice total \$61.1 billion, accounting for about 13 percent of provider reimbursement cuts (U.S. Congressional Budget Office, 2010a, U.S. Congressional Budget Office, 2010b).

In addition to the payment reductions specified in the legislation, PPACA establishes an Independent Medicare Advisory Board to address the long-range solvency of Medicare. If the increase in Medicare per capita growth rate exceeds certain targets, the new board is charged with making recommendations to reduce expenditures, and these will be implemented unless Congress enacts alternative proposals that achieve the same level of savings.

### Nursing Home Quality Reforms

Despite improvements over time, poor-quality care in nursing facilities remains a continuing issue. In 2008, quality surveyors found that almost 26 percent of facilities had one or more deficiencies that caused harm or immediate jeopardy to residents (Harrington, Carrillo, & Blank, 2009).

The health reform legislation seeks to improve quality of care in nursing homes through the nursing home transparency and improvement, workforce, and pay-for-performance provisions. The nursing home transparency and improvement provisions, the first significant change to nursing home quality assurance system since the Omnibus Budget Reconciliation Act of 1987, are based on the notion that providing more information to consumers and regulators will

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motivate providers to improve quality. These new provisions require that nursing homes disclose detailed information about ownership, staffing, and expenditures and implement compliance and ethics programs. In addition, the legislation mandates that CMS develop a standardized complaint form and improve the Nursing Home Compare Web site, which provides quality-of-care information about individual nursing homes.

Workforce problems, including high turnover, low levels of training, and poor organizational culture, are believed to be a major cause of poor quality care in nursing homes. To address workforce issues to improve quality of care, PPACA includes provisions for a national demonstration on culture change and use of information technology in nursing homes; permits the Secretary to require nursing homes to conduct dementia management and abuse prevention training, although it does not increase the number of required hours of training; and establishes a national program of criminal and background checks on direct care workers. The health reform legislation also establishes a grant program to address elder abuse, neglect, and exploitation.

Finally, PPACA includes many provisions that promote pay-for-performance reimbursement or value-based purchasing. This strategy provides higher reimbursement to providers that improve quality or supply high quality care. Although the pay-for-performance demonstration for Medicare skilled nursing facilities is ongoing, the legislation requires the Secretary to submit an implementation plan for this approach despite questions about the adequacy of the quality measures and whether the link to Medicare savings is appropriate.

### Conclusion

While not as far reaching in long-term care as it is in medical care, the health reform legislation includes major provisions that will affect the financing and delivery of services for people with disabilities of all ages. First, the law aims to provide basic health insurance to all Americans, including direct care workers and persons with disabilities who are uninsured currently. For these populations, Medicaid expansions will play a critical role.

Second, although few observers initially thought it would survive to enactment, the CLASS Act has the potential to change long-term care financing from a welfare-based to an insurance-based system. In order

to do that, it will have to overcome the substantial risk of adverse selection. The program will have its biggest impact if large numbers of people enroll, which is likely to occur only if premiums are low. How the actuaries price the initial premiums will be critical for the initial and long-run success of the program.

Third, the legislation provides several new Medicaid options for the states to expand home and community-based services, but does not mandate that they do so. Given the financial troubles of the states and the availability of other Medicaid options, it is uncertain whether states will adopt these new options.

Fourth, the legislation includes a plethora of initiatives to improve care coordination for people with disabilities. While the focus is mostly on medical rather than long-term care, attention to people with chronic conditions inevitably leads to consideration of people with disabilities of all ages. In particular, the National Pilot Program on Payment Bundling and the Medicare Hospice Concurrent Care Demonstrations have the potential to fundamentally alter how the Medicare home health, skilled nursing facility, and hospice benefits operate.

Fifth, post-acute care providers will have their Medicare reimbursement trimmed substantially, which will provide savings to be used to finance expansion of health care for the uninsured. The Medicare business likely will remain profitable, but margins will be reduced.

Sixth and finally, the nursing home quality reforms will provide additional information that will be useful for regulators and consumers in monitoring and assessing providers, but will not change substantially the current system of quality assurance.

Looking to the future, additional changes, both big and small, are inevitable in the new framework established by this year's legislation. A new world of health and long-term care policy is just beginning.

*Joshua M. Wiener, PhD, is distinguished fellow and program director for aging, disability and long-term care at RTI International in Washington, DC. He currently is conducting research on programs for Alzheimer's disease, workforce issues in long-term care, nursing home quality, and costs associated with obesity and disability.*

### References

American Academy of Actuaries. (2009, July).

- Re: Actuarial issues and policy implications of a federal long-term care insurance program.* Retrieved July 2, 2010, from [http://www.actuary.org/pdf/health/class\\_july09.pdf](http://www.actuary.org/pdf/health/class_july09.pdf)
- Foster, R. (2009). *Estimated financial effects of the "America's Affordable Health Choices Act of 2009" (H.R. 3962), as passed by the House on November 7, 2009.* Baltimore, MD: Centers for Medicare and Medicaid Services. Retrieved July 21, 2010, from: [http://www.cms.gov/ActuarialStudies/Downloads/HR3962\\_2009-11-13.pdf](http://www.cms.gov/ActuarialStudies/Downloads/HR3962_2009-11-13.pdf)
- Harrington, C., Carrillo, H., & Blank, B. W. (2009). *Nursing facilities, staffing, residents, and facility deficiencies, 2003 through 2008.* San Francisco, CA: Department of Social and Behavioral Sciences, University of California.
- Jencks, S. F., Williams, M. V., & Coleman, E. A. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *New England Journal of Medicine*, 360, 1418–1428.
- Kaye, H. S., Harrington, C., & LaPlante, M. P. (2010). Long-term care: Who gets it, who provides it, who pays, and how much? *Health Affairs*, 29, 11–21.
- Medicare Payment Advisory Commission. (2010). *Report to Congress: Medicare payment policy* [March 2010]. Washington, DC. Retrieved May 24, 2010, from [http://www.medpac.gov/document\\_TOC.cfm?id=602](http://www.medpac.gov/document_TOC.cfm?id=602)
- PHI. (2010). *Who are direct care workers? New York.* Retrieved July 2, 2010, from <http://www.directcareclearinghouse.org/download/NCDCW%20Fact%20Sheet-1.pdf>
- Squillace, M. R., Remsburg, R. E., Harris-Kojetin, L. D., Bercovitz, A., Rosenoff, E., & Han, B. (2009). The National Nursing Assistant Survey: Improving the evidence base for policy initiatives to strengthen the certified nursing assistant workforce. *The Gerontologist*, 49, 185–197.
- The SCAN Foundation & Avalere Health. (2010). *Long-term care policy simulator.* Los Angeles, CA: The SCAN Foundation. Retrieved July 2, 2010, from <http://www.Itepolycysimulator.org/>
- Thomson Reuters. (2009). *Distribution of Medicaid long-term care expenditures for A/D services, FY 2008.* Cambridge, MA: Thomson Reuters. Retrieved July 2, 2010, from <http://hebs.org/files/166/8255/FY2008InstitutionCommunityRankings.xls>
- U.S. Bureau of Labor Statistics. (2010). *Table 6: Employment status of the civilian population by sex, age, and disability status, not seasonally adjusted.* Washington, DC: U.S. Bureau of Labor Statistics. Retrieved July 2, 2010, from <http://www.bls.gov/news.release/empstat.t06.htm>
- U.S. Congressional Budget Office. (2009). *Letter to the Honorable George Miller.* , DC: U.S. Congressional Budget Office. Retrieved July 2, 2010, from [http://www.cbo.gov/ftpdocs/10769/CLASS\\_Additional\\_Information\\_Miller\\_letter.pdf](http://www.cbo.gov/ftpdocs/10769/CLASS_Additional_Information_Miller_letter.pdf)
- U.S. Congressional Budget Office. (2010a). *Letter from Douglas Elmendorf, Director of the Congressional Budget Office, to Speaker Nancy Pelosi, House of Representatives, March 20, 2010.* Washington, DC: U.S. Congressional Budget Office. Retrieved July 2, 2010, from <http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf>
- U.S. Congressional Budget Office. (2010b). *Distribution among types of providers of savings from changes to updates in section 1105 of reconciliation legislation and sections 3401 and 3131 of H.R. 3590 as passed by the Senate.* Washington, DC: Congressional Budget Office. Retrieved July 2, 2010, from <http://www.cbo.gov/ftpdocs/113xx/doc11379/Distribution.pdf>

# The CLASS Act and Long-Term Care Policy Reform: A Perspective

*Walter D. Dawson*

In the American public policy arena, long-term care generally is considered to be subsumed within health policy. While the need for health care reform has received considerable attention over the years, long-term care (LTC) has generated less interest in the public realm. Even when LTC reform was discussed,<sup>1</sup> any substantial change either was lost in the political fray or resulted in incremental change only. This disparity in public attention remained constant even as Congress debated and eventually passed comprehensive health reform earlier this year.

The provision of LTC is increasingly a public policy issue in all advanced industrialized countries of the world, driven by demographic changes as well as several societal transformations. The United States is no exception as it struggles with the challenges posed by an increased need for long-term services and supports (LTSS). Long-term care is defined as the services and supports needed when the ability to care for oneself has been reduced by chronic illness, disability, or aging (Miller, Ranji, Hisey, & Salganicoff, 2007). LTC includes services such as feeding, bathing, dressing and help with other activities of daily living (ADLs) or instrumental activities of daily living (IADLs) such as housekeeping that are difficult or impossible to carry out due to illness or disability.<sup>2</sup>

Long-term care is a particularly relevant topic given the aging of the baby boom generation. In 2009, it was estimated that there were 38.8 million Americans over the age of 65 in the United States (Kinsella & He 2009). The U.S. Census Bureau projects that by the year 2030, nearly one in every five Americans will be age 65 or older. This age group is projected to increase to 89 million people by 2050 (U.S. Census Bureau, 2009). The projected demographic changes will add further strain to an already overburdened system, particularly related to its ability to provide and finance care.

Large numbers of Americans currently require LTC and the costs associated with the provision of LTC services are exceedingly high. Recent estimates show that approximately 10 million Americans require LTC (Kaye, Harrington, & LaPlante, 2010). Sixty-nine percent of Americans over age 65 will need some form of long-term care before they die and almost one-third of the entire U.S. population will spend some time in a nursing home during their lifetime (Weiner,

2009). Yet not all people who rely on these services and supports to help carry out their ADLs are elderly. Elder Americans account for approximately 58 percent of those in need of LTC while those under 65 make up the other 42 percent (Feder, Komisar, & Friedland, 2007). While the need for LTC becomes more likely as a person ages, this need transcends age to include people born with disabilities or who become disabled at any age due to accident or illness.

Approximately 70 percent of Americans 65 years or older who rely on long-term care receive services in a home- or community-based setting, compared to 30 percent who receive care through an institutional setting (Colello, 2007). The use of home and community-based services (HCBS) has grown in popularity in recent years. A survey sponsored by The SCAN Foundation showed that approximately 92 percent of Americans would prefer to receive care in their own homes rather than in institutional settings (Lake Research Partners, 2009). At the moment, HCBS often are not a financially viable option for people who need LTC.

The LTC financing system in the United States is both fractured and highly inequitable. LTC is financed through a patchwork system that includes the government programs of Medicaid and Medicare, but also considerable out-of-pocket expenditures and private insurance. Approximately 50 percent of all LTC spending takes place through Medicaid, while Medicare accounts for about 20 percent (U.S. Department of Health and Human Services, 2010). Out-of-pocket expenditures make up another 18 percent, while seven percent comes from private insurance and five percent from other sources. The national median cost of a private room in a nursing home in 2010 was \$206 a day or \$75,190 annually, while a bedroom in an assisted living facility cost

\$3,131 a month or \$37,572 annually, and the average hourly cost of in-home care provided by a home health aide averaged \$19 an hour or \$43,472 annually (Genworth Financial, 2010). As a nation, the United States spent \$206.6 billion on LTC in 2005 (U.S. Department of Health and Human Services, 2010). The real costs of LTC, however, are difficult to estimate precisely as many services are provided informally (and unpaid) by family or friends. Estimates of the costs of informal, unpaid care range as high as \$375 billion (Houser & Gibson, 2008). The cost of LTC is projected to more than double over the next 40 years as the U.S. population ages (Allen, 2005). Given the high cost of care and the projected demographic changes ahead, the current LTC financing system is unsustainable. Yet despite the obvious need for a comprehensive LTC policy that more adequately meets the needs of all Americans, reform has remained elusive until now.

The Community Living Assistance Services and Support Act (CLASS Act) that passed Congress earlier this year as a part of comprehensive health reform is a way to address some of the systemic issues mentioned here. CLASS is also a way to provide LTC consumers greater choice and control over their care. The CLASS Act amends the existing Public Health Service Act (PHSA) to establish a national voluntary disability insurance program for the purchasing of community living assistance services and supports. While CLASS is not a comprehensive fix for all the problems of the LTC financing system, it is the first major change to LTC policy financing in over four decades. As such a groundbreaking piece of legislation in the field of LTC policy, it is interesting to look at how this piece of legislation became law.

### The Development of CLASS

In his campaign for President, Barack Obama made comprehensive health reform a top domestic policy priority. President Obama's election and a return of large Democratic majorities in both chambers of Congress ensured that comprehensive health reform would be at the top of the domestic policy agenda. But addressing health reform did not necessarily mean that LTC reform would be included. The general consensus was that health reform and LTC reform would be addressed separately, with health reform taking precedence due to the sheer numbers of the uninsured and the ballooning costs of care. The fact that LTC

reform and the CLASS Act were a part of the health reform legislation that passed Congress this year is highly significant since very little or no changes to LTC policy have taken place since the 1960s.

Disability issues were a concern of Senator Edward M. Kennedy's for many years. He first introduced the CLASS Act in the U.S. Senate in 2005 (S.B. 1759). Representative Frank Pallone of New Jersey then introduced a companion bill to CLASS in the U.S. House of Representatives. Both pieces of legislation, however, failed to gain enough support to reach a vote in that session or the subsequent session of Congress. But, when health reform moved to the top of President Obama's domestic agenda in 2009, CLASS was included in both the Senate and the House of Representative's plans for health care reform. How CLASS went from a standalone piece of legislation to part of comprehensive health reform and finally to law is a fascinating process.

On March 25, 2009, Senator Kennedy reintroduced the CLASS Act (S. 697) as bill in the Senate. At the time, Senator Kennedy chaired the Health, Education, Labor and Pensions (HELP) Committee, one of the committees tasked with drafting health reform legislation. As chairman of the HELP Committee, Kennedy merged the CLASS Act with the committee's health care reform legislation, "The Affordable Health Choices Act" (S. 1679). Sadly, Kennedy's illness meant that he had to relinquish his chairmanship of HELP. In his absence, Senator Christopher Dodd oversaw the committee's work on health legislation until Senator Harkin took over as the new Chair. The bill passed out of the HELP committee but never reached a floor vote. Meanwhile, the U.S. House of Representatives passed "The Affordable Health Care for America Act" (H.R. 3962) through the Energy and Commerce Committee, which included a placeholder for the HELP Committee's version of CLASS. The House went on to pass H.R. 3962 on November 7, 2009, but the Senate never voted on that bill.

The Senate always took the lead on CLASS due to Senator Kennedy and the work of his staff, particularly Connie Garner, the HELP Committee policy director for disability and special populations. Since 2005, Garner worked to build a broad coalition in support of CLASS that included groups from both the disability and aging communities as well as LTC providers. This was one of the first instances where the

aging and disability communities were able to unite in support of a single piece of legislation. The coalition group met for almost five years. Their support took the form of grassroots outreach, visits to Capitol Hill, and ads in several key Washington publications like *Roll Call*. Throughout the process, the coalition provided support to legislators and coalition members to keep up the fight for CLASS.

The peak of uncertainty over the fate of CLASS—at least publically—may have been December 4, 2009, when South Dakota Senator John Thune proposed an amendment to remove the CLASS Act from the Senate’s version of health reform, “The Patient Protection and Affordable Care Act” (H.R. 3950). The Thune amendment received a majority of votes (51), but failed to pass due to Senate rules that require 60 votes to strip language from a bill once it is on the Senate floor. The failure of Senator Thune’s amendment effectively meant that CLASS likely would become law as long as health reform passed. The Senate went on to pass H.R. 3950 on Christmas Eve, but the final vote on health reform did not take place for almost three months. After much uncertainty over how to merge the two separate bills (the House and Senate versions) and whether there were enough votes to pass it again in either chamber, the House finally passed the Senate’s bill (H.R. 3950) on March 23, 2010. The bill returned to the Senate where it was re-passed and then signed into law by President Obama on March 30, 2010.

### Significant Variables

Several key people were essential to the passage of CLASS, most notably Senator Kennedy and his aide, Connie Garner. As the sponsor of CLASS and the Chairman of the Senate HELP Committee, Senator Kennedy’s impact on the legislation is significant. His long-standing interest in disability issues, but also his own illness and untimely passing played their roles. Senator Kennedy saw firsthand what people in need of LTC go through on a daily basis. After he passed away, CLASS could easily have been lost in the political fray, but his aide Connie Garner who had worked on CLASS from the beginning, as well as Senators Dodd and Harkin, picked up the torch and saw CLASS through to the end. Much credit must also go to Senate Majority Leader Harry Reid and House Speaker Nancy Pelosi who kept CLASS in health reform in the

face of much criticism. Without the support of these individuals, CLASS may never have come about.

A broad coalition of advocacy groups from both the disability and aging communities as well as providers united in support of CLASS. This is one of the few instances in U.S. history where the disability and aging communities joined together behind a single piece of legislation. The aging and disability advocacy communities often compete for the same resources and attention in the political arena given the similar needs of their constituencies. This coalition, however, divided the work load between the advocacy groups making their jobs more manageable and calling greater attention to their cause. This showed members of Congress the advocacy community’s commitment to CLASS. Their joint efforts were highly significant in ensuring that CLASS remained in health reform until the final vote.

The large budgetary surplus, originally projected at \$58 billion but eventually raised to \$70 billion by the Congressional Budget Office (CBO), also played a role in the success of CLASS.<sup>3</sup> In a political environment where new programs must be self-sustaining or create a net cost savings for the federal government, CLASS’ projected surplus meant that it would be relatively safe from attacks as an unfunded entitlement. Critics of CLASS instead often pointed to the surplus as some sort of scheme to ensure its passage under the radar. But that is highly doubtful in terms of intent and political significance. Its five-year vesting period was a part of the CLASS legislation long before comprehensive health reform was even a possibility. Moreover, it was not the positive CBO score that was so important in the passage of CLASS, but rather the absence of a negative score.

### The CLASS Program

The significance of the process through which CLASS ultimately became law does not overshadow the innovative nature of the program or its potential to help people of all ages who need long-term services and supports. The CLASS Act amends the American Public Health Service Act to establish a national voluntary disability insurance program for the purchasing of community living assistance services and support (H.R. 3950). CLASS will be open to all actively working adults, regardless of

any pre-existing conditions. In place of some form of underwriting, CLASS enrollees must be working actively and must pay premiums for at least five years to be eligible to receive benefits. Participants in need of assistance to perform their ADLs will receive a cash benefit to pay for those supportive services in a home or community setting. The benefit, however, also can be applied to traditional nursing home services, although it usually will cover only a portion of institutional costs.

Unlike Social Security or Medicare, enrollment in CLASS is voluntary. Employees will automatically be enrolled in CLASS only if their employer chooses to participate, employees may opt out of CLASS at any time. The Secretary of Health and Human Services (HHS) will establish a system of enrollment into the CLASS program for people who are self-employed or whose employer does not participate. It is hoped that the voluntary approach will ensure participation levels high enough to create a large enough risk pool for financial solvency.

The premiums for CLASS will be paid through monthly payroll deductions. The amount of the monthly premiums will vary based on a person's age at enrollment, but will be set by the HHS Secretary at a level that ensures financial solvency over 75 years. Full-time students under the age of 22 and people with incomes at or below the federal poverty level will pay monthly premiums of only \$5 (adjusted for inflation). Estimates for the average monthly premiums for everyone else vary widely from CBO's assessment of \$123 to CMS' of \$240 (Elmendorf, 2010; Foster, 2010). These contrasting premium estimates reflect different levels of projected participation in CLASS. actual premium rate, however, will not be known until the HHS Secretary determinations it next year.

CLASS will provide a cash benefit of no less than \$50 a day to purchase nonmedical services and supports that the beneficiary needs in order to carry out their ADLs (with no lifetime limit on the years or amount of benefits that can be collected). Enrollees with conditions limiting their basic life activities for more than 90 days will be eligible to receive benefits. CLASS benefits will be paid into special accounts—Independence Accounts—that enrollees will access by debit card. Additional benefits provided by the CLASS program include advocacy services as well as advice and counseling on how to coordinate their LTC.

According to the CBO, CLASS will generate a \$70 billion net surplus during the first 10 years of its operation (Elmendorf, 2010). The surplus largely will be generated by a vesting period during the first five years of the program, where no benefits will be paid out to enrollees. As the cash benefit can be used to pay for nursing home costs as well as in-home care, the CLASS Act theoretically should act as a cost saving mechanism for the Medicaid program. The CBO also projects that federal expenditures on Medicaid will drop by \$2 billion over the first 10 years because the program's cash benefit will help people avoid heavy out-of-pocket expenditures on care, postponing the spend down to qualify for Medicaid.

### Conclusions

The CLASS Act represents both incremental change as well as a major departure from previous LTC policy in the United States. On the one hand, the CLASS program is small in terms of its overall costs, especially when compared to Medicare or Medicaid. Moreover, while CLASS on average will cover a majority of HCBS costs, it only will cover a small portion of institutional costs. The remaining costs will continue to be financed by the patchwork mix of out-of-pocket expenditures, private LTC insurance, and the Medicare and Medicaid programs. Nonetheless, the CLASS Act constitutes the most significant change to LTC financing arrangements since the creation of Medicaid in the 1960s. CLASS is the first national, non-means tested financing program focused solely on long-term care. It is an implicit recognition by the U.S. federal government that LTC financing is a major policy concern. The CLASS program also provides a platform from which to launch future LTC policy initiatives. In other words, CLASS opens the door to universal LTC coverage in America. The policy community should take note, as it can help indicate for future reformers what works—and what does not—in terms of the legislative process.

*Walter Dawson, D.Phil Candidate, Department of Social Policy and Social Work, Green Templeton College, University of Oxford. Dissertation Title, "Interest Groups and Long-Term Care Policy Reform in the United States: An Examination of the CLASS Act."*

## The CLASS Act and Long-Term Care Policy Reform: A Perspective

### Endnotes

1. For example, see the Pepper Commission Report and the Health Security Act of 1994.
2. Activities of daily living (ADLs) include bathing, dressing, eating, toileting, and transferring. Instrumental Activities of Daily Living (IADLs) include food preparation, medicine management, shopping, and housekeeping.
3. An actuarial assessment of the costs of health reform completed by the Centers for Medicare and Medicaid (CMS) on April 22, 2010, lowered CLASS's projected surplus to \$38 billion.

### References

- Allen, K. (2005). *Long-term care: Growing demand and cost of services are straining federal and state budgets* [Testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives]. Washington, DC: States Government Accountability Office. Retrieved July 3, 2010, from <http://www.gao.gov/new.items/d05564t.pdf>
- Colello, K. (2009). *Family Caregiving to the Older Population: Background, Federal Programs, and Issues for Congress*. Washington DC: Congressional Research Service.
- Elmendorf, D. (2010, March 11). *Letter to Senator Harry Reid from Douglas Elmendorf, CBO Director*. Washington, DC: Congressional Budget Office.
- Feder, J., Komisar, H., & Friedland, R. (2007). *Long-term care financing: Policy options for the future*. Washington DC: Georgetown University Long-Term Care Financing Project. Retrieved July 19, 2010, from <http://ltc.georgetown.edu/forum/ltcfinalpaper061107.pdf>
- Foster, R. (2010, April 22). *Estimated financial effects of the "Patient Protection and Affordable Care Act," as amended*. Washington, DC: Centers for Medicare and Medicaid Services.
- Genworth Financial. (2010). *Cost of Care survey*. Retrieved May 28, 2010, from [http://www.genworth.com/content/etc/medialib/genworth\\_v2/pdf/ltc\\_cost\\_of\\_care.Par.14625.File.dat/2010\\_Cost\\_of\\_Care\\_Survey\\_Full\\_Report.pdf](http://www.genworth.com/content/etc/medialib/genworth_v2/pdf/ltc_cost_of_care.Par.14625.File.dat/2010_Cost_of_Care_Survey_Full_Report.pdf)
- Houser, A., & Gibson, M. (2008). *Valuing the invaluable: The Economic Value of Family Caregiving, 2008 Update*. Washington, DC: AARP Public Policy Institute.
- Lake Research Partners. (2009, July 8). *National poll indicates broad support for long-term care reform*. Washington, DC: Lake Research Partners.
- Miller, B., Ranji, U., Hisey, H., & Salganicoff, A. (2007). *Financing long-term care: Background brief*. Washington, DC: Kaiser Family Foundation. Retrieved May 30, 2010, from [http://www.kaiseredu.org/topics\\_im.asp?id=680&imID=1&parentID=65](http://www.kaiseredu.org/topics_im.asp?id=680&imID=1&parentID=65)
- Kaye, S., Harrington, C., & LaPlante, M. (2010). Long-term care: Who gets it, who provides it, who pays, and how much? *Health Affairs*, 29(1), 11-21.
- Kinsella, K., & He, W. (2009). *An aging world: 2008* [U.S. Census Bureau, International Population Reports, P95/09-I]. U.S. Government Printing Office, Washington, DC.
- Wiener, J. (2009). *Long-term care: Options in an era of health reform*. Washington, DC: RTI International.
- U.S. Census Bureau. (2009). *Census Bureau reports world's older population projected to triple by 2050*. Washington, DC: U.S. Department of Commerce.
- U.S. Department of Health and Human Services. (2010). *National clearinghouse for long-term care information*. Retrieved May 30, 2010, from [http://www.longtermcare.gov/LTC/Main\\_Site/Paying\\_LTC/Costs\\_Of\\_Care/Costs\\_Of\\_Care.aspx](http://www.longtermcare.gov/LTC/Main_Site/Paying_LTC/Costs_Of_Care/Costs_Of_Care.aspx)

## Dueling Talking Points: Technical Issues in Constructing and Passing the CLASS Act

*Babara Manard*

Passage of the CLASS Act as part of health reform astonished many, including experts in the field, current supporters, and those who opposed it. As late as January 2009, it was seemingly true to most that “we have not seen the sustained media coverage that is necessary to create a sense of urgency about either the unmet needs or the hardships that are created by a means-tested approach to LTSS [long term services and supports]. There are few if any interest groups or foundations for which reform of LTSS financing is a top priority” (Goldberg, 2009, pp. 6-7). Even today, stories about the CLASS Act frequently begin with the phrase “a little known part of health reform,” as if it had come as an afterthought.

### Getting to CLASS

The genesis of the CLASS Act with Senator Ted Kennedy and Connie Garner, initially working largely with the disability community, is described elsewhere in this issue. Specialists in aging and long-term care (LTC) may know better the long debate between those who favored an all-inclusive, tax-supported social insurance plan and those who favored relying more or totally on private long-term care insurance. In 2003, at a conference where many excellent thinkers debated the matter, economist Bill Scanlon said “after 20-some years of no progress in the area of financing it would really be good to think creatively.” He noted that “much of our discussion about long-term care has always been in the context of another health service, that the only problem with long-term care financing today is that it wasn’t put on the list of services covered by one of our insurance programs and I think that the reality is that is a sort of narrow view that isn’t going to help,” and called for new options that better took into account how LTC differs from acute care: “long-term care ... while it is about maintaining life in the face of a disability it’s also about how you maintain your life, what is the sort of situation that you live in, what’s the degree of comfort that you have, what is the burden that’s imposed upon your family that’s living with you” (Scanlon, 2003).

The CLASS Act—a voluntary, consumer-financed, publicly administered, cash-benefit insurance plan—turned out to be the creative approach that worked. In 2003, work on an early version of the CLASS Act was well underway; this version was initially unknown to us at the American Association of Homes and Services for the Aging (AAHSA), which advocates for “the future of aging services in a place

called home” and represents non-profit services across the continuum. AAHSA leadership, also thinking it was time for new approaches, convened a task force in 2004 to analyze options and propose solutions. In 2005, as the analytical work and development of recommendations neared completion, we recognized them as closely compatible with principles embodied in the 2005 CLASS Act legislation that was circulating before its introduction in November. AAHSA formally adopted its proposed approach in 2006 (AAHSA Board of Directors, 2006). By 2007, I was presenting at many conferences about a topic we hoped to make true: “Financing LTC: An Emerging Consensus” (Manard, 2007).

As AAHSA and other groups from the aging side of things joined with those from the disability side of things, a powerful advocacy coalition was formed. While it might have seemed in January 2009 that not much was going on to suggest LTSS might really be included in health reform, by February 2009 an energized CLASS Act coalition was actively at work and even had a website: <http://www.passtheclassact.org/about-this-site>, onto which talking points and documents related to CLASS continue to be added in 2010.

The four critical keys to passing CLASS were congressional champions (e.g., members such as Kennedy and Dodd and the indefatigable staffer Connie Garner), presidential backing, an effective grassroots coalition, and the newly developed approach—a voluntary, consumer-financed, publicly administered, cash-benefit insurance plan. Below I outline some technical issues in that development. I am telling just one part of this story, as I saw it, from the perspective of a long-ago academic, privileged

to voyage with the political specialists, grassroots advocates, and leaders who secured the historic achievement of passing the CLASS Act.

### It's Not an Entitlement

Two strands of policy analysis over the years combine in CLASS, creating the approach that passed. First, cash benefits long have been the preferred approach in disability (income support) insurance, but rare in long-term care insurance (Driscoll & Lynch, 2009). Over a decade ago, however, Robyn Stone, argued for using cash benefits in a public approach to long-term care insurance, helping to implement then later reporting on the early days of the “Cash and Counseling” experiment (Stone, 1996). That experiment, which ultimately proved the idea worked extremely well in Medicaid programs, became a favorite inspiration for financing reform ideas at key conservative think tanks (Froque, 2003). CLASS’ cash benefit, selected originally by the law’s early supporters from the disability community, appealed across party lines.

Second, the use of premium-financed insurance—with help for low income people—became the general approach to national health insurance reform, following the model implemented in Massachusetts. It resonated with those who supported Medicare Part D—the voluntary prescription drug plan for Medicare beneficiaries—while it distressed others who favored a different approach such as a national public insurance plan, financed by progressive income taxes, spreading the financing cost more equitably from that perspective. In this regard, CLASS is a unique hybrid: a national, voluntary, publicly administered insurance plan, but one in which the law stipulates “no [federal] taxpayer funds shall be used for payment of benefits.”

Premiums pay for less than half of Medicare benefits, including the voluntary Part D; the rest comes from taxes. But by law, the CLASS Act is consumer financed, or “internally financed,” to use the more technical term. Even the subsidies for low income people—people below 100 percent of the poverty line and working students pay \$5 per month—are internally financed, and thus limited in order not to increase too much the premiums for those with higher incomes who also pay for the subsidies. The self-financing aspect of CLASS was one key to its passage. It meant that CLASS wasn’t kicked out, begging for a

share of scarce “pay-for” dollars.

The scarcity of those “pay for” dollars also meant it was virtually impossible to make CLASS mandatory, even if that might otherwise have been desirable or politically plausible. A mandatory program would require finding substantial dollars external to CLASS to subsidize more low income people, possibly up to the 400 percent of poverty settled on for “regular” health insurance reform. At that point, CLASS would have actually become the “new government entitlement” ill-informed critics labeled the voluntary, self-financing plan. Instead, congressional CLASS designers and advocates stuck with the newer concept, fully aware of the risks of adverse selection in a voluntary plan forbidding exclusion (among those otherwise eligible) of those who would more certainly use the benefits, and the need for exceptionally effective implementation. It was certainly not true in November 2009, as one blogger who favors a mandatory plan suggested, that “CLASS backers face a tough choice: pass a second-best program that runs the risk of failure, or come back again in a couple of years with a better plan” (Gleckman, 2009). The greatest risk was not taking a risk in the present time. The choices adopted in crafting the legislation in the HELP Committee and beyond were geared to designing a “first-best” program, to the best of participants’ abilities, which meant (as would have been the case at any time) efforts to balance many kinds of risks: political, administrative and actuarial.

### Addressing a Key Puzzle in April-June, 2009

One goal of those drafting the CLASS Act portion of the HELP Committee’s health reform bill was to keep as close as possible to previous versions of the stand-alone CLASS Act, which had already been widely circulated and had garnered many co-sponsors and advocates. One part that needed change was the \$30 per month premiums appearing in the earlier versions. That specific dollar amount had been based on limited analyses available at the earliest point, with long-standing plans for congressional drafters to seek a more refined estimate of actuarially sound premiums from the Congressional Budget Office (CBO) or the Congressional Research Service (CRS) as the drafting progressed. But by spring 2009, some external analyses made clear that the \$30 per month premiums were too low for a sustainable

program—long a key goal of the CLASS developers. Neither the Moran Company study, an analysis commissioned by AAHSA, nor another detailed actuarial study made available to committee staff and CBO perfectly matched the CLASS Act details emerging from policy discussion in early 2009. The Moran study presented a range of premium prices that resulted from modeling a mandatory program and varying the benefit length and segments of the population mandated to participate (The Moran Company, 2007). The other study presented a range of premium prices garnered from modeling both a mandatory program and a voluntary one using various estimates of participation, biased/adverse selection, and disability rate changes, but including certain features of CLASS that already had been changed from earlier versions. The two reports, despite wide differences in many respects, reported closely similar sustainable premiums for a mandatory plan for working age (or actually employed) people in the range of \$60 to \$70 per month, using a benefit trigger of 2+ limitations of activities of daily living (ADLs) and a daily cash benefit of \$75; details of the options considered in each report facilitated drafting the legislation prior to further analysis by CBO.

The challenge for drafters updating the CLASS Act legislation was crafting a bill that (1) met program goals to be a voluntary, self-financing plan and to provide cash sufficient for a foundational level of supports and services pegged to disability level (the early version called for a daily cash benefit of \$50 for 2 to 3 ADLs and \$100 for 4+ ADLs); (2) had sufficient detail to be modeled by CBO, which was charged with producing estimates of the legislation's effect on the federal budget; and (3) provided an appropriate balance between assuring basic congressional intent sufficiently expressed in the law with allowing sufficient administrative flexibility to assure on-going program financial integrity.

In modeling a plan like CLASS, after specifying the broad outline of the population eligible for enrollment (in this case, those age 18+ and working), one needs to specify two of the following three variables and have a complex computer model to solve for the third: the amount of the daily cash benefit, the minimum benefit trigger level (e.g., 2+ ADLs or a more stringent 3+ ADLs), and the average premium price. Differences among modelers in solving those equations result from differences in the underlying

data sets used and different assumptions about inflation rates, disability incidence and continuance, participation, and adverse selection. Those choices about data and assumptions would be CBO's to make independently. The legislation, however, needed to deal with the three variables identified above.

The solution for drafting the CLASS Act that was introduced for debate by the HELP Committee was this: the legislation directed the Secretary of Health and Human Services "in consultation with appropriate actuaries and other experts" to develop "an actuarially sound" plan. Among the many possible combinations of benefit levels, triggers, and premiums for a plan, the legislation put one critical stake in the ground, saying the benefit, on average, could not be less than \$50 per day, increased annually by inflation. The Secretary was given the flexibility to select the benefit trigger from two specified options: either 2+ ADLs or a more stringent 3+ADLs (the more stringent trigger would lower premiums if all else remained constant). Finally, the legislation specified a target average maximum premium price ("for all reasonably anticipated new and continuing enrollees") of \$65 per month in 2009 dollars. But that stipulation was followed by a clause many missed that gave the Secretary the authority to adjust the \$65 per month "as necessary to ensure payment of the minimum cash benefit" in the *actuarially sound* plan to be developed. The procedure for determining plan details specified in the version debated by the HELP Committee, and still in the version now law, called for a presidentially appointed advisory council to review a set of actuarially sound options developed by the Secretary and recommend one for adoption that "best balances price and benefits to meet enrollees' needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program." The Advisory Council in CLASS drew its inspiration from the successful Health Insurance Benefits Advisory Council which developed program details after the Medicare law was passed (Feder, 1977).

### Endorsed by the President and Actuarially Sound for 75 Years

On the morning of July 7, 2009, advocates, reporters, and C-SPAN cameras jammed a senate hearing room to watch the HELP Committee debate and consider changes to the CLASS Act provisions of

the Committee's health reform bill. The day before, a crucial letter to Chairman Kennedy had arrived from Secretary Sebelius, saying the President "believes it is appropriate to include the CLASS Act as part of health reform because enactment of this important legislation would expand resources available to individuals and families to purchase long-term services and supports and enable them to remain in their own homes in the community. The CLASS Act is an innovative voluntary program that will provide important benefits to people who need them" (Sebelius, 2009).

Senator Chris Dodd (D-CT) chaired in the absence of ailing Senator Kennedy. Thick notebooks prepared by staffers containing talking points and summaries of the more than 300 amendments previously filed (35 or so on CLASS) were piled on the tables. One summary referred to an amendment championed by Senator Gregg (R-NH) that sought "to change the conditions under which the Secretary *must* adjust premiums for solvency: the legislation currently specifies that if the Secretary determines that funds are insufficient for the next *20 years*, the Secretary *shall adjust* them. The amendment proposes changing that *to 75 years*." Talking points on the Democratic side listed reasons for opposing the amendment, informed by caution that "the future is more uncertain than commonly acknowledged" (Friedland & Summer, 1999).

But Senators were focused not so much on the exact language of the bill, as on the CBO analysis of costs—one of many instances when the model became assumed to be the law. CBO's model had the plan chosen by the Secretary starting out for the first decade with people paying \$65 per month for a \$75-per-day benefit. In the second decade, as modeled, the Secretary seemingly realized that this approach would not work for the long-term and therefore changed the program so that all participants (new entrants and old) got only \$50 per day benefits, and new participants paid premiums of \$85 per month. Republicans mocked this as "bait and switch" and "a loss leader approach better kept in the grocery story." One added, "Look, even if the premiums are \$100 per month, it's still a really good deal and could be a good program." Senator Dodd, wisely ignoring the talking points, advised committee members that he thought they should accept the Gregg amendment and called for a vote and the 75-year solvency amendment was adopted unanimously. Remaining amendments

were withdrawn. Thus, CLASS was included with bi-partisan support in the HELP bill. Senator Gregg quickly issued a press statement, saying "our nation needs to address the growing problem of providing health care services for older individuals who have trouble with activities and tasks of daily life.... My amendment ensures that instead of promising more than we can deliver, the [CLASS] program will be fiscally solvent, and we won't be handing the bill to future generations" (Gregg, 2009).

### Reports from the CMS Actuary

As the CLASS Act moved beyond the HELP Committee, CBO estimates of CLASS Act premiums reflected the Gregg amendment as well as key differences that emerged between the House bill, which was passed November 7, 2009, and the Senate version, which was passed by the Senate on December 24, 2009 and subsequently passed by the House, becoming law when signed by the President March 23, 2010. While the CBO is the official scorekeeper for legislation, the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) also weighed in with its own analyses of CLASS. Although the CMS Actuary—Richard Foster—is technically part of the administration, his analyses of health reform legislation, including CLASS, were published with this disclaimer: "The Office of the Actuary has prepared this memorandum in our longstanding capacity as an independent technical advisor to both the Administration and the Congress.... The statements, estimates, and other information provided in this memorandum are those of the Office of the Actuary and do not represent an official position of the Department of Health & Human Services or the Administration" (Foster, 2010, p. 1).

Foster wrote skeptically of CLASS' possibility of success, itemizing a litany of risks: low participation, costly premiums, and adverse selection potentially leading to a classic "insurance death spiral" (e.g., too many people with existing disabilities signing up, too few who would never use the benefit) (Foster, 2010). The CBO also described potential risks, but additionally suggested some counter-considerations including that "by keeping administrative costs to a minimum, the CLASS program might attract relatively healthy enrollees because the resulting premiums could be lower than the premiums that would be charged for many private policies that have substantially higher

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administrative costs and devote a share of their premiums to profit” (Elmendorf, 2009).

What is unclear about the CMS Actuary reports is how the Office of the Actuary calculated the reported financial results. Foster issued four reports on health reform bills that included nearly identical paragraphs about CLASS (Foster, 2010), key information from which is shown in Table 1, which compares Foster’s numbers with those of other analysts.

There were two key differences between the Senate and House versions of CLASS. First, in the Senate bill, only active workers were eligible to enroll. In the House bill, both active workers and their non-working spouses were eligible to enroll. CBO anticipated “that the average non-working spouse

who would enroll in the program would have more functional limitations than the average enrolled worker, which would make non-working spouses more likely to qualify in the future for the program’s benefits” and concluded that monthly premiums for a sustainable CLASS program would be 20 percent *higher* in the House version (\$147) than in the Senate version (\$123). Foster judged the reverse, concluding that premiums would be 25 percent *lower* in the House version (\$180) than in the Senate version (\$240), and mentions nothing about non-working spouses, so it is unclear whether that difference was taken into account.

A second difference is that the Senate (but not the House) bill specified that working students and those with incomes below 100 percent of poverty

**Table 1** Estimates of Monthly Premiums for a Sustainable CLASS Plan

Analyst	Average Daily Benefit	Assumed Participation Rate [Estimated number of adult pop. Enrolled]	Non Working Spouses May Enroll	Average Monthly Premiums	Net Deficit Reduction 2010-2019
<b>CMS Actuary</b> (11/13/2009) “House Bill as passed”	Not stated	2% [about 2.8 million by 2013]	Not stated, but should be “Yes”	<b>\$180</b>	\$38.7Billion
<b>CMS Actuary</b> (1/8/2010) “Senate Bill as passed”	Not stated	2% [about 2.8M by 2013]	Not stated, but should be “No”	<b>\$240</b>	\$37.8Billion
<b>CBO</b> (11/19/2009) House bill	\$75/day	5-6% [slightly >10M, about 4% of adults by 2019]	Yes	<b>\$147</b>	\$101.6B
<b>CBO</b> (10/29/2009) Senate bill	\$75/day	5-6% [slightly <10M, about 3.5% of adults by 2019]	No	<b>\$123</b>	\$72.5B
<b>AAA/SOA</b> (7/22/2009)	\$76/day	6%	Yes	<b>\$160</b>	Not estimated

**Sources:** CMS estimates available at [https://www.cms.gov/ActuarialStudies/05\\_HealthCareReform.asp#TopOfPage](https://www.cms.gov/ActuarialStudies/05_HealthCareReform.asp#TopOfPage); CBO estimates available in Memorandum to Senator Harkin, dated November 25, 2009, at [http://www.cbo.gov/ftpdocs/108xx/doc10823/CLASS\\_Additional\\_Information\\_Harkin\\_Letter.pdf](http://www.cbo.gov/ftpdocs/108xx/doc10823/CLASS_Additional_Information_Harkin_Letter.pdf). AAA/SOA letter found at [http://www.actuary.org/pdf/health/class\\_july09.pdf](http://www.actuary.org/pdf/health/class_july09.pdf).

**Notes:** (1) benefits increase annually with inflation; premiums for each cohort are constant from point of enrollment, each successive cohort starts with premiums higher (by inflation) than the cohort joining the previous year. (2) CBO uses 2.5 ADLs as a benefit trigger; AAA/SOA uses 2 ADLs; CMS does not say what it used.

would pay \$5 per month premiums. Foster's text regarding the different bills is identical except for one phrase found in the report on the Senate bill, but not in that on the House bill; he lists in text regarding the Senate bill "the effect of subsidizing participants paying the \$5 premium" among other reasons for low participation. But if the internal subsidies have such an effect on premiums, accounting for a 25 percent difference, then why does the Actuary estimate that participation will be identically low in reports on both versions of the bill?

Even more inexplicable are Foster's estimates of 10-year federal deficit reduction. Those numbers, as can be seen in the CBO estimates, largely reflect accumulating premiums with totals driven by the number of people paying premiums and the average premiums paid monthly. Thus CBO, with higher premiums in the House version (\$147) estimated higher (\$101.6 billion) deficit reduction for that bill; contrasting with the Senate bill's lower premiums (\$123) and resulting lower (\$72.5 billion) deficit reduction. In contrast, Foster's substantially lower premiums in the House version (\$180) than in the Senate version (\$240), with identical numbers participating in each, result in nearly identical deficit reduction: \$38.7 billion (House) and \$37.8 billion (Senate).

What the CMS Actuary says makes a difference beyond CLASS. (Witness the on-going debate over his analyses of health reform financing in general at <http://blog.kaiserhealthnews.org/index.php/2010/04/28/arguments-persist-over-cms-actuary-report/>.) In his reports on CLASS, Foster reveals so little about his methods that he appears more careless than iconoclastic.

### Future Talking Points

We are beginning to hear some say that CLASS passed because the CBO scored it as a \$70B+ net deficit reducer over the 10-year period critical to accounting for the costs of health care reform. Nearly all of that deficit reduction reflects premiums collected and accounted for by the standard rules that CBO is required to follow. About \$2 billion is for savings to Medicaid (federal share). As accumulated surpluses in the CLASS Act trust fund pay for benefits later, in years when cash coming in is less than cash going out, it counts as a deficit increase in federal budget accounting, even as CLASS remains self-sustaining.

It is certainly true that CLASS could not have passed if it had scored as a substantial 10-year deficit increaser. But it would be hard to conclude that \$70B+ in the first 10 years made the sale, given the concerns that dominated so much of the CLASS debates over assuring that funds are available when participants in large numbers start drawing benefits. There were serious issues over the CLASS funds; there was also understandable confusion among even the better reporters who misled by taking phrases out of context from complicated budget analyses. There was also much mischief (Google for "the CLASS Act" with "ponzi scheme"). In February, Congress took an additional step important to CLASS and the nation, adopting rules for future accounting that require calculating budget deficits with CLASS funds off the table (Keith, 2010). We need better talking points and reporting to get the CLASS financial story right.

Will CLASS work? No one knows. It hasn't been tried before. What we have tried is not working. We need to try something different. By design, the law has built-in flexibility for the details to be created by rule. Obviously, even the best plan will surely fail if poorly implemented. More talking points needed; volunteers welcome.

*Barbara Manard, PhD, is vice president of long-term care/health strategies at the American Association of Homes and Services for the Aging in Washington, DC.*

### References

- AAHSA Board of Directors. (2006). Financing long-term care: A framework for America. Washington, DC: American Association of Homes and Services for the Aging. Retrieved July 9, 2010, from <http://aahsa.org/WorkArea/DownloadAsset.aspx?id=1160>
- AAA/SOA. (2009, July 22). Letter addressed to the U.S. Senate Committee on Health, Education, Labor and Pensions "Re: Actuarial Issues and Policy Implications of a Federal Long-term Care Insurance Program."
- Driscoll, M. K., & Lynch, M. (2009, October 14). What the CLASS Act can teach the long term care insurance industry. National Underwriter Life and Health. Retrieved July 9, 2010,

## Dueling Talking Points: Technical Issues in Constructing and Passing the CLASS Act

from <http://www.lifeandhealthinsurancenews.com/Exclusives/2009/10/Pages/What-the-Class-Act-can-teach-the-long-term-care-insurance-industry.aspx>

- Elmendorf, D. (2009, November 25). Letter from the CBO Director to Senator Tom Harkin.
- Feder, J. M. (1977). Medicare implementation and the policy process. *Journal of Health Politics, Policy and Law*, 2(2), 173-189.
- Foster, R. (2010, January 8). Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Passed by the Senate on December 24, 2009. Washington, DC: Centers for Medicare and Medicaid Services. Retrieved July 9, 2010, from [https://www.cms.gov/ActuarialStudies/Downloads/S\\_PPACA\\_2010-01-08.pdf](https://www.cms.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf)
- Froegue, J. (2003). The future of Medicaid: Consumer-directed care. Washington, DC: The Heritage Foundation. Retrieved July 9, 2010, from <http://www.heritage.org/Research/Reports/2003/01/The-Future-of-Medicaid-Consumer-Directed-Care>
- Friedland, R. B., & Summer, L. (1999). Demography is not destiny. Washington, DC: National Academy on an Aging Society.
- Gleckman, H. (2009, November 15). Medicare actuary: Few will buy CLASS long-term care insurance. Blog: Caring For Our Parents. Retrieved July 9, 2010, from [http://abytesgen01.securesites.net/howard\\_gleckman/2009/11/cms-actuary-few-will-buy-class.html](http://abytesgen01.securesites.net/howard_gleckman/2009/11/cms-actuary-few-will-buy-class.html)
- Goldberg, L. (2009). Long-term services and supports as part of health care reform: Relief for the invisible uninsured? A one-year review of the 2008 conference roundtable (Health and Income Security Brief No. 12). Washington, DC: National Academy of Social Insurance. Retrieved July 9, 2010, from [http://www.nasi.org/usr\\_doc/Security\\_Brief\\_No\\_12\\_-\\_Long-Term\\_Services\\_and\\_Supports\\_.pdf](http://www.nasi.org/usr_doc/Security_Brief_No_12_-_Long-Term_Services_and_Supports_.pdf)
- Gregg, J. (2009, July 7). Gregg eliminates \$2 trillion in future debt. Press Release. Retrieved July 9, 2010, from <http://gregg.senate.gov/news/press/release/print.cfm?id=bf8e56c-fa54-414f-a90f-6f5f622144f9>
- Keith, R. (2010). The Statutory Pay-As-You-Go Act of 2010: Summary and legislative history (Congressional Research Report for Congress, April 2, 2010).
- Manard, B. (2007). Financing long-term care: An emerging consensus. Presentation at the AARP International conference: U.S.-German Dialogue on Long-Term Care, October 30, 2009, Washington, DC. Retrieved July 9, 2010, from [http://www.aarpinternational.org/conference\\_sub/conference\\_sub\\_show.htm?doc\\_id=679099](http://www.aarpinternational.org/conference_sub/conference_sub_show.htm?doc_id=679099)
- Scanlon, W. (2003). Overview: Getting to a better long-term care system. Presentation at the Georgetown University Financing Project conference: The 21st Century Challenge: Providing and Paying for Long-Term Care, May 21, 2003, Washington, DC. Retrieved July 9, 2010, from [http://www.kaisernetwork.org/health\\_cast/hcast\\_index.cfm?display=detail&hc=869](http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=869)
- Sebelius, K. (2009, July 6). Letter from Secretary Sebelius to Senator Kennedy..Retrieved July 9, 2010, from <http://www.passtheclassact.org/hill-materials>
- Stone, R. I. (1996). Providing long-term care benefits in cash: Moving to a disability model. *Health Affairs*, 20(6), 96-107.
- The Moran Company. (2007). Modeling a new long-term care financing plan (Prepared for the American Association of Homes and services for the Aging). Washington, DC: The Moran Company.

# The Circular Relationship Between Enrollment and Premiums: Effects on the CLASS Program Act

*Anne Tumlinson*

*Weiwen Ng*

*Eric Hammelman*

The Affordable Care Act (ACA) contains a provision, the Community Living Assistance Services and Supports (CLASS) program, which creates a national, public, and voluntary long-term care insurance program. When implemented, working adults will be eligible to participate, either through their employers or directly through an alternative mechanism. Employers will be permitted to enroll their workers automatically, much like they would auto-enroll workers in 401(k) plans; if auto-enrolled, workers will be free to opt out. Additionally, full-time students and people under the Federal Poverty Limit will receive significant discounts to participate. The program then will pay cash benefits averaging at least \$50 per day over the lifetime of anyone who is vested in the program and becomes disabled. These benefits can be used to pay for long-term services and supports such as home care, durable medical equipment, or home modifications.

This new law is the first major attempt to address this nation's lack of widespread insurance protection for long-term care. Before the ACA, the U.S. lacked any vehicle to spread the financial risk of long-term care throughout the population and provide a reliable funding source for the care some people will need. While Medicaid acts as a safety net for individuals with few resources or whose resources have been exhausted by out-of-pocket medical and long-term care costs, most people have little protection against the possibility of impoverishment. Likewise, state budgets are strained by the lack of widespread insurance coverage. More than one-third of Medicaid spending is devoted to long-term care for people who have neither insurance nor the resources to pay for all of their care out-of-pocket.

The federal government faces a number of challenges in implementing this new law. Perhaps most significantly, it must set premiums in a manner that ensures the program has funds adequate to pay benefits. At the same time, it must keep the premiums low enough to attract a sufficient number of enrollees over whom to spread risk and ensure that premiums can remain affordable into the future. Central to the question of setting premiums is the initial assumption program actuaries make about how many people eligible to enroll in the program choose to participate (called the "participation rate"). This brief explains the relationship between this assumption and the calculation of premium levels. We present data showing the premium levels we calculate for different participation rate assumptions.

## Participation Assumptions as a Key Driver of the Program's Premiums and Enrollment

The CLASS Act has generated a great deal of interest because it does not exclude individuals from enrollment based on health status, and yet it does not mandate that individuals participate. In a voluntary insurance program without underwriting, the possibility exists that certain individuals will have better knowledge than others of their own likelihood for developing a severe disability. People with this better knowledge or people who already have severe disabilities will be more likely to enroll in a program that covers costs of long-term supports and services. The enrolled population may therefore receive benefits at a higher rate than would occur if the entire population eligible for the program enrolled. This pattern, called adverse selection, leads to higher total program costs, which must be balanced via higher premiums.

Assuming overall participation rates of three-and-a-half and two percent respectively, the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services Office of the Actuary (OACT) calculated premiums the program would require from each enrolled individual in order to cover the costs generated by enrollees using benefits. In doing so, these agencies estimated the impact of adverse selection on the CLASS program, which at such low overall rates of participation likely would be fairly high. The ultimate premium estimates that CBO and OACT generated using the three-and-a-half and two percent participation rate assumptions

## The Circular Relationship Between Enrollment and Premiums

are \$123 and \$240 respectively. These premiums are based on cash benefits averaging \$75 per day.

These premium calculations are unable to capture fully the circular nature of the relationship between participation rate assumptions, premiums, and the actual enrollment levels that likely will be affected greatly by the initial premium amount. The CBO and OACT used very low participation rate assumptions, which led to high premium calculations because of presumed adverse selection. On the face of things, very few people would enroll in the CLASS program if its average premiums actually were \$240 per month. This premium likely would deter enrollment in CLASS, since private insurance policies would be less expensive (LifePlans, Inc, 2007). The premiums generated by CBO and OACT seem to preordain the participation rate assumptions used to calculate them.

Unfortunately, these agencies were not able to provide information on how the premiums would decrease under more liberal participation rate assumptions. We do not know how much higher the participation rate assumption would need to be to produce a substantially lower premium calculation. In other words, we do not have a sense of the relationship between these rates and the premiums in the CBO and OACT premium models. Such information would give policymakers and CLASS implementers the opportunity to assess the participation rate assumption at which premiums would fall into an “affordable” range.

In order to provide some information about the relationship between participation rates and premiums, we used the analytics underlying The SCAN Foundation’s (TSF) Long-Term Care Policy Simulator (LTC-PS) to explore how premium levels change under varying participation rate assumptions. The LTC-PS, which can be found at [\[www.ltcpsimulator.org\]\(http://www.ltcpsimulator.org\), produces premium estimates for a range of long-term care reform options, including a voluntary cash benefit. While the policy parameters in the simulator differ from the CLASS specifications in some important ways \(e.g., the LTC-PS assumes spouses are covered by the benefit\), we are able to use the underlying analytics to test how different participation rate assumptions relate to different premium calculations for a social insurance cash-based program. The model’s technical report \(Hammelman, Tumlinson, Broyles, & Weier, 2010\)](http://www.ltcpoli</a></p></div><div data-bbox=)

contains more detail on how we created these participation rates and is available on the website.

For the premium estimates that the LTC-PS generates (on TSF’s website), we have created modeling rules that produce different participation rate assumptions depending on the relative affordability of the set of policy parameters a user chooses. Therefore,

LTC-PS users cannot vary participation rate assumptions explicitly, but when they choose less costly policy parameters, the underlying participation assumption goes up and when they choose more costly policy parameters, the assumption goes down. For the purposes of this article, we use the underlying model to alter the participation rate assumption for one unchanging set of policy parameters.

We examine the relationship between premiums and participation rates for a \$50-per-day, cash, lifetime benefit for individuals with two or more activities of daily living (ADL) limitations. This analysis assumes that enrollees must pay premiums for five years before qualifying to receive benefits but will face no waiting period for benefits once they satisfy the five-year vesting requirement and meet the disability level. We assume enrollees must be working at the time of enrollment and that non-working spouses of employed individuals are eligible to enroll. This analysis also

**Figure 1** Premiums Go Down as Participation Goes Up



Source: Avalere Health, LLC (2010)

assumes no low-income subsidy.

Using the underlying LTC-PS model, we estimate that under the parameters described above, a mandatory program with 100 percent participation would require premiums of \$37 per month. As the figure below shows, we calculate rising premiums as assumptions of participation go down. These rising premiums illustrate the impact of presumed adverse selection on premiums. As participation rates drop, a greater proportion of those enrolled in the program have a disability or are likely to have one in the future. Assuming a 30 percent participation rate would lead to a premium of \$62, a 15 percent rate would require a premium of \$79 and a 5 percent rate would require a premium of \$124.

This analysis shows, not surprisingly, that low participation rate assumptions lead to high premiums. Using the underlying LTC-PS model and the program specifications we describe above, we see that adverse selection most dramatically increases premiums below a six percent participation rate assumption. If we assume participation to be under three percent, then we also assume enrollment will be dominated by people who already have or will probably develop ADL limitations. These assumptions result in higher premiums, probably to the point where it would be less expensive for potential enrollees to buy private policies. Very likely, few healthy individuals would choose to enroll in the program as a result. In the worst case, the program could enter an adverse selection “death spiral,” as higher premiums lead to lower participation, which again lead to the need for higher premiums.

The analysis also shows that, with a more generous assumption about participation, a program’s premiums likely are to be affordable to a greater number of Americans. If we assume enrollment levels are relatively high, say over 20 percent of the eligible population, we presume that healthy individuals participating in the program offset our projections of adverse selection. It is not that fewer persons with severe disabilities will receive benefits under the program, but instead, that the group of people with disabilities comprises a smaller percentage of the total enrolled population. This higher participation rate assumption effectively allows for the calculation of a lower premium, which subsequently could help ensure actual robust enrollment and program stability. In other words, ensuring adequate participation and offering an

initial premium that assumes adequate participation will be important for the program’s success.

### Conclusion

In setting premiums for the CLASS program, the federal government will have to acknowledge and take into account that very pessimistic participation rate assumptions will lead to high initial premiums, which very likely could set up a vicious cycle of low and declining enrollment. Given how little we know about participation, we believe experts may consider a wide range of participation assumptions to be plausible. Although we do not have certainty about how potential enrollees will react to various price points, the lower end of possible participation rate assumptions (e.g., two percent) would seem almost certainly to ensure very low participation among healthy individuals.

As our example above demonstrates, implementing the CLASS program in such a way as to attract a larger percentage of the population, and plausibly to allow for more liberal participation rate assumptions, will in turn lead to lower premiums. These lower premiums undoubtedly will allow for higher participation and program sustainability that will go a long way towards helping to accomplish the underlying goal of the CLASS program of “providing a means for individuals with functional limitations a way to maintain their personal and financial independence” (Patient Protection and Affordable Care Act, 2010).

### References

- Hammelman, E., Tumlinson, A., Broyles, I., & Weier, S. (2010). *Technical assumptions informing an interactive, web-based model of public long-term care insurance programs*. Washington, DC: Avalere Health LLC. Retrieved July 1, 2010, from <http://www.ltcpolycysimulator.org/LTC-Policy-Simulator-Technical-Paper.pdf>
- LifePlans, Inc. (2007) *Who buys long-term care insurance? A 15-year study of buyers and non-buyers, 1990-2005*. Washington, DC: America’s Health Insurance Plans. Retrieved June 2, 2010, from [http://www.ahipresearch.org/pdfs/ltc\\_buyers\\_guide.pdf](http://www.ahipresearch.org/pdfs/ltc_buyers_guide.pdf)
- Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, Title XXXII, §3201 (2010).

## Community Living Assistance Services and Supports (CLASS) Program and Medicaid Home and Community-Based Services Improvements in the Federal Health Care Reform Law

*Rhonda Richards*

Earlier this year, the Patient Protection and Affordable Care Act (P.L. 111-148) was signed into law, containing provisions that could help millions of Americans not only access quality affordable health care, but also access long-term services and supports to help them live independently in their homes and communities. These provisions could help older Americans and persons with disabilities of all ages who need help with daily activities such as eating, bathing, and dressing.

Enacted earlier this year, the health care legislation and some of its provisions have drawn much attention in the national media, but among its lesser known attributes is that in the long run, it could help many Americans remain living in their homes and communities, which they prefer over nursing homes and assisted living facilities. The vast majority (89 percent) of Americans age 50 and older want to remain in their homes for as long as possible (AARP Public Policy Institute, 2006).

However, limited options currently are available to pay for long-term services and supports (LTSS) or long-term care (LTC). Most care is provided by unpaid family members, friends, and neighbors (collectively referred to as family caregivers), who make up the backbone of LTSS in this country. About 29 percent of the U.S. adult population, or 65.7 million people, are caregivers (Barrett, 2009). In fact, the estimated economic value of family caregivers' unpaid contributions was about \$375 billion in 2007, more than the total Medicaid spending in 2007 (Houser & Gibson, 2008). Medicare generally does not cover LTSS—despite many people's beliefs to the contrary. Medicare covers limited home health and skilled nursing facility care. Individuals pay for services out-of-pocket and some individuals have private long-term care insurance to help cover their LTC costs. Not all individuals, however, can afford such insurance or qualify for it due to pre-existing conditions.

The largest payer of LTSS is Medicaid, the joint federal-state program to help those with limited incomes and assets or very high costs of care. Medicaid, like Medicare, has an institutional bias. Federal law requires that Medicaid pay for institutional care, such as nursing homes, but most home and community-based services (HCBS) are

“optional,” meaning that states are not required to cover them and can limit the number of people receiving services and the services provided. States do provide Medicaid HCBS to varying degrees and with great variation among states, but these services are subject to cuts and reductions in general, and especially during tough economic times, in a way that institutional services are not. An example of Medicaid's institutional bias is that nationally in 2007, 73 percent of Medicaid's LTC spending for older adults and adults with physical disabilities went toward nursing homes, while only 27 percent went toward HCBS (Houser, Fox-Grage & Gibson, 2009). Both states and the federal government are dealing with the financial challenges of growth in Medicaid spending overall, and not just from LTC.

It is against this backdrop that Congress considered health care reform legislation and whether or not to include provisions regarding LTSS. The inclusion of LTSS provisions in health care reform legislation was far from a forgone conclusion. Some legislators were concerned that there were so many issues to address in health care reform that Congress could not also devote attention to LTSS. Some were concerned that including LTSS in health care reform might slow or hinder the passage of health care reform or cost too much. Some wanted Congress to address LTSS separately after health care reform. Congress, however, often faces immediate pressing issues that they must address, so issues that are longer-term in nature or not part of an immediate crisis can be harder for Congress to devote significant time to address. This also shows why it is important for any bill or issue to have legislative champions in the House and Senate who, with persistence and determination, work with their colleagues and the Administration to enact

## Community Living Assistance Services and Supports (CLASS) Program and Medicaid...

it. Champions need to be in a position to push forward the proposal themselves and work with others who are able help them get it across the finish line.

Advocates in the aging and disability communities strongly believed that provisions addressing LTSS should be part of health care reform legislation and made their voices heard in Congress. In November 2008, the Senate Finance Committee released a blueprint for health care reform that included a modest discussion of LTSS issues and later released options papers that included LTSS options. The Senate Special Committee on Aging held a hearing in March 2009 focusing on the issue of LTSS and health care reform. AARP and other groups submitted written statements for the hearing record, and multiple other conversations and events were held that addressed to include LTSS in health care reform. Advocates began to urge both Congress and the Administration to address this issue in health care reform. In May of 2009, AARP announced six priority elements for inclusion in health care reform, including increasing federal funding and eligibility for HCBS through Medicaid so that older Americans can live in their homes and avoid more costly institutional settings as they age. Helping older adults live in their homes is an important priority to AARP's members.

A number of members of Congress had already introduced or were working to introduce legislation that would help older adults and persons with disabilities get the services and supports necessary to live in their homes and communities. Some bills already had been introduced in multiple Congresses and others would be introduced for the first time in 2009. In general, proposals ranged from the creation of a national insurance program for LTSS to improvements in Medicaid HCBS to other proposals to address HCBS outside of Medicaid.

Among the proposals that had been around for a few years was the Community Living Assistance Services and Supports (CLASS) Act (S. 697/H.R. 1721), sponsored by the late Senator Kennedy (D-MA) and Representatives Pallone (D-NJ) and Dingell (D-MI). This Act initially was introduced by Senator Kennedy and Senator DeWine (R-OH) in 2005. The CLASS Act was referred to the Health, Education, Labor and Pensions (HELP) Committee in the Senate and the Energy and Commerce, Ways and Means, Budget, and Rules Committees in the House of Representatives. Senator Kennedy initially chaired

the HELP Committee, but due to his declining health, asked Senator Dodd (D-CT) to take the overall lead on health care reform within the HELP Committee.

The CLASS Act would establish the CLASS Program, a voluntary national insurance program for long-term services and supports. Under the CLASS Program, individuals would pay a monthly premium and after a five-year vesting period, if they met other eligibility criteria, they would be eligible for a daily cash benefit to help them pay for the services and supports they need to help them live in their homes. The benefit could pay for services such as home care, respite care, home modifications, assistive technology, accessible transportation, and nursing support. The benefit also could pay for services in other settings, such as assisted living or nursing homes. The cash benefit in CLASS would give consumers greater choice and control over the services and supports they need to maintain their independence. The program aimed to cover a large number of individuals and spread the risk over a significant size risk pool, some of whom may not have coverage for LTSS otherwise. Many aging, disability, and other stakeholder groups had endorsed CLASS in the years prior to health care reform, and in 2009, sponsors of CLASS, their staffs, and supporters focused on passing CLASS as part of health care reform legislation.

One of the ongoing concerns raised about CLASS was its long-term financial sustainability. Would the program as designed be sustainable in the long term? Would the premiums pay for the benefits and the number of people that would enroll in the program? As with many bills in Congress, the CLASS proposal was modified as it moved through the legislative process to address concerns raised. Without Senator Kennedy's physical presence in the Senate, Senator Dodd took on a lead role championing CLASS in the HELP Committee and in the Senate. Senator Dodd included the CLASS Program in the HELP Committee's health care reform bill that they would consider and amend ("mark up") in Committee. CLASS was modified heading into the Committee mark up, such as by changing the premium and giving the Department of Health and Human Services (HHS) more flexibility in setting the benefit amounts (rather than benefit amounts defined in statute).

During the HELP Committee mark up, another important development occurred; the Congressional Budget Office released a budget score of the CLASS

proposal that showed CLASS reducing the deficit in the 10-year budget window (largely due to the fact that premiums would be collected for five years before any benefits would be paid out). This was important since there was sensitivity to the cost of health care reform legislation. In the 10-year budget window, CLASS was projected to come at no cost to the federal government, and in fact, was projected to show some savings to the federal government in Medicaid. Proposals with high projected costs were harder to include in health reform. The fact that CLASS did not cost the federal government, at least in the short term, was helpful.

During the HELP Committee mark up, AARP sent a letter to the HELP Committee endorsing the CLASS provisions in the HELP Committee's bill and urging that the CLASS provisions be included in any final health care reform bill. During the HELP Committee mark up, a number of amendments to the CLASS provisions were adopted, including an amendment by Senator Gregg (R-NH) requiring that CLASS premiums be based on an actuarial analysis of the 75-year costs of the program that ensures solvency over those 75 years. This helped to further ensure the program was designed to be solvent over the long term. The CLASS program passed the HELP Committee in July 2009 as part of the Committee's health reform bill and would await the passage of the Finance Committee's health reform bill for the two committees' bills to be merged into one combined bill for consideration by the full Senate.

After the Finance Committee passed its bill, Senate Majority Leader Harry Reid (D-NV) took the lead in merging the HELP and Finance Committees' bills. He faced pressure from some Senate Democrats not to include CLASS in the Senate bill due to their concerns about the long-term impact on the deficit, the potential creation of an entitlement that would result in long-term spending increases that exceeded revenue, and the use of deficit reduction dollars from CLASS as an offset to pay for other provisions in health care reform. Some long-term care insurers also raised concerns about CLASS. Advocates who supported CLASS urged the Majority Leader to include CLASS in the merged Senate bill, as it could help people live independently in their own homes, begin to save money in Medicaid, and create a new option for people to plan and pay for LTSS. Aging and disability advocates met with Senate offices to make the case for

why CLASS was important and should be included in health reform, answering questions, and sometimes helping to clear up misinformation or confusion about CLASS. Ultimately, Majority Leader Reid included CLASS—with some modifications to address concerns raised—in the Senate health care reform bill that would be considered on the Senate floor.

Meanwhile in the House of Representatives, at the July Energy and Commerce Committee mark up, Health Subcommittee Chairman Pallone offered a shell (placeholder) of CLASS as an amendment that required the Secretary to establish the CLASS Program that met certain specific criteria. The amendment passed by voice vote and received verbal support from Ranking Member Joe Barton (R-TX) and former Health Subcommittee Ranking Member Nathan Deal (R-GA). Thus, a version of CLASS passed the House Energy and Commerce Committee as part of its health care reform bill that later would be merged with the health care reform bills passed by the Ways and Means Committee and the Education and Labor Committee. Supporters urged the House to include CLASS in the merged health care reform bill that would come before the full House. Ultimately, the full CLASS Program was included in the House health care reform bill that passed the House on November 7, 2009.

Back in the Senate, supporters of CLASS continued to push to make sure the CLASS provisions stayed in the Senate bill; the Leadership Council of Aging Organizations and the Consortium for Citizens with Disabilities organized a briefing for Senate staff on the LTSS provisions in health care reform. In early December, during floor debate on the Senate bill, Senator Thune (R-SD) offered an amendment to strike the CLASS provision from the Senate bill. The amendment was debated by speakers on both sides of the issue. Supporters of CLASS went to the Senate to show their support. AARP issued a press statement that was read on the Senate floor by Senator Harkin (D-IA) reaffirming AARP's support for the CLASS program and its enactment. The amendment needed 60 votes to pass and delete CLASS from the bill. The final vote was 51 votes for the amendment and 47 votes against; it did not pass. The CLASS provisions stayed in the Senate bill and passed the Senate as part of the overall health care reform bill on December 24, 2009. CLASS had passed both the House and Senate.

On a parallel track, advocates for LTSS

provisions also pushed for improvements in Medicaid that would expand beneficiaries' access to HCBS. Several bills were introduced on this issue in the House and Senate. In February, Senators Kerry (D-MA) and Grassley (R-IA) reintroduced their bipartisan Empowered at Home Act (S. 434) from the previous Congress. Among other provisions, the bill would make improvements to the Medicaid HCBS state plan option that only a few states had adopted to date. For example, the bill would allow states to cover a broader scope of HCBS, increase the income eligibility limit for individuals to receive services under the option, and allow provision of services under the HCBS state plan option to individuals eligible for HCBS waiver services. Importantly, the bill also required that the spousal impoverishment protections for the spouses of nursing home residents on Medicaid also be provided to the spouses of individuals receiving Medicaid HCBS. Representatives Pallone (D-NJ) and DeGette (D-CO) reintroduced a similar version of the Empowered at Home Act (H.R. 2688) in the House in June. AARP endorsed both of these bills, as did other aging and disability advocates.

Also in the Senate, Senators Cantwell (D-WA) and Kohl (D-WI) introduced the Home and Community Balanced Incentives Act (S. 1256) in June. This bill would offer temporary financial incentives to states to expand HCBS and balance their LTSS systems. To be eligible to participate, states must be spending less than 50 percent of their Medicaid LTSS spending for non-institutionally based LTSS. States with lower levels of LTSS spending on non-institutionally based LTSS would receive higher levels of funding (limited overall to \$3 billion in federal dollars). States that participate would have to make certain structural changes to their LTSS systems, including development of a statewide single-point-of-entry entry point, conflict-free case management, and core standardized assessment instruments. The bill also included provisions that improved the Medicaid HCBS state plan option, among other provisions.

Also pending in both the Senate and House was the Community Choice Act (S. 683/H.R. 1670) from longtime sponsors Senators Harkin (D-IA) and Specter (D-PA) and Representative Danny Davis (D-IL). This bill would require states to offer Medicaid coverage of community-based attendant services and supports to individuals who are Medicaid eligible, require an institutional level of care, and choose to receive

such services and supports. Under the bill, financial incentives would be available to states that adopt the requirement early. This bill had strong support from the disability community, especially, but also support in the aging community.

Heading into the Finance Committee health reform mark up, the Committee's bill included modest provisions on HCBS, but none of the provisions in the bills referenced above. Several Senators on the Finance Committee who sponsored or supported the above bills filed amendments to the Committee's bill. Senator Kerry filed an amendment that included several provisions from the Empowered at Home Act; Senator Cantwell filed an amendment reflecting the Home and Community Balanced Incentives Act; and Senator Schumer filed an amendment that was a modified version of the Community Choice Act, giving states the option to provide coverage of community-based attendant services and supports and receive an enhanced federal Medicaid matching rate for these services. Many aging and disability groups supported these amendments and urged their inclusion in the Committee's bill. During the mark up, Chairman Max Baucus (D-MT) accepted these amendments or modified versions of them. When the Finance Committee passed its bill, it included these amendments as well as other LTSS provisions on nursing home transparency, criminal background checks for certain employees of long-term care providers, and the Elder Justice Act.

As with the HELP Committee CLASS provisions, the aging and disability communities and individual organizations urged the inclusion of the Finance Committee HCBS provisions in the merged Senate health reform bill. Ultimately, Majority Leader Reid included the Finance Committee's HCBS provisions in the merged Senate bill, except for financial incentives for states to balance their LTSS systems that were later included in the Manager's Amendment to the Senate bill. The bill that passed the Senate included the HELP Committee's CLASS provisions, the Finance Committee's HCBS provisions, and other important LTSS provisions. While the health reform bill that passed the House included several LTSS provisions, including CLASS, it did not include significant HCBS provisions due to cost.

After both the House and Senate passed their respective health care reform bills, the aging and

disability communities—including AARP—continued to work together to include the CLASS and HCBS provisions in any final health care reform law. Due to dynamics beyond and generally separate from these provisions, Congress enacted health care reform by sending the Senate health care reform bill (H.R. 3590) to the President followed by an additional bill (H.R. 4872) that made modifications to the Senate bill. They are now law, and AARP is working to help its members and the public understand the new health care law so they can make the best decisions for themselves and their families, including how provisions may provide them with new options to help them live in their homes and communities.

The new law contains significant provisions on LTSS due to the individual and collective efforts of the aging and disability communities; champions in the Senate and House, their staff, and committee staff who advocated for these provisions; leaders who listened and acted; some factors beyond our control; and the compelling personal stories of individuals and their families across the country who need services and supports and the loved ones who care for them. This is no longer an abstraction. Members of the House and Senate deal with this in their own families and so do their staffs. It is not a partisan issue. It affects Republicans, Democrats, and Independents. It is about living independently, living the fullest and most productive life possible, living at home, caring for loved ones, and aging with dignity, purpose, choice, and control. It was and it is time to act.

*Rhonda Richards is a senior legislative representative on the Federal Health and Long-Term Care Team in AARP's Government Relations and Advocacy Department, handling long-term term services and supports issues. Prior to AARP, she worked in the U.S. Senate and is a graduate of Bryn Mawr College.*

### References

- AARP Public Policy Institute. (2006). *The state of 50+ America 2006*. Washington, DC: AARP. Retrieved July 2, 2010, from [http://assets.aarp.org/rgcenter/econ/fifty\\_plus\\_2006.pdf](http://assets.aarp.org/rgcenter/econ/fifty_plus_2006.pdf)
- Barrett, L. (2009). *Caregiving in the U.S.: 2009*. Washington, DC: AARP.
- Houser, A. N., & Gibson, M. (2008). *Valuing the invaluable: The economic value of family caregiving, 2008 update*. Washington, DC: AARP Policy Institute. Retrieved July 2, 2010, from [http://www.aarp.org/relationships/caregiving/info-11-2008/i13\\_caregiving.html](http://www.aarp.org/relationships/caregiving/info-11-2008/i13_caregiving.html)
- Houser, A., Fox-Grage, W., & Gibson, M. (2009). *Across the states: Profiles of long-term care and independent living*. Washington, DC: AARP Public Policy Institute. Retrieved, July 2, 2010, [http://www.aarp.org/home-garden/livable-communities/info-03-2009/across\\_the\\_states\\_2009\\_profiles\\_of\\_long-term\\_care\\_and\\_independent\\_living.html](http://www.aarp.org/home-garden/livable-communities/info-03-2009/across_the_states_2009_profiles_of_long-term_care_and_independent_living.html)

## The CLASS Act: A New Paradigm for Aging in America

*Kathryn R. Roberts*

For many Americans, the CLASS Act is still a relatively little-known piece of legislation, but as the future unfolds, it could become one of the most transformative and beneficial aspects of health care reform. The CLASS Act has the possibility to change the paradigm of how we provide and pay for long-term care services in America. Collaboration of the public and private sectors around the CLASS Act will benefit our country in major ways: it will provide a long-term care insurance option for people who have none and can't afford or qualify for private insurance; it will empower more people to stay where they most want to live—in their homes—when they experience disabilities or long-term illnesses while at the same time preserving a Medicaid safety net for those who can't escape poverty.

Many Americans incorrectly believe that the government covers their long-term care. They believe that if they suffer from Alzheimer's disease or another chronic illness or disability, Medicare will cover home services or assisted living. Although it might pay for some short-term services, such as rehabilitation following joint replacement surgery, it will not pay for the long-term services many Americans need to live fully, such as help with bathing and eating.

When Medicare and Medicaid were passed in 1965, policymakers didn't anticipate today's record longevity, smaller family sizes, and dual-earner households. Consequently, as we face an unprecedented demographic shift from young to old in America, states already are struggling to pay Medicaid obligations and are not equipped with alternative solutions.

Some Americans have purchased private long-term care coverage, but it is a small minority. Passage of the CLASS Act alone will not assure universal compliance in paying premiums for the first voluntary public long-term care insurance plan. But it will focus a national spotlight on long-term care needs and services, the need to plan for them, and the opportunity to gain coverage.

Many people still think of long-term care insurance as “nursing home” insurance, which is not exactly a motivating incentive to purchase coverage. In 2007, Ecumen commissioned a statewide poll of Minnesota baby boomers. More than 99 percent said they didn't want to live in a nursing home; it's very much like being asked, “Do you want to live in a hospital?” Of course we don't.

As the CLASS Act's details and national roll-out

plan are developed, designers should keep foremost in their mind that human beings are hardwired for independence. The CLASS Act must be positioned as a solution that helps preserve independence and allows individuals to live as fully as possible with chronic health conditions or physical disabilities. It is a tool that will keep Americans out of the place that they say they fear most – the nursing home.

The CLASS Act enrollment campaign has to break the myth that Americans already have long-term care coverage. American citizens need to understand there is very limited coverage, and Medicaid only kicks in when a person has become impoverished. If citizens want more control over how they will live with disabilities or illnesses and want to prevent overburdening loved ones with financial loss, they need CLASS Act or other coverage.

Aging is not a partisan issue. We all do it. The CLASS Act is a call for the common good, highlighting that planning for the possibility of long-term care helps us individually, it helps our families, and it makes America stronger by slowing our movement to Medicaid and preserving a safety net for our most vulnerable.

Approaching long-term care in this new way also would benefit from new voices. Actor George Clooney recently lent his support and celebrity to advocate against the closure of a Hollywood nursing home. I suspect that Clooney might not realize that many American nursing homes close because they lack a long-term care financing system. Government dollars come nowhere near covering the cost of providing care. Clooney and other high-profile stars could help educate and engage all Americans in a

## The CLASS Act: A New Paradigm for Aging in America

national campaign to take individual responsibility for our futures and how we live during our senior years by turning to the CLASS Act and/or private insurance coverage.

The most effective place to deliver these messages to the most people is in the workplace during annual benefit enrollment. The CLASS Act is designed as an automatic enrollment program with an opt-out choice—the same approach that has increased 401K participation in many companies. But first, companies have to offer the CLASS Act. As the legislation currently stands, it is not a mandated benefit. Part of the national CLASS Act education campaign must make clear that in this new era of aging, long-term care is in fact a business issue.

Caring for a loved one while simultaneously working is extremely difficult to juggle. Caregiving often inflicts a heavy health toll on the caregiver. Studies show caregivers at high risk for hypertension, pulmonary disease, diabetes, and depression, all of which ultimately contribute to higher health premiums.

Caregiving impacts productivity. Significant costs are incurred by absenteeism, unpaid leave, and replacing employees. The MetLife Study of Employer Costs for Working Caregivers puts the total cost to employers for all full-time employed caregivers in the U.S. at \$33.6 billion, which undoubtedly will rise unless people have easy access to care services (MetLife Mature Market Institute & National Alliance for Caregiving, 2006).

Another player needed to leverage fully the CLASS Act is private insurers. The CLASS Plan does not provide comprehensive coverage. Its cash benefit will be about \$50 per day at a minimum. Although that doesn't sound like much, it could help pay for up to half a year of assisted living services in some states or significant home care services. As we elevate the need for personal planning for long-term care, private insurers have the opportunity to create supplemental wrap-around policies, much like supplemental Medicare policies, so that people can extend their CLASS benefits to get more coverage. This would benefit customers and the insurance companies.

State governments could collaborate in this effort by providing online long-term care information hubs that lay out the various options available—from the CLASS Act to Long-Term Care Partnership Plans to private insurance. State information hubs

could endorse private insurance plans with “Good Housekeeping” seals. This would build trust in the products and aid consumers in the confusing purchase process. Such consumer information hubs would benefit consumers as well as company human resources benefit directors seeking credible answers for their employees as they make benefit enrollment choices.

The CLASS Act promotes increased consumer empowerment. CLASS Act beneficiaries, and those with high-quality private plans, will direct their own dollars and will be able to vote with their feet, which isn't always possible with a governmental-funded long-term care program because reimbursement requirements likely limit a customer's options. This will create more flexibility for the customer, increase competition for the customer's loyalty, drive increased innovation in senior services, and lead to more choices for the next generations of seniors. Below, I highlight several ways I see this paradigm shift impacting long-term care delivery.

**At-Home Services.** People always have desired to live in the places they call home. As more people have CLASS Act benefit dollars and/or private insurance benefits, they will demand more service options that enhance their lives in their own homes. This consumer selectiveness is no different than selectivity applied consumers of any other service.

While the CLASS Act will not pay for every service, we as senior housing and services providers must be prepared to meet the market-defined needs and services. Senior housing has a tremendous opportunity to adapt and offer expertise and skills found within their existing bricks and mortar and bring it to the larger community via a variety of at-home services.

As more senior housing providers bring home health services outside their facilities and into people's homes, consumers will seek services beyond physical health care. Wellness also includes a person's intellectual, spiritual, social, emotional, and vocational health, and increasingly, home health services will distinguish themselves by going beyond medical services and fully integrating other aspects of wellness to meet customers' desires, not just their needs.

**At-Home Technology.** Several years ago, Ecumen adopted GE sensor technology in its assisted living communities and home services. These are very small sensors located in a person's home, such

as in doorways, the refrigerator door, and bathrooms. They unobtrusively track a person's motion patterns and send the data to a care professional or family member's computer. The data then help identify small health issues before they become critical.

Such devices just scratch the surface of technological possibilities for aging in place. More technologies are in development, and companies such as Intel, GE, and Philips are working in this space. At the same time, our customers increasingly are expecting technology to enhance their living experiences. We now are serving the last senior cohort that didn't experience personal technology as a ubiquitous part of their lifestyle. Home services providers increasingly will include technologies among their services, and the CLASS Act and other insurance could help pay for those technologies and keep people living more independently.

**Virtual Villages.** From Beacon Hill Village in Boston to Mill City Commons in Minneapolis—which Ecumen helped create—virtual villages are expanding nationally. These are grassroots communities where residents in close proximity join together and typically pay a yearly membership fee for social activities and access to contracted services such as home or computer repair, grocery shopping, and other services. While many such villages include a health care component, the communities lead with a social connectivity rather than a medical model. I envision these village concepts expanding to other vibrant communities such as churches, synagogues, and other faith communities. And, as with at-home services, the CLASS Act can provide dollars for village members to self-direct services they deem most important to maintaining their optimal wellbeing.

**The Chronic Care Center.** Changing the paradigm of long-term care financing through the CLASS Act will help focus on the individual with simple or complex needs. This new focus will position care centers even more fully as short-term stay chronic care centers.

Here's an example of how this might work: A person with diabetes has hypoglycemia, and rather than going to the emergency room, she comes to our care center where we stabilize her, consult with her primary care physician, and then complete a discharge home. We will provide a self-care plan for her to follow and perhaps will offer in-person or computer check-ins with our dietary team or others to

provide wellness checks and answer questions. Such an approach builds upon what many nursing homes already do with short-stay, sub-acute rehabilitation services, and can improve the individual's experience and save money by preventing bounce backs to the hospital emergency room. It would use resources more collaboratively and smartly to provide the right care in the right place at the right time and empower people in managing their own wellness.

Aging is changing America in unprecedented ways. The CLASS Act provides a tremendous opportunity to ensure that aging changes for the better.

*Kathryn Roberts, PhD, is president and CEO of Ecumen ([www.ecumen.org](http://www.ecumen.org)), an innovative non-profit senior housing and services company based in the Twin Cities of Minneapolis and St. Paul, MN. She serves on the board of directors of the American Association of Homes and Services for the Aging (AAHSA).*

### References

MetLife Mature Market Institute & National Alliance for Caregiving. (2006). *The MetLife Caregiving Cost Study: Productivity Losses to U.S. Business*. New York: MetLife. Retrieved July 2, 2010, from <http://www.caregiving.org/data/Caregiver%20Cost%20Study.pdf>

# A Summary of the Patient Protection and Affordable Care Act (P.L. 111-148) and Modifications by the Health Care and Education Reconciliation Act of 2010 (H.R. 4872)

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (H.R. 3590, P.L. 111-148), which was passed by the Senate on December 24, 2009 and by the House on March 21, 2010. Following closely on its heels was the Health Care and Education Reconciliation Act of 2010, which makes changes to the Patient Protection and Affordable Care Act. The reconciliation bill was passed by both houses of Congress on March 25, 2010 and signed into law by the President on March 30, 2010. This Policy Brief presents an analysis of the Patient Protection and Affordable Care Act, covering those elements that provide support for the continuum of care for seniors. The Health Care and Education Reconciliation Act of 2010 modified a few provisions in the health reform law specific to the continuum of care, and these modifications are noted where relevant.

The organizing framework for this analysis includes the following concepts about the continuum of care: 1) support the rebalancing of the long-term services and supports (LTSS) available to seniors toward home and community-based services; 2) improve the coordination of health and supportive services, especially for those with chronic illnesses; 3) improve access to medications and reduce the cost burden on seniors; 4) reinforce the existing workforce and establish initiatives to grow the workforce that serves seniors, including direct care workers; and 5) strengthen quality and consumer protections for seniors.

## The Patient Protection and Affordable Care Act (Public Law 111-148)

## Health Care and Education Reconciliation Act of 2010 (H.R. 4872)

Dates Introduced &  
Passed

Announced: November 18, 2009; Passed by Senate: December 24, 2009; Passed by House: March 21, 2010; Signed into Law: March 23, 2010

Introduced March 18, 2010; Passed by House: March 21, 2010; Passed by Senate with Revisions: March 25, 2010; Revised Bill Passed by House: March 25, 2010; Signed into Law: March 30, 2010

### 1. Bolstering Supportive Services Delivered at Home and in the Community

Community Living Assistance Services and Supports (CLASS) plan

Establishes a new public long-term care insurance program, to be known as the CLASS Independence Benefit Plan, for the purchase of community living assistance services and supports by individuals with functional limitations.

No changes made.

- Financed by voluntary payroll deductions or contributions from all eligible adults
- Those eligible to enroll are actively employed (including self-employed) adults age 18 and older

**The Patient Protection and Affordable Care Act  
(Public Law 111-148)**

**Health Care and Education  
Reconciliation Act of 2010  
(H.R. 4872)**

- Automatic enrollment with an opt-out option; if an employer does not elect to deduct and withhold premiums on behalf of an employee, an alternate payment mechanism will be available for an eligible individual
- 5-year vesting period
- Enrollees will be eligible for benefits after meeting specified disability criteria (functional and/or cognitive impairment that is expected to last for 90 days or more and is certified by a licensed health care practitioner)
- Upon determination of eligibility, a cash benefit will be paid based on functional ability, averaging not less than \$50 per day, with no lifetime or aggregate limit
- Secretary is required to establish premiums to ensure solvency for 75 years
- Medicaid enrollees receiving home and community-based services (HCBS) or Program for All Inclusive Care of the Elderly (PACE) would retain 50 percent of their cash benefit while living in the community
- Medicaid enrollees in institutions would retain 5 percent of their cash benefit
- Premium subsidies would be available for eligible individuals ages of 18 to 22 who are full-time students while working or for any individual with income below the poverty line
- Self-employed individuals could enroll
- The CLASS program will be treated in the same manner as a qualified long-term care insurance policy
- No taxpayer funds (e.g., Federal funds from any source other than from premiums collected in the CLASS program) will be used to pay benefits under this provision.
- The Secretary must establish an eligibility assessment system by January 1, 2012 and designate the benefit plan by October 1, 2012. (Title VIII, Sec. 8002)

Community First Choice Option

Establishes a Medicaid State Plan Option to provide a community-based attendant services and supports benefit to those who meet the state’s nursing facility clinical eligibility standards.

- Provides 6 percentage point increase in FMAP to States choosing this option
- States would be authorized to provide community transitions support (e.g., rent/utility deposits, first month’s rent and utilities, bedding, basic kitchen supplies) to institutionalized individuals who meet the eligibility criteria.
- Effective start date was October 1, 2010. (Title II, Subtitle E, Sec. 2401)

The Reconciliation Bill changed the implementation start date to October 1, 2011. (Title I, Subtitle C, Sec. 1205)

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Removal of Barriers to Providing Home and Community-Based Services	<p>Amends Section 1915(i) of the Social Security Act to remove barriers to providing HCBS by giving States the option to provide more types of HCBS through a State Plan amendment to individuals with higher levels of need, rather than through waivers.</p> <ul style="list-style-type: none"> <li>• Requires “State-wideness” of the HCBS State Plan benefit</li> <li>• Prohibits States from setting caps on the number of individuals who receive coverage for the benefit</li> <li>• Enables States to target benefits to individuals with selected conditions if the State wishes</li> <li>• Individuals receiving coverage under the State Plan are grandfathered into services if the criteria for eligibility are modified for as long as their condition meets the previous criteria.</li> <li>• Effective on the first day of the first fiscal year quarter that begins after the date of enactment of this Act. (Title II, Subtitle E, Sec. 2402)</li> </ul>	No changes made.
Money Follows the Person Rebalancing Demonstration	<ul style="list-style-type: none"> <li>• Extends the Money Follows the Person Rebalancing Demonstration, originally authorized in the DRA, through September 30, 2016. Modifies eligibility rules, which originally required that individuals reside in facility for not less than 6 months, by requiring that individuals reside in an inpatient facility for not less than 90 consecutive days. Amendments effective 30 days after enactment of this Act. (Title II, Subtitle E, Sec. 2403)</li> </ul>	No changes made.
Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment	<p>Requires States to apply spousal impoverishment rules to beneficiaries who receive HCBS. This provision would apply for a five-year period beginning on January 1, 2014. (Title II, Subtitle E, Sec. 2404)</p>	No changes made.
Funding to Expand State Aging and Disability Resource Centers	<p>Appropriates to the Secretary of HHS \$10 million for each of FYs 2010 through 2014 to carry out Aging and Disability Resource Center (ADRC) initiatives provided in the Older Americans Act. (Title II, Subtitle E, Sec. 2405)</p>	No changes made.
Sense of the Senate Regarding Long-Term Care	<p>Expresses the <i>Sense of the Senate</i> that during the 111th Congress, Congress should address long-term services and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need, in the community as well as in institutions. (Title II, Subtitle E, Sec. 2406)</p>	No changes made.

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Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes

Creates the State Balancing Incentive Payments Program with new financial incentives for States to shift Medicaid beneficiaries out of nursing homes and into home and community-based services.

No changes made.

- Eligible States are those that spend less than 50 percent of total expenditures for LTSS on services in the home or community
- The Secretary may determine among the States that apply and qualify which will participate
- Qualifying States with less than 25 percent of total LTSS expenditures for HCBS will receive a 5 percentage point increase in FMAP; States with 25-50 percent will receive a 2 percentage point increase
- As part of this provision, States may increase the income eligibility for HCBS
- Requires qualifying States to establish a statewide “No wrong door – single entry point system” to enable consumer to access LTSS
- Requires qualifying States to develop case management services to assist in the development of a service plan for beneficiaries and for family caregivers; also provide case management to support the transition from institutional to community-based services
- Allocates up to \$3 billion for Medicaid HCBS. (Title X, Subtitle B, Part I, Sec. 10202)

**2. Improving Coordination of Health Care and Supportive Services**

***Building Infrastructure for Program and Policy Development***

Medicaid and CHIP Payment and Access Commission (MACPAC)

Clarifies the topics to be reviewed by the Medicaid and CHIP Payment and Access Commission (MACPAC) including:

No changes made.

- Medicaid and CHIP enrollment and retention processes, coverage policies, quality of care, how interactions of policies between Medicare and Medicaid affect access to services, payments, and dually-eligible individuals, and additional reports of State specific data
- Authorizes \$11 million to fund MACPAC for FY2010. (Title II, Subtitle J, Sec. 2801)

Improved Coordination and Protection for Dual Eligibles

Requires the Secretary to establish a Federal Coordinated Health Care Office (CHCO) within the Centers for Medicare and Medicaid Services (CMS) by March 1, 2010. The purpose of the CHCO will be to bring together officials of the Medicare and Medicaid programs to:

No changes made.

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- More effectively integrate benefits under those programs, and
- Improve the coordination between the federal and state governments for individuals eligible for benefits under both Medicare and Medicaid (dual eligibles) to ensure that dual eligibles have full access to the items and services to which they are entitled.
- The goals of the CHCO are:
  - Provide dual eligibles full access to benefits to which they are entitled under Medicare and Medicaid;
  - Simplify the process by which dual eligibles access services;
  - Improve the quality of health and long-term care services for dual eligibles;
  - Increase dual eligibles understanding of and satisfaction with coverage;
  - Eliminate regulatory conflicts between Medicare and Medicaid;
  - Improve care continuity for dual eligibles;
  - Eliminate cost shifting between Medicare and Medicaid and among related health care providers; and
  - Improve the quality of performance of providers under Medicare and Medicaid.
- Specific responsibilities include:
  - Provide States, Special Needs Plans, and providers with education and tools to align Medicare and Medicaid benefits;
  - Support State efforts to coordinate and align acute and long-term care services for dual eligibles;
  - Provide support for coordination, contracting and oversight by States and CMS with respect to integrating Medicare and Medicaid;
  - Consult and coordinate with MedPAC and MACPAC regarding relevant policies;
  - Study the provision of drug coverage for new full-benefit dual eligibles and monitor and report total annual expenditures, outcomes and access to benefits for dual eligibles; and
  - Submit an Annual Report to Congress with recommendations for legislation to improve care coordination and benefits for dual eligibles.
- Effective March 1, 2010. (Title II, Subtitle H, Sec. 2602)

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Establishment of Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services (CMS)

Establishes within CMS a Center for Medicare & Medicaid Innovation. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. Dedicated funding is provided to allow for testing of models that require benefits not currently covered by Medicare as well as payment reform models. Successful models can be expanded nationally. Requires the Secretary to focus on models that both improve quality and reduce costs. Effective January 1, 2011. (Title III, Subtitle A, Part 3, Sec. 3021)

No changes made.

**Demonstration Programs and New Delivery Models**

Accountable Care Organizations

Rewards Accountable Care Organizations (ACOs) that take responsibility for the costs and quality of care received by their patient panel over time.

No changes made.

- ACOs can include groups of health care providers (including physician groups, hospitals, nurse practitioners and physician assistants, and others)
- ACOs that meet quality-of-care targets and reduce the costs of their patients relative to a spending benchmark are rewarded with a share of the savings they achieve for the Medicare program.
- Offers the Secretary the flexibility to consider a partial capitation model (where the ACO is at financial risk for some, but not all, services) or other payment models, including those used by private payors.
- Shared savings program effective January 1, 2012. (Title III, Subtitle A, Part 3, Sec. 3022)

Medical Homes

Creates a program to establish and fund the development of community health teams to support the development of medical homes for persons with chronic conditions by increasing access to comprehensive, community-based, coordinated care. Establish pilot program by January 1, 2013; expand program, if appropriate, by January 1, 2016. (Title III, Part 3, Subtitle F, Sec. 3502)

No changes made.

Provides States the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. Health homes would be composed of a team of health professionals and would provide a comprehensive set of medical services, including care coordination. Provides states taking up the option with 90 percent FMAP for two years. Effective January 1, 2011. (Title II, Subtitle I, Sec. 2703)

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Independence at Home Demonstration Program	Creates a new demonstration program for chronically ill Medicare beneficiaries to test a payment incentive and service delivery system that utilizes physician and nurse practitioner directed home-based primary care teams aimed at reducing expenditures and improving health outcomes. Effective January 1, 2012. (Title III, Subtitle A, Part 3, Sec. 3024)	No changes made.
Implementation of Medication Management Services in Treatment of Chronic Disease	Establishes a new program to implement medication therapy management (MTM) services provided by licensed pharmacists as part of a collaborative approach to the treatment of chronic diseases with the aim of improving quality of care and reducing overall costs of care in the treatment of such diseases. Requires an annual comprehensive medication review by a licensed pharmacist or other qualified provider and follow-up interventions based on the findings of the annual review. Also requires the prescription drug plan sponsor to have a process in place to assess the medication use of individuals who are risk but not enrolled in the MTM program, including individuals who have experienced a transition in care. Plans must also enroll beneficiaries who qualify on a quarterly basis with an opt-out provision. Effective May 1, 2010. (Title III, Part 3, Subtitle F, Sec. 3503)	No changes made.
Community-Based Care Transitions Program	Provides funding to hospitals and community-based entities that furnish evidence-based care transition services to Medicare beneficiaries at high risk for readmission. Effective January 1, 2011. (Title III, Subtitle A, Part 3, Sec. 3026)	No changes made.
Medicare Hospice Concurrent Care Demonstration Program	Directs the Secretary to establish a three-year demonstration program that would allow patients who are eligible for hospice care to also receive all other Medicare covered services during the same period of time. The demonstration would be conducted in up to 15 hospice programs in both rural and urban areas and would evaluate the impacts of the demonstration on patient care, quality of life and spending in the Medicare program. (Title III, Subtitle B, Part 3, Sec. 3140)	No changes made.
Patient Navigator Program	Reauthorizes demonstration programs to provide patient navigator services within communities to assist patients in overcoming barriers to health services. Program facilitates care by assisting individuals in coordinating health services and provider referrals; and assists community organizations in helping individuals receive better access to care, providing information on clinical trials, and conducting outreach to health disparity populations. Authorizes \$3.5 million for FY2010 and allocating funds as needed for FY2011 through FY2015. (Title III, Part 3, Subtitle F, Sec. 3510)	No changes made.

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<p>Payment Reform – Bundling</p>	<p>Directs the Secretary to develop a national, voluntary pilot program encouraging hospitals, doctors, and post-acute care providers to improve patient care and achieve savings for the Medicare program through bundled payment models.</p>	<p>No changes made.</p>
	<ul style="list-style-type: none"> <li>• Covers Medicare beneficiaries who are hospitalized for one of ten conditions (a mix of chronic and acute)</li> <li>• Requires the Secretary to establish this program by January 1, 2013 for a period of five years</li> <li>• Before January 1, 2016, the Secretary is also required to submit a plan to Congress to extend the pilot program if doing so will improve patient care and reduce spending. (Title III, Subtitle A, Part 3, Sec. 3023)</li> </ul>	
	<p>Establishes a demonstration project, in up to eight States, to study the use of bundled payments for hospital and physicians services under Medicaid. The demonstration will begin by January 1, 2012 through December 31, 2016. (Title II, Subtitle I, Sec. 2704)</p>	
<p>Extension of Special Needs Plan (SNP) Program</p>	<p>Extends the SNP program through December 31, 2013 and requires SNPs to be National Committee for Quality Assurance (NCQA) approved.</p>	<p>No changes made.</p>
	<ul style="list-style-type: none"> <li>• Allows HHS to apply a frailty payment adjustment to fully-integrated, dual-eligible SNPs that enroll frail populations</li> <li>• Requires HHS to transition beneficiaries to a non-specialized Medicare Advantage plan or to original fee-for-service Medicare who are enrolled in SNPs that do not meet statutory target definitions and requires dual-eligible SNPs to contract with State Medicaid programs beginning 2013</li> <li>• Also requires an evaluation of Medicare Advantage risk adjustment for chronically ill populations. (Title III, Subtitle C, Sec. 3205)</li> </ul>	
<p>Medicare Senior Housing Plans</p>	<p>Allows demonstration plans that serve residents in continuing care retirement communities to operate under the Medicare Advantage program. Effective January 1, 2010. (Title III, Subtitle C, Sec. 3208)</p>	<p>No changes made.</p>

***New Benefits Supporting Care Coordination***

<p>Medicare Coverage of Annual Wellness Visit</p>	<p>Provides coverage under Medicare, with no co-payment or deductible, for an annual wellness visit and personalized prevention plan services.</p>	<p>No changes made.</p>
	<ul style="list-style-type: none"> <li>• Such services would include a comprehensive health risk assessment</li> </ul>	

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- A personalized prevention plan would take into account the findings of the health risk assessment and include elements such as: a five- to ten-year screening schedule; a list of identified risk factors and conditions and a strategy to address them; and health advice and referral to education and preventive counseling or community-based interventions to address modifiable risk factors such as physical activity, smoking, and nutrition.
- Effective January 1, 2011. (Title IV, Subtitle B, Sec. 4103)

**3. Improve Medicare Part D Access and Reduce the Medication Cost Burden**

Reduction or Elimination of the Coverage Gap in Medicare Part D	Increases the initial coverage limit in the standard Part D benefit by \$500 for 2010, thus decreasing the time that a Part D enrollee would need to be in the coverage gap. This provision applies only to 2010; the initial coverage limit for subsequent years will be separately determined. (Title III, Subtitle D, Sec. 3315)	This section was repealed by the Reconciliation Bill. (Title I, Subtitle B, Sec. 1101)
Medicare Coverage Gap Discount Program	Requires drug manufacturers to provide a 50 percent discount to Part D beneficiaries for brand-name drugs and biologics purchased during the coverage gap beginning July 1, 2010. (Title III, Subtitle D, Sec. 3301)	<p>This section is further amended to include:</p> <ul style="list-style-type: none"> <li>• Provides a \$250 rebate to Medicare beneficiaries who reach Part D coverage gap in 2010 (Effective January 1, 2010)</li> <li>• Gradually phases down the coinsurance rate in the Medicare Part D coverage gap from 100 percent to 25 percent by 2020</li> <li>• For brand name drugs, requires pharmaceutical manufacturers to provide a 50 percent discount on prescriptions filled in the coverage gap (Effective January 1, 2011), in addition to federal subsidies of 25 percent of the brand-name drug cost by 2020 (Phased in beginning January 1, 2013)</li> <li>• For generic drugs, provides federal subsidies of 75 percent of generic drug cost by 2020 for prescriptions filled in coverage gap (Phased in starting in 2011) (Title I, Subtitle B, Sec. 1101)</li> </ul>

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<p>Improved Assistance to Low-Income Subsidy (LIS) Beneficiaries</p>	<p>The following sections improve access to Medicare Part D plans for LIS beneficiaries and beneficiary outreach and education activities.</p> <ul style="list-style-type: none"> <li>• Allows Part D plans that bid a nominal amount above the regional low-income subsidy (LIS) benchmark to absorb the cost of the difference between their bid and the LIS benchmark in order to remain a \$0 premium LIS plan. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3303)</li> <li>• Allows the surviving spouse of an LIS-eligible couple to delay LIS redetermination for one year after the death of a spouse. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3304)</li> <li>• Requires HHS, beginning in 2011, to transmit formulary and coverage determination information to subsidy-eligible beneficiaries who have been automatically reassigned to a new Part D low-income subsidy plan. Effective January 1, 2011. (Title III, Subtitle D, Sec. 3305)</li> <li>• Provides \$45 million for outreach and education activities to State Health Insurance Programs, Administration on Aging, Aging Disability Resource Centers and the National Benefits Outreach and Enrollment beginning FY2009. (Title III, Subtitle D, Sec. 3306)</li> </ul>	<p>No changes made.</p>
<p>Elimination of Part D Cost-Sharing for Selected Non-Institutionalized Dual Eligible Individuals</p>	<p>Eliminates Part D cost sharing for people receiving care under a home and community-based waiver who would otherwise require institutional care. (Title III, Subtitle D, Sec. 3309)</p>	<p>No changes made.</p>

**4. Enhancing and Revitalizing the Health and Supportive Service Workforce**

<p>Demonstration Project to Address Health Professions Workforce Needs</p>	<ul style="list-style-type: none"> <li>• Establish a demonstration program to offer low income individuals the opportunity to obtain training and education for occupations in the health care field that are expected to experience labor shortages or be in high demand.</li> <li>• Requires the Secretary to establish demonstration programs in up to 6 States for no less than 3 years through competitive grants for purposes of developing core competencies, pilot training curricula, and develop certification programs for personal and home care aides.</li> <li>• Appropriates \$85 million for 5 years (FY 2010-2014), no more than \$5 million per year (FY 2010-2012) allocated for the personal and home care aide demonstration (Title V, Subtitle F, Sec. 5507)</li> </ul>	<p>No changes made.</p>
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<p>Training Opportunities for Direct Care Workers</p>	<p>Establishes grants to eligible entities to provide advanced training opportunities for direct care workers employed in long-term care settings (including nursing homes, assisted living facilities, intermediate-care facilities, and home and community-based settings).</p> <ul style="list-style-type: none"> <li>▪ Funds are to be allocated in the form of tuition or fee support for eligible individuals</li> <li>▪ A condition of receiving assistance is that participating individuals agree to work in the fields of geriatrics, disability services, long term services and supports, or chronic care management for at least 2 years following completion of training</li> <li>▪ This provision authorizes \$10 million for FY 2011-2013 for these grants. (Title V, Subtitle D, Sec. 5302)</li> </ul>	<p>No changes made.</p>
<p>Expanding Physician Assistants' Role in Medicare</p>	<p>Authorizes physician assistants to order skilled nursing facility care. This provision is effective starting January 1, 2011. (Title III, Subtitle B, Part 1, Sec. 3108)</p>	<p>No changes made.</p>
<p>Payment Incentives for Selected Primary Care Services</p>	<p>Increases the Medicare payment rate by 10 percent to primary care practitioners for primary care services.</p> <ul style="list-style-type: none"> <li>▪ Primary care practitioners are those with a family, internal, geriatric, or pediatric medicine and for whom primary care services account for at least 60 percent of allowed charges (Effective FY 2011-2016). (Title V, Subtitle F, Sec. 5501)</li> </ul>	<p>No changes made.</p>
<p>Geriatric Education and Training; Career Awards; Comprehensive Geriatric Education</p>	<p>Authorizes \$10.8 million for FY 2011 to FY 2014 for geriatric education centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools, direct care workers, and family caregivers.</p> <ul style="list-style-type: none"> <li>▪ Funds are allocated to develop curricula and best practices in geriatrics focusing on mental health, medication safety, and communication skills in dementia care</li> <li>▪ These funds also expand the geriatric career awards to advanced practice nurses, clinical social workers, pharmacists, and psychologists; create a parallel geriatrics career incentive award program for Master's level candidates; and establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing. (Title V, Subtitle D, Sec. 5305)</li> </ul>	<p>No changes made.</p>

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Health Workforce  
Evaluation and  
Assessment

- Establishes a national commission tasked with reviewing health care workforce and projected workforce needs. The overall goal of the Commission is to provide comprehensive, unbiased information to Congress and the Administration about how to align Federal health care workforce resources with national needs. Congress will use this information when providing appropriations to discretionary programs or in restructuring other Federal funding sources. Appointments to be made by September 20, 2010. (Title V, Subtitle B, Sec. 5101)
- Codifies existing national center and establishes several state and regional centers for health workforce analysis to collect, analyze, and report data related to Title VII (Public Health Service Act) primary care workforce programs. The centers will coordinate with State and local agencies collecting labor and workforce data and coordinate and provide analyses and reports on Title VII to the Commission. Authorizes \$7.5 million for each fiscal year 2010 through 2014 to carry out activities of the National Center. Also authorizes \$4.5 million for each fiscal year 2010 through 2014 to carry out the activities of the state and regional centers. (Title V, Subtitle B, Sec. 5103)

No changes made.

**5. Strengthening Quality and Consumer Protections**

***Improving Transparency of Information on Skilled Nursing Facilities, Nursing Facilities, and Other Long-Term Care Facilities***

Required Disclosure of  
Ownership and Additional  
Disclosable Parties

Requires skilled nursing facilities (SNFs) and nursing facilities (NFs) to disclose information on ownership and facility organizational structure and requires the Secretary of HHS to develop a standardized format for such information within two years of date of enactment. Final regulations must be promulgated within 2 years following the enactment of this Act. Information will be publicly available one year following the publication of final regulations. (Title VI, Subtitle B, Part 1, Sec. 6101)

No changes made.

Accountability  
Requirements for SNFs  
and NFs

Requires SNFs and NFs to operate compliance and ethics programs on or after the date that is 36 months after enactment. Directs the Secretary to develop a quality assurance and improvement program for SNFs and NFs no later than December 31, 2011. (Title VI, Subtitle B, Part 1, Sec. 6102)

No changes made.

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Nursing Home Compare Medicare Website	Directs the Secretary to publish the following information on the Nursing Home Compare Medicare website: standardized staffing data, links to state internet websites regarding state survey and certification programs, the model standardized complaint form, a summary of substantiated complaints, and the number of adjudicated instances of criminal violations by a facility or its employee. Each informational element shall be published on the website one year after the date of enactment of the relevant subsection of the bill. (Title VI, Subtitle B, Part 1, Sec. 6103)	No changes made.
Reporting of Expenditures	<p>Requires SNFs to separately report expenditures for direct care staffing services, indirect care services, capital assets, and administrative costs on cost reports for cost reporting periods.</p> <ul style="list-style-type: none"> <li>▪ Requires Secretary to redesign the SNF cost report to meet the needs of this section no later than 1 year following enactment</li> <li>▪ Effective on or after two years following redesign of the cost report. (Title VI, Subtitle B, Part 1, Sec. 6104)</li> </ul>	No changes made.
Standardized Complaint Form	<p>Directs the Secretary to develop a standardized complaint form for use by residents or a person acting on a resident's behalf in filing complaints with a State survey and certification agency and a State long-term care ombudsman program.</p> <ul style="list-style-type: none"> <li>▪ States would also be required to establish complaint resolution processes.</li> <li>▪ Effective one year after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6105)</li> </ul>	No changes made.
Ensuring Staffing Accountability	Requires the Secretary to develop a program for facilities to report staffing information in a uniform format based on payroll data, and to also take into account services provided by any agency or contract staff. Effective two years after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6106)	No changes made.
GAO Study and Report on Five-Star Quality Rating System	Requires the Government Accountability Office to conduct a study on the Five-Star Quality Rating System which would include an analysis of the systems implementation and any potential improvements to the system. A Report to Congress is due two years after the date of enactment of this Act. (Title IV, Subtitle B, Part 1, Sec. 6107)	No changes made.

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National Demonstration Projects on Culture Change and Use of Information Technology in Nursing Homes	<p>Requires the Secretary to conduct two facility-based demonstration projects that would develop best practice models in two areas:</p> <ul style="list-style-type: none"> <li>▪ To identify best practices in facilities that are involved in the “culture change” movement, including the development of resources where facilities may be able to access information in order to implement culture change; and</li> <li>▪ To develop best practices in information technology that facilities are using to improve resident care.</li> <li>▪ The demonstration projects shall be implemented no later than one year following the date of enactment of this Act. The demonstration projects shall be conducted for a period not to exceed three years. (Title IV, Subtitle B, Part 2, Sec. 6114)</li> </ul>	No changes made.
Dementia and Abuse Prevention Training	<p>Permits the Secretary to require SNFs and NFs to conduct dementia management and abuse prevention training in pre-employment training programs, and, if the Secretary determines appropriate, as part of ongoing training. Effective one year after the date of enactment of this Act. (Title IV, Subtitle B, Part 3, Sec. 6121)</p>	No changes made.
Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers	<p>Establishes a national program for long term care facilities and providers to conduct screening and criminal and other background checks on prospective direct access patient employees. Authorizes an amount not to exceed \$160 million for the period FY2010 to FY2012. (Title IV, Subtitle C, Sec. 6201)</p>	No changes made.
<b>Other Quality Provisions</b>		
Elder Justice	<p>Establishes advisory capacity and grants to further elder justice providing for the following:</p> <ul style="list-style-type: none"> <li>▪ An Elder Justice Coordinating Council within the Office of the Secretary that will make recommendations to the Secretary, coordinating with the Department of Justice and other relevant federal, state, local, and private agencies and entities related to elder abuse, neglect, exploitation and other crimes against elders</li> <li>▪ Establishes an Advisory Board on Elder Abuse, Neglect and Exploitation to create strategic plans around elder justice in long-term care</li> </ul>	No changes made.

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- Grants to eligible entities to establish elder abuse, neglect and exploitation forensic centers
- Awards grants and carry out activities that provide greater protection to those individuals seeking care in facilities that provide long-term services and supports and provide greater incentives for individuals to train and seek employment at such facilities. (Title VI, Subtitle H, Sec. 6703)

**The SCAN Foundation**  
3800 Kilroy Airport Way, Suite 400, Long Beach, CA 90806  
(888) 569-7226 | [info@thescanfoundation.org](mailto:info@thescanfoundation.org)  
[www.TheScanFoundation.org](http://www.TheScanFoundation.org)





March 01, 2011 - Topic: Health Care Reform

## Obama Supports Giving States More Flexibility in Reform Law

On Monday, President Obama told the National Governors Association that he supports legislation that would allow states to obtain waivers for provisions in the federal health reform law as early as 2014, three years before the overhaul currently permits, the *Washington Post* reports.

The bill (**S 248**) was introduced last year by Sens. Scott Brown (R-Mass.), Mary Landrieu (D-La.) and Ron Wyden (R-Ore.).

Obama said that states could obtain "innovation waivers" if they could prove to federal officials that they can still achieve the law's central goals, including:

- Making insurance benefits as affordable and comprehensive as the reform law;
- Covering the same number of residents as the federal overhaul; and
- Not increasing the federal deficit.

According to the *Post*, Obama's concession is an attempt to refocus the debate over the health reform law. With a majority of states challenging the overhaul in the courts and many states criticizing the law for providing too much federal oversight, Obama's concession now forces critics of the law to prove that their ideas on how to reform the U.S. health system could be successful.

### Legislation Also Provides States With Medicaid Flexibility

The legislation also would give states the ability to work around Medicaid requirements in the reform law, which stipulate who must be covered and to what medical services they must have access (Goldstein/Balz, *Washington Post*, 3/1).

As most states deal with large budget deficits, many governors have taken issue with strict Medicaid regulations under the overhaul. They have called for the federal government to allow them more flexibility with the program to address escalating costs (*California Healthline*, 2/28).

Obama suggested that states create a bipartisan group to negotiate with HHS about Medicaid reform strategies. He said, "If you can come up with more ways to reduce Medicaid costs while producing quality care to those who need it, I will support those proposals."

A senior administration official later said that the White House hopes the group would focus on coordinating care, preventing hospital readmissions and keeping beneficiaries who wish to live on their own out of nursing homes (Pecquet, "*Healthwatch*," *The Hill*, 2/28).

### Governors' Reaction

Obama's message generally was well received, although many governors said they wanted to hear more specifics before endorsing the new plan.

Mississippi Gov. Haley Barbour (R) said, "The devil's in the details."

Meanwhile, Sen. Orrin Hatch (R-Utah) said moving up the timetable for waivers is a "gimmick," rather than a solution.

Kansas Gov. Sam Brownback (R) said the proposal would not change Republicans' opposition to the overhaul, which he said they would continue to fight in the courts.

Mike Leavitt, former HHS secretary and former governor of Utah, said Obama's endorsement of the proposal is "sort of a hollow victory" for GOP-led states. He said that Obama essentially is telling states, "We'll give you permission to ask for permission sooner rather than later." Leavitt added, "What Republicans are saying is that we don't want to have to ask for permission at all, because we can't afford to build the system that you've laid out for us" (*Washington Post*, 3/1).

### **Prospects for Legislation, Waivers**

The legislation's chances of passage "appear dim," the *New York Times* reports.

House Republican leaders on Monday said they are committed to repealing the overhaul and not just changing it. Further, even if the bill became law, states would have difficulty proving they could meet the requirements for the federal waiver, according to the *Times* (Stolberg/Sack, *New York Times*, 2/28).

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# Health Care Reform Timeline

This timeline will help you keep track of when the law's key changes will occur.

Jan. 2010

**Small businesses** can count 35 percent of the money spent on employee health insurance as a tax deduction for 2010.

The doughnut hole for Medicaid Part D recipients shrinks as initial coverage rises \$500.

June 2010

**Temporary high-risk pools** are created to cover those with pre-existing conditions.

Rebates of \$250 start going out to seniors who have reached the gap in Medicare Part D coverage.



Sept. 2010

Lifetime limits on **insurance benefits** banned.

Parents' insurance plans that cover dependents must be extended to cover young adults 26 and under.

No deductibles allowed for certain types of **preventive care**.

Canceling coverage after the fact, known in the industry as "rescission," becomes illegal.

10% tax imposed on indoor tanning services.

July 2010



2011

Insurance companies must create appeals processes for denied claims.

Insurance companies can no longer exclude a child's pre-existing condition from an **insurance policy**.

**Medicare Advantage** is restructured to cut **Medicare costs**, leading to possible cutbacks in benefits for those enrolled.

**Extra-cost drugs** in the Medicare Part D coverage gap are discounted by 50 percent.



Over-the-counter drugs can't be reimbursed through an HRA or FSA, or tax-free from an MSA or Archer MSA, without a prescription.

The income threshold that triggers beneficiary premiums for Medicare Part B stops rising with inflation until 2019.

Medicare Part D premium subsidies for higher-income taxpayers are reduced.

States can begin expanding their Medicaid rolls to include those made eligible by the new law.

Medicare beneficiaries begin making free annual wellness visits and getting certain other preventive care with no co-payments.

Distributions from **MSAs or Archer MSAs** not used for eligible medical expenses are taxed at higher rates.

2013

Maximum contribution to a **flexible spending account** falls to \$2,500 a year and is tied to inflation.

Medicare taxes go up for individuals earning more than \$200,000 and married couples filing jointly earning more than \$250,000.

Federal subsidy of 25 percent of the cost of same-brand drugs filed in the Medicare Part D coverage gap starts to phase in.

Threshold for deducting medical expenses jumps from 7.5 percent to 10 percent of adjusted gross income.



Continue to page 2

# Health Care Reform Timeline

(Continued)

2014

State-based insurance exchanges for individuals and small businesses will be online with four standard levels of coverage.

Tax credits are issued to help the uninsured earning from 100% to 400% of the federal poverty line to buy ~~health~~ **insurance**.



States expand their Medicaid programs to include newly ~~eligible~~ **beneficiaries**.



Insurance plans can't exclude pre-existing conditions or consider them when setting rates and deciding whom to cover.

Tax penalty begins phasing in for those without insurance. Tax starts at \$95 per year in 2014, or 1 percent of taxable income.

Maximum small-business tax credit for buying ~~health~~ **insurance** jumps 50 percent.



Medicaid covers children, parents and childless adults not ~~under Medicaid~~ who earn up to 133 percent of the poverty line.

Employees who get insurance through their employers can opt to receive a voucher for the exchanges instead.



~~Employer plans~~ can no longer place annual dollar limits on the amount of ~~benefit~~ a participant can receive.

2015

Maximum tax penalty for not having insurance rises to \$325 a year, or 2 percent of taxable income.

Businesses with more than 50 employees are required to provide health insurance to employees or pay hefty fees.



~~Employer plans~~ can no longer place annual dollar limits on the amount of ~~benefit~~ a participant can receive.

2016

Maximum tax penalty for not having insurance rises to \$695 a year, or 2.5 percent of taxable income.

Businesses with more than 100 employees can shop for ~~health~~ **insurance** on state insurance exchanges.

2017



Excise tax begins on health plans costing more than \$27,500 for ~~families~~ and \$10,200 for individuals.

2020

Drug makers' discounts and government subsidies rise on brand-name drugs for ~~Medicare recipients~~, closing the "doughnut hole."



Return to page 1

Risley, Carol@SCDD

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**From:** ACF Add\_Information (ACF) [Add\_Information@acf.hhs.gov]  
**Sent:** Friday, February 25, 2011 11:45 AM  
**To:** ACF Add\_Information (ACF)  
**Subject:** HHS ISSUES ADDITIONAL INFORMATION TO STATES ABOUT MEDICAID ELIGIBILITY UNDER THE AFFORDABLE CARE  
**Attachments:** MOE-SHO-Ltr-2-25-11 For Display.pdf

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## ADMINISTRATION ON DEVELOPMENTAL DISABILITIES

DISABILITY IS A NATURAL PART C

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*News And Updates From Office Of Commissioner  
February 25th, 2011*

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**For Immediate Release:** Friday, February 25, 2011  
**Contact:** CMS Office of Public Affairs  
202-690-6145

### **HHS ISSUES ADDITIONAL INFORMATION TO STATES ABOUT MEDICAID ELIGIBILITY UNDER THE AFFORDABLE CARE ACT** **NEW GUIDANCE ON MAINTENANCE OF EFFORT PROVIDES MORE FLEXIBILITY TO STATES**

U.S. Department of Health and Human Services Secretary Kathleen Sebelius today issued a new letter and a frequently asked questions (FAQ) document that explain Medicaid and Children's Health Insurance Program (CHIP) provisions in the Affordable Care Act in ways that afford greater flexibility to States. The new guidance clarifies aspects of the maintenance of effort (MOE) rules for Medicaid and CHIP. Further guidance will follow.

The Medicaid MOE provision in the Affordable Care Act generally ensures that States' eligibility rules for adults under the Medicaid program remain in place pending implementation of eligibility rules changes that become effective in January 2014. The MOE provision for children extends to 2019.

The letter and supporting FAQ document address three aspects of the MOE provisions:

- The MOE exemption for higher-income adult populations in States that are experiencing budget deficits. Under the Affordable Care Act, if a State has or projects a budget deficit, the MOE provision does not apply to adults who are not eligible for coverage on the basis of pregnancy or disability and whose incomes are above 133 percent of the Federal poverty level. The FAQ document explains State options and how States can seek this exemption.
- The implication of the MOE provision on Section 1115 demonstration projects. Some States cover groups of people under Medicaid through a Section 1115 demonstration. As explained in the FAQ

document, the MOE provision generally applies to these waivers and demonstrations. However, waivers and demonstration are, by their terms, time limited. The guidance clarifies that the MOE provision does not require States to seek a new or renewed waiver after the expiration of their waiver or demonstration.

- How premiums are treated under the MOE requirements. Because premiums and premium increases have an impact on eligibility, previous guidance under the Recovery Act explained that new or increased premiums were considered to be a violation of the Recovery Act MOE requirement. Because the period during which the Affordable Care Act MOE provisions apply is considerably longer than the MOE period under the Recovery Act, this new guidance offers States additional flexibility relating to premiums and the MOE requirements under the Affordable Care Act. This will help a number of States that have been requesting the ability to adjust premiums for populations such as children in CHIP with family incomes above 150 percent of the Federal poverty line.

“Ensuring that our most vulnerable populations continue to receive Medicaid coverage during these difficult times requires as much flexibility as possible,” said Secretary Sebelius. “We will continue to review the maintenance of effort provisions under the Affordable Care Act and will issue further guidance to States, as needed.”

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, Maryland 21244-1850



**Center for Medicaid, CHIP and Survey & Certification**

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SMDL# 11-001

February 25, 2011

**Re: Maintenance of Effort**

Dear State Medicaid Director:

This letter and the accompanying Questions and Answers (Q&As) are part of a series that provide guidance on the “maintenance of effort” (MOE) provisions in the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010; P.L. 111-152 (together known as the Affordable Care Act). In this letter and the enclosed Q&As, we address the Affordable Care Act MOE provisions for Medicaid and the Children’s Health Insurance Program (CHIP) generally, and specifically answer questions related to their application to the nonapplication of the MOE provision for certain adult populations in States with a budget deficit, section 1115 waivers and demonstration projects, and the treatment of premiums.

The MOE provisions in the Affordable Care Act generally ensure that States’ coverage for adults under the Medicaid program remains in place pending implementation of coverage changes that become effective in January 2014. The Medicaid MOE provisions relating to adults expire when the Secretary determines that an Exchange established by the State under section 1311 of the Affordable Care Act is fully operational. The MOE provisions for children under age 19, in both Medicaid and CHIP are effective through September 30, 2019.

In general, the Affordable Care Act MOE statutory provisions are very similar to the MOE provisions in section 5001(f)(1) of the American Recovery and Reinvestment Act (Recovery Act, P.L. 111-5). Therefore, unless otherwise indicated, the Recovery Act MOE provisions and guidelines that have been issued by the Centers for Medicare & Medicaid Services (CMS) are applicable to implementation of the Affordable Care Act MOE provisions and continue to apply through the remainder of the Recovery Act increased FMAP period which ends on June 30, 2011. The guidance set forth in the enclosures clarifies some points that were not previously addressed, and also addresses the different context of the Affordable Care Act provisions. We continue to review the application of the MOE provisions under the Affordable Care Act and will be issuing further guidance based on questions and issues that arise.

Page 2 – State Medicaid Director

We hope this guidance is informative. Please submit any questions you have about the Affordable Care Act MOE provisions to Mr. Bill Lasowski at [William.Lasowski@cms.hhs.gov](mailto:William.Lasowski@cms.hhs.gov).

Sincerely,

/s/

Cindy Mann  
Director

Enclosures

cc:

CMS Regional Administrators

CMS Associate Regional Administrators  
Division of Medicaid and Children's Health

Acting Director  
APHS

Joy Wilson  
Director, Health Committee  
National Conference of State Legislatures

Director of Health Legislation  
National Governors Association

Debra Miller  
Director for Health Policy  
Council of State Governments

Christine Evans, M.P.H.  
Director, Government Relations  
Association of State and Territorial Health Officials

Alan R. Weil, J.D., M.P.P.  
Executive Director  
National Academy for State Health Policy

President  
National Association of Medicaid Directors

**ENCLOSURE A: THE AFFORDABLE CARE ACT  
MAINTENANCE OF EFFORT (MOE)--QUESTIONS & ANSWERS**

***MOE In General***

**Q1. What are the general Medicaid and CHIP MOE provisions under the Affordable Care Act?**

Answer. The MOE provisions in the Affordable Care Act specify that existing coverage for adults under the Medicaid program generally remains in place until the Secretary determines that an Exchange established by the State under section 1311 of the Affordable Care Act is fully operational, which is likely to be January 1, 2014, and, for children, under both Medicaid and the Children’s Health Insurance Program (CHIP), through Federal fiscal year 2019. As discussed below, exceptions apply to the Medicaid MOE for States experiencing or projecting a deficit to permit Medicaid eligibility restrictions for certain nonpregnant, nondisabled adults.

Sections 1902(a)(74) and 1902(gg) of the Social Security Act (the Act), as added by section 2001(b) of the Affordable Care Act, contain the Medicaid MOE provision. With certain exceptions, as a condition of receiving Federal Medicaid funding, States must maintain Medicaid “eligibility standards, methodologies, and procedures” that are no more restrictive than those in effect on March 23, 2010 (the date of enactment of the Affordable Care Act). The CHIP MOE provision is in section 2105(d)(3) of the Act, as added by section 2101(b) of the Affordable Care Act. The CHIP MOE also requires maintenance of CHIP “eligibility standards, methods and procedures” in effect on March 23, 2010 as a condition of continued Medicaid funding, with certain exceptions such as to permit enrollment of CHIP eligibles in qualified health plans certified by the Secretary if funding under the State’s available Federal CHIP allotments is insufficient after September 30, 2015, or to allow the State to impose a limitation related to the establishment of waiting lists in order to limit expenditures under the CHIP program to those for which Federal funds are available.

The statutory language requiring maintenance of “eligibility standard, methods and procedures” is very similar to the Medicaid MOE provision in section 5001(f)(1) of the American Recovery and Reinvestment Act (Recovery Act, P.L. 111-5). Therefore, in general, and unless otherwise indicated, the Recovery Act MOE provisions and guidelines are applicable to implementation of Affordable Care Act Medicaid MOE provisions. We are continuing to review these guidelines and new questions and issues as they arise and may issue further Q&A’s; please continue to let us know your questions.

***Nonapplication of Medicaid MOE***

**Q2. Are there circumstances under which the Affordable Care Act Medicaid MOE rules do not apply?**

Answer. Yes. Under section 1902(gg)(3) of the Act, as added by the Affordable Care Act, during the period January 1, 2011 through December 31, 2013, if the State submits a certification to the Secretary that it has or projects a budget deficit for the current or following State fiscal year, the Medicaid MOE provision does not apply for certain adults during that year. (See Q4 about the interaction with the Recovery Act MOE provision.) Specifically, this exception to the MOE provision may be applied to adults who are not eligible for coverage on the basis of pregnancy or disability and whose incomes are above 133 percent of the Federal poverty level (FPL). (See Q5 for more details on the specific options available to States.)

It is important to note that, while the MOE would not apply, the State would need to submit a Medicaid State plan amendment (or amendment to a waiver/demonstration under section 1115 of the Social Security Act, as appropriate) to implement any reduction in eligibility.

**Q3. What conditions must a State meet in order to qualify for the nonapplication of the Medicaid MOE provision?**

Answer. The State must submit to the Secretary a certification, signed by a State official responsible for State finances, that:

- the State has or projects a budget deficit during the State fiscal year (SFY) for which the certification is made, and/or
- the State projects it will have a budget deficit for the SFY following the SFY in which the certification is submitted.

Enclosure B to this document provides a template for Affordable Care Act certification that a State could use for purposes of certifying the circumstances that would permit the nonapplication of the MOE provision.

**Q4. When the State submits such a certification, what is the effective date of the nonapplication of the Affordable Care Act Medicaid MOE for the specified populations?**

Answer. The period of nonapplication of the MOE provisions for the specified populations may begin no earlier than January 1, 2011 and end no later than December 31, 2013.

The effective/beginning date of the nonapplication of MOE period is the later of:

- January 1, 2011,

- The date the State submits and CMS receives the certification referenced in Q3, or
- A later date requested by the State.

Interaction with Recovery Act Medicaid MOE Provision during the Period January 1, 2011 through June 30, 2011. States should be aware that the Medicaid MOE provisions of the Recovery Act, along with the associated increased matching rate, remain applicable through June 30, 2011. The budget deficit exception to the Affordable Care Act Medicaid MOE does not apply to the Recovery Act. Any violation of such Recovery Act Medicaid MOE provisions could result in the loss of the increased FMAP available under the Recovery Act. In that regard, States should carefully consider the implications of any more restrictive eligibility provisions they may wish to implement during the first two calendar quarters of 2011. CMS can provide technical assistance to States that are considering whether to proceed prior to July 2011.

The ending date of the nonapplication of MOE period with respect to a particular certification submitted by a State is the earlier of:

- The last day of the current SFY in which the certification is submitted, or the last day of the succeeding SFY for which the State certifies a budget deficit or
- December 31, 2013.

Example. If a State certifies it has a budget deficit for the current SFY (for example, SFY 2011) and projects it will have a budget deficit for the following SFY (SFY2012), the MOE provisions would not apply for the individuals identified in Q2 during both SFYs. Based on this certification, the period of nonapplication of the MOE provision would extend only through the end of SFY 2012. If the State sought to begin or continue the application of more restrictive eligibility provisions in SFY 2013 under the nonapplication of MOE provision, it would need to provide a certification of a projected deficit for SFY 2013 by the end of SFY 2012.

In accordance with the date a State submits and CMS receives the State certification of a budget deficit, and the State's request for a particular (later) effective date, if any, CMS will respond in writing to the State indicating the period of the nonapplication of the MOE provision.

**Q5. Does a qualifying State that submits a certification have flexibility in how the nonapplication of the Affordable Care Act Medicaid MOE provision would apply?**

Answer. Yes, a State could choose to apply eligibility restrictions for all of the individuals for which the nonapplication of MOE provision applies, or a State has the flexibility to impose less encompassing restrictions in their eligibility

provisions in order to continue to provide eligibility for certain groups of individuals. Any eligibility restrictions that the State imposes must be included in a Medicaid State plan amendment (or waiver amendment, as applicable) and CMS will work with States to determine what options are allowable based on the specific circumstances in the State. The following are some of the options (which are not mutually exclusive) that may be available to States:

Option 1. Apply more restrictive eligibility criteria immediately to all affected individuals above 133 percent of the FPL (new applicants and existing beneficiaries) with an effective date requested by the State (in accordance with the MOE provisions).

Option 2. Apply more restrictive criteria immediately only to affected individuals who are new applicants, and for affected individuals who are current beneficiaries apply the more restrictive criteria at the time of their next redetermination (phase in changes).

Option 3. Apply the more restrictive criteria to some eligibility groups of individuals. For example, a State that covered nonpregnant, nondisabled adults up to 200 percent of the FPL could decide to lower eligibility to 185 percent of the FPL rather than 133 percent of the FPL.

We will work with States interested in making changes for applicants but not for current beneficiaries (grandfathering in current beneficiaries). Whether and how this can be done will depend on the specific circumstances in the State.

In exercising any of the above options, States must still follow all applicable requirements for making changes in its Medicaid program; for example, States must still submit and have approved any appropriate Medicaid State plan amendments or waivers/waiver amendments. States must also follow all existing rules regarding the termination of coverage, including determining whether an individual's eligibility should continue under another unaffected eligibility category and providing all applicable notice and appeal rights.

In implementing any changes, States must ensure that the application of any more restrictive eligibility standards, methodologies, or procedures, or combination of such (more restrictive) provisions would not result in the loss of eligibility for individuals who are eligible based on pregnancy or disability or whose income is at or below 133 percent of the FPL, as would be determined in accordance with the standards, methodologies and procedures in effect on March 23, 2010. CMS will work with States to develop and implement the appropriate mechanisms to ensure that this requirement is met.

**Q6. Do these nonapplication provisions apply to adults covered through CHIP 1115 demonstrations?**

Answer. No, but neither do the Affordable Care Act MOE provisions for CHIP apply to adults; that is, the CHIP MOE provision in section 2105(d)(3) of the Act, as amended by the Affordable Care Act, only applies to children. The nonapplication of MOE provisions in section 1902(gg)(3) of the Act do not apply to children - whether in CHIP or Medicaid. However, adults covered in a dual XIX Medicaid-CHIP demonstration could be affected by the Medicaid MOE provisions in section 1902(gg) of the Act and therefore potentially by the nonapplication provisions as well.

***MOE and Section 1115 Waivers and Demonstrations***

**Q7. Do the Affordable Care Act MOE provisions apply to Medicaid section 1115 waivers and demonstrations?**

Answer. Yes. The Medicaid MOE provisions in the Affordable Care Act, like those in the Recovery Act, refer to the eligibility requirements “under the State plan ... or under any waiver of such plan” under Medicaid including a waiver/demonstration under section 1115 of the Social Security Act. As discussed below, the MOE provisions apply subject to, and in accordance with, the requirements in each State’s section 1115 waiver/demonstration in effect on March 23, 2010.

**Q8. How is the termination or modification of a Medicaid section 1115 demonstration affected by the Affordable Care Act MOE provisions?**

Answer. Every section 1115 demonstration includes an expiration date in the special terms and conditions (STCs). A State’s assumption of responsibilities under a demonstration and the Secretary’s approval of a demonstration are time limited. The MOE provision in the Affordable Care Act does not require a State to request that the Secretary continue a demonstration after the date that the demonstration would expire under the STCs in effect on March 23, 2010. However, during the time period covered by a demonstration in effect as of March 23, 2010, a State may not terminate or modify the demonstration to the extent that such termination or modification would result in more restrictive eligibility standards, methodologies and procedures without violating the MOE provision. Specifically:

- If a State chose to terminate a demonstration that was in effect on March 23, 2010 at the end of the demonstration approval period, that would not constitute an MOE violation. The extent to which a State may then restrict eligibility and still comply with the MOE provisions will depend on the specifics of each State’s demonstration and its underlying State Plan. However, if a State chooses to end its demonstration prior to the expiration of the demonstration

approval period, that would constitute an MOE violation to the extent that eligibility is adversely affected.

- If a State requests a renewal at the end of the demonstration in effect as of March 23, 2010, with modifications to the terms and conditions, it may do so. This would not be an MOE violation. However, if a State seeks to modify its terms and conditions in ways that would restrict eligibility standards, methodologies or procedures before the demonstration approval period has expired, that would constitute an MOE violation.
- A State could move coverage of individuals out of its demonstration project and into its State plan as long as the end result is the individuals who would be eligible under the demonstration project as of March 23, 2010 remain eligible for medical assistance (see question 4 below). This would not be an MOE violation.

NOTE: Refer to Questions 11 and 12 regarding the effects of provisions in the original CHIP law which could be affected by potential terminations or modifications of a Medicaid demonstration.

**Q9. What is the interaction between the MOE provision and Medicaid section 1115 demonstration budget neutrality requirements?**

Answer. The STCs governing section 1115 demonstrations include budget neutrality requirements that are designed to assure that the costs to the Federal Government in the Medicaid program under the demonstration are not greater than such costs would have been absent such demonstration. In general, a State is at risk for expenditures incurred under the demonstration in excess of the Federal budget cap.

The Affordable Care Act MOE requires that a State not adopt demonstration eligibility “standards, methodologies, and procedures” that are more restrictive than those in effect on March 23, 2010. However, if a State anticipates that the Federal costs under its section 1115 demonstration could exceed what would be permitted under the demonstration’s budget neutrality agreement, it may comply with the procedures specified in the STCs to change its program to maintain budget neutrality without violating the MOE provisions. For example, if the demonstration STCs explicitly allow the State to impose an enrollment cap to keep expenditures within the budget caps, the State may do so consistent with the STCs in effect on March 23, 2010, to the extent necessary to comply with the demonstration budget requirements. If the STCs do not specify the actions a State may take to keep expenditures within the budget caps, the State should work with CMS to address and adhere to the budget neutrality requirements in accordance with the STCs and the MOE provisions in the Affordable Care Act.

NOTE: Refer to Questions 11 and 12 regarding the effects of provisions in the original CHIP law which could be affected by potential terminations or modifications of a Medicaid demonstration.

**Q10. Would a State that moves coverage of populations currently covered under a section 1115 demonstration to coverage under a State plan be in compliance with the Affordable Care Act MOE provisions?**

Answer. Yes, as long as the State, at a minimum, maintains the eligibility standards, methodologies, and procedures in effect on March 23, 2010. Under the new section 1902(gg)(4)(B), conversion to State plan coverage that does not restrict eligibility relative to March 23, 2010, would be in compliance with the MOE provisions. States considering such a conversion should work with CMS to discuss the details relative to their particular demonstration.

**Q11. How do the Affordable Care Act MOE provisions for section 1115 demonstrations under the Children's Health Insurance Program (CHIP) differ from such requirements for section 1115 demonstrations under Medicaid?**

Answer. The MOE provisions in the Affordable Care Act specify that existing coverage for adults under the Medicaid program generally remains in place through January 2014, or when the Secretary determines that a State Exchange is fully operational, and, for children, under both Medicaid and CHIP through Federal fiscal year 2019. Other than with respect to these different periods during which the MOE provisions apply, the treatment of the Affordable Care Act MOE provisions, as applied to Section 1115 demonstrations under CHIP, is the same as the treatment under the Medicaid program, as described in questions 7 through 10 above.

NOTE: Refer to Question 12 regarding the effect of provisions in the original CHIP law applicable under CHIP which could be affected by potential terminations or modifications of a Medicaid demonstration.

**Q12. How do other requirements in CHIP that applied prior to the Affordable Care Act which continue to apply, affect States' Medicaid section 1115 demonstrations?**

Answer. The CHIP law in effect prior to the enactment of the Affordable Care Act includes provisions which continue to apply after the enactment of the Affordable Care Act, and could have an impact on the termination or modification of a State's Medicaid 1115 demonstration.

In particular, the provision in CHIP statute at section 2105(d)(1) of the Act provides that no payment shall be made from a State's available CHIP allotments

if the State adopts any income and resource eligibility standards for children under its Medicaid program that are more restrictive than were applied under the State's Medicaid State plan as of June 1, 1997. If a State terminates the Medicaid demonstration without providing coverage for children eligible as of June 1, 1997 under its Medicaid State plan (or another demonstration), it would violate this CHIP provision.

Additionally, dropping children by terminating or amending a Medicaid demonstration may have other effects on CHIP. Many States define the CHIP population to include individuals with family incomes under a certain level who are not eligible for Medicaid. In that instance, children who are no longer eligible under a Medicaid demonstration would become eligible under CHIP. We also note that the CHIP statute at section 2102(b)(1)(B)(i) of the Act provides that, within any defined group of targeted low-income children, States are precluded from covering children with higher family income levels without covering children with lower family incomes. As a result, some States (such as those which drop children through the termination or amendment of a demonstration) may need to adjust CHIP financial eligibility levels to ensure coverage of children with lower family incomes.

States seeking to drop children from a Medicaid demonstration should work with CMS to determine whether adjustments are necessary to ensure compliance with CHIP requirements.

#### *Treatment of Premiums under MOE Provisions*

**Q13. How does the treatment of premiums under the Affordable Care Act MOE differ from that under the Recovery Act?**

Answer. Under the Recovery Act Medicaid MOE provision, CMS guidance indicated that the imposition and requirement for individuals to pay premiums was considered to be an eligibility provision for purposes of the MOE compliance. Thus, the imposition of increases to existing premiums or the imposition of new premiums after the Recovery Act MOE date was not consistent with the MOE. In general, under the Affordable Care Act MOE provisions this is still the case.

Particularly in light of the longer time frame for the Affordable Care Act MOE period, we have reevaluated the part of our guidance that precluded customary incremental increases in premiums to reflect authorization already in a State plan or demonstration, inflation adjustments, or in certain cases of new coverage. Inflation adjusted increases were permitted by Congress with respect to nominal cost sharing under section 1916 of the Act, and, it would be consistent with that provision to permit such increases under the MOE. Thus, we are revising our prior guidance so that the following would not be considered an MOE violation in Medicaid and CHIP:

- States that had explicit language approved in their State plan or demonstration, as of July 1, 2008 for Medicaid (the date of the Recovery Act MOE provision) and March 23, 2010 for CHIP (the Affordable Care Act enactment), to automatically increase premiums on a regular basis (e.g., based on annual changes in Federal poverty level, or increases tied to capitation payments for health plans), may increase premiums in accordance with their approved State plan or demonstration language. These policies will be considered “in effect” as of the applicable MOE date and therefore not a violation of the MOE.
- For premiums in effect as of July 1, 2008 for Medicaid or March 23, 2010 for CHIP, States can adopt, through State plan or demonstration amendments, certain inflation-related adjustments to those premium levels. Such inflation adjustments must be based on (and no more than) the percentage increase in the Consumer Price Index trended forward using the applicable CPI-M (or another State specific index submitted by the State and approved by CMS). States can apply the inflation adjustment retroactive to the premium base amount in effect on March 23, 2010; or they can apply a more limited adjustment (e.g., covering only the past year). For example, in SFY 2013, a State could adopt a premium adjustment equal to the change in the CPI-M for 2013 compared to the CPI-M for 2012.
- States are not precluded from adopting premiums if they are applied to new coverage provided after July 1, 2008 for Medicaid and March 23, 2010 for CHIP, and the new coverage and premium amount is consistent with other provisions of law. For example, if a State expands CHIP eligibility for children with incomes between 200 and 225 percent of the FPL, it can impose a premium on the newly eligible children, consistent with the CHIP statute and regulations.

**Q14. Would a premium increase related to a beneficiary enrolling in a higher cost health plan be considered "new coverage"?**

Answer. The imposition of a higher premium for individuals enrolling in a higher cost plan would not be a violation of MOE provisions as long as it is the choice of the beneficiary to enroll in the higher cost plan and the premium increase is not a condition of eligibility. However, if a beneficiary enrolled in a lower-cost plan is required to enroll in the higher-cost plan, and then such individuals are required to pay the higher-cost premiums, that would be a violation of the MOE.

**Q15. Is an increase in copayments implemented before or after March 23, 2010 considered a MOE violation?**

Answer. No. Copayments are not conditions of eligibility (but instead are related to the use of covered benefits) and increases in copayments are not considered to be an MOE violation.

## Enclosure B: State Certification Statement Template

The following language can be used by States for the certification required by a State under the nonapplication of MOE provision of section 1902(gg)(3) of the Social Security Act, as amended by the Affordable Care Act. As applicable for the period(s)/State fiscal years for which the State is indicating its certification of a budget deficit, the State should check either the first, second, or both check boxes indicated.

The Honorable Kathleen Sebelius  
Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, S. W.  
Washington, D.C. 20201

Dear Secretary Sebelius:

In accordance with and for the purposes of section 1902(gg)(3) of the Social Security Act, as amended by the Affordable Care Act, I certify that the State of *(Fill-in)*:

- Has or projects to have a budget deficit during the State fiscal year *(fill-in SFY)* representing the period *(fill-in the MM/DD/YYYY - MM/DD/YYYY of the SFY)*
- Projects a budget deficit for the State fiscal year *(fill-in SFY)* representing the period *(fill-in the MM/DD/YYYY - MM/DD/YYYY of the SFY)* following the State fiscal year in which this certification is submitted.

Sincerely yours,

**(Enter Name of Appropriate Official in the State who has the delegated authority in the State to certify as to the status of the State budget and projected budget deficits in the State) )**

**Date: (Enter Date of Certification)**



## COUNCIL AGENDA ITEM DETAIL SHEET

**Bill NUMBER/ISSUE:** Assembly Bill (AB) 171, autism spectrum disorder

**BILL SUMMARY:** This bill requires health care service plans and health insurers to provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. It prohibits coverage from being denied solely on the basis of a diagnosis of an autism spectrum disorder. This bill also indicates that its provisions do not reduce any obligation to provide services to enrollees under individualized program plans, individualized family service plan, prevention program plans, individualized education programs, or individual service plans. Lastly, this bill explicitly does not require its provisions to be provided through the California Health Benefit Exchange that exceed the essential health benefits required under federal law.

**BACKGROUND:** Although a medical issue, it has been reported by many families that private insurers will not cover services associated with their child's diagnosis of autism or autism spectrum disorders. This includes a service known as applied behavioral analysis (ABA), which research has determined to be effective in the treatment of autism and autism spectrum disorders. AB 171 is sponsored by the Alliance of California Autism of Organizations. A similar bill was introduced last session, SB 1282.

**ANALYSIS/DISCUSSION:** If this bill passes, it may enable many families with children with autism or autism spectrum disorders to receive the treatment they need through their insurance providers without engaging in costly appeals or litigation. Additionally, it may make such treatment more readily available than by obtaining it through schools and/or regional centers.

Because the provisions of this bill that exceed essential health benefits under federal law through the California Health Benefit Exchange, a two tier system may be created.

**COUNCIL STRATEGIC PLAN OBJECTIVE:** Shape public policy that positively impacts Californians with developmental disabilities and their families.

**PRIOR COUNCIL ACTIVITY:** A similar bill, SB 1282 (Steinberg), was introduced last session and died in committee. The Council did not take a position before the bill died. On February 17, 2011, the Legislative and Public Policy Committee (LPPC) took action to recommend the Council support AB 171. The bill has not been amended since the LPPC's review at the time of this writing.

**RECOMMENDATION(S):** Support AB 171.

**ATTACHMENT(S):** AB 171

**PREPARED:** Christofer Arroyo, February 24, 2011

**ASSEMBLY BILL**

**No. 171**

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**Introduced by Assembly Member Beall**

January 20, 2011

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An act to add Section 1374.73 to the Health and Safety Code, and to add Section 10144.51 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 171, as introduced, Beall. Autism spectrum disorder.

(1) Existing law provides for licensing and regulation of health care service plans by the Department of Managed Health Care. A willful violation of these provisions is a crime. Existing law provides for licensing and regulation of health insurers by the Insurance Commissioner. Existing law requires health care service plan contracts and health insurance policies to provide benefits for specified conditions, including certain mental health conditions.

This bill would require health care service plan contracts and health insurance policies to provide coverage for the screening, diagnosis, and treatment of autism spectrum disorders. The bill would, however, provide that no benefits are required to be provided by a health benefit plan offered through the California Health Benefit Exchange that exceed the essential health benefits required under federal law. The bill would prohibit coverage from being denied for specified reasons. Because the bill would change the definition of a crime with respect to health care service plans, it would thereby impose a state-mandated local program.

(2) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 1374.73 is added to the Health and Safety  
2 Code, to read:

3 1374.73. (a) Every health care service plan contract issued,  
4 amended, or renewed on or after January 1, 2012, that provides  
5 hospital, medical, or surgical coverage shall provide coverage for  
6 the screening, diagnosis, and treatment of autism spectrum  
7 disorders. A health care service plan shall not terminate coverage,  
8 or refuse to deliver, execute, issue, amend, adjust, or renew  
9 coverage, to an enrollee solely because the individual is diagnosed  
10 with, or has received treatment for, an autism spectrum disorder.

11 (b) Coverage required to be provided under this section shall  
12 extend to all medically necessary services and shall not be subject  
13 to any limits regarding age, number of visits, or dollar amounts.  
14 Coverage required to be provided under this section shall not be  
15 subject to provisions relating to lifetime maximums, deductibles,  
16 copayments, or coinsurance or other terms and conditions that are  
17 less favorable to an enrollee than lifetime maximums, deductibles,  
18 copayments, or coinsurance or other terms and conditions that  
19 apply to physical illness generally under the plan contract.

20 (c) Coverage required to be provided under this section is a  
21 health care service and a covered health care benefit for purposes  
22 of this chapter. Coverage shall not be denied on the basis that the  
23 treatment is habilitative, nonrestorative, educational, academic, or  
24 custodial in nature.

25 (d) A health care service plan may request, no more than once  
26 annually, a review of treatment provided to an enrollee for autism  
27 spectrum disorders. The cost of obtaining the review shall be borne  
28 by the plan. This subdivision does not apply to inpatient services.

29 (e) A health care service plan shall establish and maintain an  
30 adequate network of qualified autism service providers with  
31 appropriate training and experience in autism spectrum disorders  
32 to ensure that enrollees have a choice of providers, and have timely  
33 access, continuity of care, and ready referral to all services required

1 to be provided by this section consistent with Sections 1367 and  
2 1367.03 and the regulations adopted pursuant thereto.

3 (f) (1) This section shall not be construed as reducing any  
4 obligation to provide services to an enrollee under an individualized  
5 family service plan, an individualized program plan, a prevention  
6 program plan, an individualized education program, or an  
7 individualized service plan.

8 (2) This section shall not be construed as limiting benefits that  
9 are otherwise available to an enrollee under a health care service  
10 plan.

11 (3) This section shall not be construed as affecting litigation  
12 that is pending on January 1, 2012.

13 (g) On and after January 1, 2014, to the extent that this section  
14 requires health benefits to be provided that exceed the essential  
15 health benefits required to be provided under Section 1302(b) of  
16 the federal Patient Protection and Affordable Care Act (Public  
17 Law 111-148), as amended by the federal Health Care and  
18 Education Reconciliation Act of 2010 (Public Law 111-152) by  
19 qualified health plans offering those benefits in the California  
20 Health Benefit Exchange pursuant to Title 22 (commencing with  
21 Section 100500) of the Government Code, the specific benefits  
22 that exceed the federally required essential health benefits are not  
23 required to be provided when offered by a health care service plan  
24 contract through the Exchange. However, those specific benefits  
25 are required to be provided if offered by a health care service plan  
26 contract outside of the Exchange.

27 (h) As used in this section, the following terms shall have the  
28 following meanings:

29 (1) "Autism spectrum disorder" means a neurobiological  
30 condition that includes autistic disorder, Asperger's disorder, Rett's  
31 disorder, childhood disintegrative disorder, and pervasive  
32 developmental disorder not otherwise specified.

33 (2) "Behavioral health treatment" means professional services  
34 and treatment programs, including behavioral intervention therapy,  
35 applied behavioral analysis, and other intensive behavioral  
36 programs, that have demonstrated efficacy to develop, maintain,  
37 or restore, to the maximum extent practicable, the functioning or  
38 quality of life of an individual and that have been demonstrated  
39 to treat the core symptoms associated with autism spectrum  
40 disorder.

1 (3) “Behavioral intervention therapy” means the design,  
2 implementation, and evaluation of environmental modifications,  
3 using behavioral stimuli and consequences, to produce socially  
4 significant improvement in behaviors, including the use of direct  
5 observation, measurement, and functional analyses of the  
6 relationship between environment and behavior.

7 (4) “Diagnosis of autism spectrum disorders” means medically  
8 necessary assessment, evaluations, or tests to diagnose whether  
9 an individual has one of the autism spectrum disorders.

10 (5) “Evidence-based research” means research that applies  
11 rigorous, systematic, and objective procedures to obtain valid  
12 knowledge relevant to autism spectrum disorders.

13 (6) “Pharmacy care” means medications prescribed by a licensed  
14 physician and surgeon or other appropriately licensed or certified  
15 provider and any health-related services deemed medically  
16 necessary to determine the need or effectiveness of the medications.

17 (7) “Psychiatric care” means direct or consultative psychiatric  
18 services provided by a psychiatrist or any other appropriately  
19 licensed or certified provider.

20 (8) “Psychological care” means direct or consultative  
21 psychological services provided by a psychologist or any other  
22 appropriately licensed or certified provider.

23 (9) “Therapeutic care” means services provided by licensed or  
24 certified speech therapists, occupational therapists, or physical  
25 therapists or any other appropriately licensed or certified provider.

26 (10) “Treatment for autism spectrum disorders” means all of  
27 the following care, including necessary equipment, prescribed or  
28 ordered for an individual diagnosed with one of the autism  
29 spectrum disorders by a licensed physician and surgeon or a  
30 licensed psychologist or any other appropriately licensed or  
31 certified provider who determines the care to be medically  
32 necessary:

33 (A) Behavioral health treatment.

34 (B) Pharmacy care.

35 (C) Psychiatric care.

36 (D) Psychological care.

37 (E) Therapeutic care.

38 (F) Any care for individuals with autism spectrum disorders  
39 that is demonstrated, based upon best practices or evidence-based  
40 research, to be medically necessary.

1 SEC. 2. Section 10144.51 is added to the Insurance Code, to  
2 read:

3 10144.51. (a) Every health insurance policy issued, amended,  
4 or renewed on or after January 1, 2012, that provides hospital,  
5 medical, or surgical coverage shall provide coverage for the  
6 screening, diagnosis, and treatment of autism spectrum disorders.  
7 A health insurer shall not terminate coverage, or refuse to deliver,  
8 execute, issue, amend, adjust, or renew coverage, to an insured  
9 solely because the individual is diagnosed with, or has received  
10 treatment for, an autism spectrum disorder.

11 (b) Coverage required to be provided under this section shall  
12 extend to all medically necessary services and shall not be subject  
13 to any limits regarding age, number of visits, or dollar amounts.  
14 Coverage required to be provided under this section shall not be  
15 subject to provisions relating to lifetime maximums, deductibles,  
16 copayments, or coinsurance or other terms and conditions that are  
17 less favorable to an insured than lifetime maximums, deductibles,  
18 copayments, or coinsurance or other terms and conditions that  
19 apply to physical illness generally under the policy.

20 (c) Coverage required to be provided under this section is a  
21 health care service and a covered health care benefit for purposes  
22 of this part. Coverage shall not be denied on the basis that the  
23 treatment is habilitative, nonrestorative, educational, academic, or  
24 custodial in nature.

25 (d) A health insurer may request, no more than once annually,  
26 a review of treatment provided to an insured for autism spectrum  
27 disorders. The cost of obtaining the review shall be borne by the  
28 insurer. This subdivision does not apply to inpatient services.

29 (e) A health insurer shall establish and maintain an adequate  
30 network of qualified autism service providers with appropriate  
31 training and experience in autism spectrum disorders to ensure  
32 that insureds have a choice of providers, and have timely access,  
33 continuity of care, and ready referral to all services required to be  
34 provided by this section consistent with Sections 10133.5 and  
35 10133.55 and the regulations adopted pursuant thereto.

36 (f) (1) This section shall not be construed as reducing any  
37 obligation to provide services to an insured under an individualized  
38 family service plan, an individualized program plan, a prevention  
39 program plan, an individualized education program, or an  
40 individualized service plan.

1 (2) This section shall not be construed as limiting benefits that  
2 are otherwise available to an enrollee under a health insurance  
3 policy.

4 (3) This section shall not be construed as affecting litigation  
5 that is pending on January 1, 2012.

6 (g) On and after January 1, 2014, to the extent that this section  
7 requires health benefits to be provided that exceed the essential  
8 health benefits required to be provided under Section 1302(b) of  
9 the federal Patient Protection and Affordable Care Act (Public  
10 Law 111-148), as amended by the federal Health Care and  
11 Education Reconciliation Act of 2010 (Public Law 111-152) by  
12 qualified health plans offering those benefits in the California  
13 Health Benefit Exchange pursuant to Title 22 (commencing with  
14 Section 100500) of the Government Code, the specific benefits  
15 that exceed the federally required essential health benefits are not  
16 required to be provided when offered by a health insurance policy  
17 through the Exchange. However, those specific benefits are  
18 required to be provided if offered by a health insurance policy  
19 outside of the Exchange.

20 (h) As used in this section, the following terms shall have the  
21 following meanings:

22 (1) "Autism spectrum disorder" means a neurobiological  
23 condition that includes autistic disorder, Asperger's disorder, Rett's  
24 disorder, childhood disintegrative disorder, and pervasive  
25 developmental disorder not otherwise specified.

26 (2) "Behavioral health treatment" means professional services  
27 and treatment programs, including behavioral intervention therapy,  
28 applied behavioral analysis, and other intensive behavioral  
29 programs, that have demonstrated efficacy to develop, maintain,  
30 or restore, to the maximum extent practicable, the functioning or  
31 quality of life of an individual and that have been demonstrated  
32 to treat the core symptoms associated with autism spectrum  
33 disorder.

34 (3) "Behavioral intervention therapy" means the design,  
35 implementation, and evaluation of environmental modifications,  
36 using behavioral stimuli and consequences, to produce socially  
37 significant improvement in behaviors, including the use of direct  
38 observation, measurement, and functional analyses of the  
39 relationship between environment and behavior.

1 (4) “Diagnosis of autism spectrum disorders” means medically  
2 necessary assessment, evaluations, or tests to diagnose whether  
3 an individual has one of the autism spectrum disorders.

4 (5) “Evidence-based research” means research that applies  
5 rigorous, systematic, and objective procedures to obtain valid  
6 knowledge relevant to autism spectrum disorders.

7 (6) “Pharmacy care” means medications prescribed by a licensed  
8 physician and surgeon or other appropriately licensed or certified  
9 provider and any health-related services deemed medically  
10 necessary to determine the need or effectiveness of the medications.

11 (7) “Psychiatric care” means direct or consultative psychiatric  
12 services provided by a psychiatrist or any other appropriately  
13 licensed or certified provider.

14 (8) “Psychological care” means direct or consultative  
15 psychological services provided by a psychologist or any other  
16 appropriately licensed or certified provider.

17 (9) “Therapeutic care” means services provided by licensed or  
18 certified speech therapists, occupational therapists, or physical  
19 therapists or any other appropriately licensed or certified provider.

20 (10) “Treatment for autism spectrum disorders” means all of  
21 the following care, including necessary equipment, prescribed or  
22 ordered for an individual diagnosed with one of the autism  
23 spectrum disorders by a licensed physician and surgeon or a  
24 licensed psychologist or any other appropriately licensed or  
25 certified provider who determines the care to be medically  
26 necessary:

27 (A) Behavioral health treatment.

28 (B) Pharmacy care.

29 (C) Psychiatric care.

30 (D) Psychological care.

31 (E) Therapeutic care.

32 (F) Any care for individuals with autism spectrum disorders  
33 that is demonstrated, based upon best practices or evidence-based  
34 research, to be medically necessary.

35 SEC. 3. No reimbursement is required by this act pursuant to  
36 Section 6 of Article XIII B of the California Constitution because  
37 the only costs that may be incurred by a local agency or school  
38 district will be incurred because this act creates a new crime or  
39 infraction, eliminates a crime or infraction, or changes the penalty  
40 for a crime or infraction, within the meaning of Section 17556 of

- 1 the Government Code, or changes the definition of a crime within
- 2 the meaning of Section 6 of Article XIII B of the California
- 3 Constitution.

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## COUNCIL AGENDA ITEM DETAIL SHEET

**BILL NUMBER/ISSUE:** Assembly Bill (AB) 181

**BILL SUMMARY:** This bill seeks to add mental health services as an enumerated (listed) right for children in foster care.

**BACKGROUND:** Currently, children who are removed from their family by a juvenile court are given enumerated (listed) rights by existing law; however, missing from those rights are mental health treatment rights.

**ANALYSIS/DISCUSSION:** When a child is removed from their family, a child can become confused and withdrawn and need mental health services. Although existing law provides rights that include care, placement, investigation and other services, no specific rights are provided with regard to mental health services.

This bill would make it a specific right for foster children to receive necessary mental health services, make a choice regarding therapy and the individual therapist, and to refuse mental health services unless deemed medically necessary by a court.

One major concern is that there is no specific right to refuse psychotropic medication unless the child experiences potentially dangerous side effects or experiences significant drug interactions. Although the bill provides children the right to refuse mental health treatment, it is of significant concern that the right to refuse psychotropic medication is not listed as a right.

**COUNCIL STRATEGIC PLAN OBJECTIVE:** Shape public policy that positively impacts Californians with developmental disabilities and their families.

**PRIOR COUNCIL ACTIVITY:** On February 17, 2011, the LPPC took action to recommend a support if amended position.

**RECOMMENDATION(S):** Support AB 181 if amended to reflect a right to refusal psychotropic medications.

**ATTACHMENT(S):** AB 181

**PREPARED:** Melissa C. Corral, February 24, 2011

**ASSEMBLY BILL**

**No. 181**

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**Introduced by Assembly Member Portantino**  
(Principal coauthor: Senator Steinberg)

January 24, 2011

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An act to amend Section 16164 of, and to add Section 16001.10 to, the Welfare and Institutions Code, relating to foster youth.

LEGISLATIVE COUNSEL'S DIGEST

AB 181, as introduced, Portantino. Foster youth: mental health bill of rights.

Existing law provides that, when a child is removed from his or her family by the juvenile court, placement of the child in foster care should secure, as nearly as possible, the custody, care, and discipline equivalent to that which should have been given the child by his or her parents. Existing law provides enumerated rights for children who are placed in foster care. Existing law establishes the Office of the State Foster Care Ombudsperson to disseminate specified information, including the stated rights of foster youth, and to investigate and attempt to resolve complaints made by or on behalf of children placed in foster care, related to their care, placement, or services.

This bill would enumerate rights for foster youth relating to mental health services. The bill would require the office, in consultation with various entities, to develop, no later than July 1, 2012, standardized information explaining the rights specified and to distribute this information to foster youth.

Vote: majority. Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 16001.10 is added to the Welfare and  
2 Institutions Code, to read:

3 16001.10. (a) It is the policy of the state that all children in  
4 foster care shall have the following rights relating to mental health  
5 services:

- 6 (1) To receive needed mental health services.
- 7 (2) To interview a therapist prior to commencing treatment.
- 8 (3) To discontinue psychotropic medication, as deemed  
9 appropriate by a physician, if the youth experiences potentially  
10 dangerous side effects.
- 11 (4) To be presented with mental health options, including, but  
12 not limited to, holistic or natural approaches, mentoring, peer  
13 counseling, therapy, and medication.
- 14 (5) To continue services with their therapist or counselor when  
15 their residential placement changes for at least one year, or as long  
16 as it is in the best interest of the youth, as determined by a court.
- 17 (6) To be evaluated by a medical professional.
- 18 (7) To have mental health services provided outside of the place  
19 of residence.
- 20 (8) To be provided with information on how to seek mental  
21 health services in their county of residence.
- 22 (9) To gain access to personal mental health records.
- 23 (10) Consistent with other state laws, to be guaranteed the  
24 protection of confidentiality when interacting with mental health  
25 professionals, unless the youth is deemed at risk of harming himself  
26 or herself or others.
- 27 (11) To be given age-appropriate information on drug  
28 interactions if prescribed more than one psychotropic medication.
- 29 (12) To receive timely mental health services in the county of  
30 residence and not to be denied services because of the county of  
31 origin.
- 32 (13) To refuse mental health treatment at any time unless  
33 deemed medically necessary by the court.

34 (b) The Office of the State Foster Care Ombudsperson, in  
35 consultation with the State Department of Mental Health, the  
36 Department of Public Health, the State Department of Health Care  
37 Services, foster youth advocacy and support groups, and groups  
38 representing children, families, foster parents, and children's

1 facilities, and other interested parties, shall develop, no later than  
2 July 1, 2012, standardized information explaining the rights  
3 specified in this section. The information shall be presented in an  
4 age-appropriate manner and shall reflect any relevant licensing  
5 requirements and medical information laws.

6 SEC. 2. Section 16164 of the Welfare and Institutions Code is  
7 amended to read:

8 16164. (a) The Office of the State Foster Care Ombudsperson  
9 shall do all of the following:

10 (1) Disseminate information on the rights of children and youth  
11 in foster care and the services provided by the office. The rights  
12 of children and youths in foster care are listed in ~~Section~~ *Sections*  
13 *16001.9 and 16001.10*. The information shall include notification  
14 that conversations with the office may not be confidential.

15 (2) Investigate and attempt to resolve complaints made by or  
16 on behalf of children placed in foster care, related to their care,  
17 placement, or services.

18 (3) Decide, in its discretion, whether to investigate a complaint,  
19 or refer complaints to another agency for investigation.

20 (4) Upon rendering a decision to investigate a complaint from  
21 a complainant, notify the complainant of the intention to  
22 investigate. If the office declines to investigate a complaint or  
23 continue an investigation, the office shall notify the complainant  
24 of the reason for the action of the office.

25 (5) Update the complainant on the progress of the investigation  
26 and notify the complainant of the final outcome.

27 (6) Document the number, source, origin, location, and nature  
28 of complaints.

29 (7) (A) Compile and make available to the Legislature all data  
30 collected over the course of the year including, but not limited to,  
31 the number of contacts to the toll-free telephone number, the  
32 number of complaints made, including the type and source of those  
33 complaints, the number of investigations performed by the office,  
34 the trends and issues that arose in the course of investigating  
35 complaints, the number of referrals made, and the number of  
36 pending complaints.

37 (B) Present this compiled data, on an annual basis, at appropriate  
38 child welfare conferences, forums, and other events, as determined  
39 by the department, that may include presentations to, but are not  
40 limited to, representatives of the Legislature, the County Welfare

1 Directors Association, child welfare organizations, children's  
2 advocacy groups, consumer and service provider organizations,  
3 and other interested parties.

4 (C) It is the intent of the Legislature that representatives of the  
5 organizations described in subparagraph (B) consider this data in  
6 the development of any recommendations offered toward  
7 improving the child welfare system.

8 (D) The compiled data shall be posted so that it is available to  
9 the public on the existing *Internet* Web site of the State Foster  
10 Care Ombudsperson.

11 (8) Have access to any record of a state or local agency that is  
12 necessary to carry out his or her responsibilities,—and.  
13 *Representatives of the office* may meet or communicate with any  
14 foster child in his or her placement or elsewhere.

15 (b) The office may establish, in consultation with a committee  
16 of interested individuals, regional or local foster care ombudsperson  
17 offices for the purposes of expediting investigations and resolving  
18 complaints, subject to appropriations in the annual Budget Act.

19 (c) (1) The office, in consultation with the California Welfare  
20 Directors Association, Chief Probation Officers of California,  
21 foster youth advocate and support groups, groups representing  
22 children, families, foster parents, children's facilities, and other  
23 interested parties, shall develop, no later than July 1, 2002,  
24 standardized information explaining the rights specified in Section  
25 16001.9. The information shall be developed in an age-appropriate  
26 manner, and shall reflect any relevant licensing requirements with  
27 respect to foster care providers' responsibilities to adequately  
28 supervise children in care.

29 (2) The office, counties, foster care providers, and others may  
30 use the information developed in paragraph (1) in carrying out  
31 their responsibilities to inform foster children and youth of their  
32 rights pursuant to Section 1530.91 of the Health and Safety Code,  
33 Sections 27 and 16501.1, and this section.

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## COUNCIL AGENDA ITEM DETAIL SHEET

**Bill NUMBER/ISSUE:** Assembly Bill (AB) 39 (Beall), special education: funding

**BILL SUMMARY:** This bill appropriates \$57 million from the Mental Health Services Fund (which was established under Proposition 63) to give to the county mental health departments to pay for the provision of special education services. Proposition 63 requires that all funds in the Mental Health Services Fund are continuously appropriated – and this has not always occurred.

Additionally, this bill also creates a work group composed of county mental health directors and the Superintendent of Public Instruction to develop a transitional program to transfer responsibilities from the county mental health departments to the Department of Education in the provision of special education services pertaining to mental health.

**BACKGROUND:** Assembly Bill 3632, passed in 1984, created the procedures and funding structure to ensure that students in special education who need mental health services would receive them; however, the previous administration defunded this program – contrary to the Proposition 63 requirement – in its entirety (\$133 million) thus eliminating it. Litigation is in process at the time of this writing.

The California Alliance of Child and Family Services are sponsoring this bill to ensure adequate funding of mental health services for students receiving special education services.

**ANALYSIS/DISCUSSION:** Many families and students have had difficulty or have been unable to obtain AB 3632 services. Moreover, it has been reported that many school districts have refused to implement AB 3632 services without adequate funding.

Although the AB 3632 program was defunded, it:

- did not release the Proposition 63 requirement to continuously fund programs; and,
- did not release the school districts of their obligation to provide students in special education with a free appropriate public education (FAPE) to meet their unique needs and prepare them for further education, independent living, and employment.

Without adequate funding in place, the educational system has substantial and legitimate difficulties in meeting its special education obligations and the required appropriations to the Mental Health Services Fund are not being met.

**COUNCIL STRATEGIC PLAN OBJECTIVE:** Shape public policy that positively impacts Californians with developmental disabilities and their families.

**PRIOR COUNCIL ACTIVITY:** On February 17, 2011, the Legislative and Public Policy Committee (LPPC) took action to recommend that the Council support AB 39. The bill has not been amended since the LPPC's review at the time of this writing.

**RECOMMENDATION(S):** Support AB 39.

**ATTACHMENT(S):** AB 39

**PREPARED:** Christofer Arroyo, February 24, 2011

**ASSEMBLY BILL**

**No. 39**

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**Introduced by Assembly Member Beall**

December 6, 2010

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An act relating to special education, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 39, as introduced, Beall. Special education: funding.

Existing law, the Mental Health Services Act, an initiative measure enacted by the voters as Proposition 63, establishes the Mental Health Services Fund to fund specified county mental health programs. The act provides that all moneys in the Mental Health Services Fund are continuously appropriated to the State Department of Mental Health. The act may be amended only by a  $\frac{2}{3}$  vote of both houses of the Legislature and only so long as the amendment is consistent with and furthers the intent of the act.

This bill would require the department to allocate \$57,000,000 of those moneys to county mental health departments for purposes of providing special education services, thereby making an appropriation. The bill also would require the Superintendent of Public Instruction and county mental health directors to jointly convene a technical working group to develop a transitional program to transfer the responsibilities associated with providing special education services from county mental health departments to the State Department of Education.

This bill would declare that it furthers the purposes of the Mental Health Services Act.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: yes. Fiscal committee: yes.  
State-mandated local program: no.

*The people of the State of California do enact as follows:*

1 SECTION 1. (a) From the moneys continuously appropriated  
2 from the Mental Health Services Fund pursuant to Section 5890  
3 of the Welfare and Institutions Code, the State Department of  
4 Mental Health shall allocate the sum of fifty-seven million dollars  
5 (\$57,000,000) to county mental health departments for purposes  
6 of providing special education services.

7 (b) The Superintendent of Public Instruction and county mental  
8 health directors shall jointly convene a technical working group  
9 to develop a transitional program to transfer the responsibilities  
10 associated with providing special education services from county  
11 mental health departments to the State Department of Education.

12 SEC. 2. The Legislature finds and declares that this act further  
13 the purposes of the Mental Health Services Act.

14 SEC. 3. This act is an urgency statute necessary for the  
15 immediate preservation of the public peace, health, or safety within  
16 the meaning of Article IV of the Constitution and shall go into  
17 immediate effect. The facts constituting the necessity are:

18 In order for pupils to continue to receive all of the special  
19 education services they need at the earliest possible time, it is  
20 necessary for this act to take effect immediately.



## COUNCIL AGENDA ITEM DETAIL SHEET

**BILL NUMBER/ISSUE:** Senate Bill (SB) 121 (Liu), special education: incarcerated minors

**BILL SUMMARY:** This bill declares that it is the intent of the Legislature to improve special education services for incarcerated minors.

**BACKGROUND:** Senator Liu is the sponsor of SB 121, which is a spot bill. A spot bill is a bill that acts as a placeholder to be amended into a more substantial bill after the deadline to introduce bills has passed.

On 1/31/11, the Senator's staff confirmed that this bill is a placeholder for SB 1059 (Liu), which was vetoed last session. SB 1059 (Liu) eliminated an ambiguity of the law regarding students with disabilities who are in special education, are detained in juvenile hall, and are "parentless". Special education due process cases regarding this matter have been heard by the Office of Administrative Hearings (OAH). The decisions that have been issued vary widely – some have assigned responsibility to school districts, others to COE, and still others to the California Department of Education (CDE). SB 1059 made it very clear which local educational agency (LEA) is responsible for providing a free appropriate public education (FAPE) to the student.

Because of ambiguities in the law and the need to go to due process to resolve which LEA is responsible for providing a FAPE, proponents of SB 1059 argued that this has resulted in students being detained in juvenile hall for extended periods of time. If indeed students are being detained in juvenile hall unnecessarily as a result of ambiguity in the law, SB 1059 would have provided clarity to resolve this concern. Additionally, the Assembly Committee on Education's staff analysis indicated that the ongoing due process hearings and litigation result in added costs to LEAs and potentially increased costs of incarceration time for students with disabilities. It is for these reasons that the Council supported SB 1059 (Liu). The governor vetoed SB 1059 because of pending litigation...which continues at the time of this writing.

**ANALYSIS/DISCUSSION:** None at this time.

**COUNCIL STRATEGIC PLAN OBJECTIVE:** Shape public policy that positively impacts Californians with developmental disabilities and their families.

**PRIOR COUNCIL ACTIVITY:** The Council supported SB 1059. On February 17, 2011, the Legislative and Public Policy Committee (LPPC) took action to recommend that Council watch SB 121. The bill has not been amended since the LPPC's review at the time of this writing.

**RECOMMENDATION(S):** Watch SB 121 and if amended into a bill that is the same as the former SB 1059, support the bill.

**ATTACHMENT(S):** SB 121 and SB 1059 and veto message (prior session)

**PREPARED:** Christofer Arroyo, February 24, 2011

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Introduced by Senator Liu

January 24, 2011

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An act to add Section 56049 to the Education Code, relating to special education.

LEGISLATIVE COUNSEL'S DIGEST

SB 121, as introduced, Liu. Special education: incarcerated minors. Existing law requires every individual with exceptional needs who is eligible to receive special education instruction and related services, as specified, to receive that instruction and those services at no cost to his or her parents or, as appropriate, to him or her.

This bill would state the intent of the Legislature to improve special education services for incarcerated minors.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. Section 56049 is added to the Education Code,
- 2 to read:
- 3 56049. It is the intent of the Legislature to improve special
- 4 education services for incarcerated minors.

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BILL NUMBER: SB 1059  
VETOED DATE: 09/30/2010

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To the Members of the California State Senate:

I am returning Senate Bill 1059 without my signature.

I have always been committed to ensuring that every child receives a free and appropriate public education, including students with special needs through the implementation of an Individualized Education Plan. This bill attempts to provide additional clarification on which local educational agency is responsible for foster care pupils with special needs who have been detained in a juvenile hall. While I appreciate the intent to address this complex issue, in light of pending litigation regarding this issue, it is premature to enact these statutory changes.

For this reason, I am unable to sign this bill.

Sincerely,

Arnold Schwarzenegger

**Senate Bill No. 1059**

\_\_\_\_\_

Passed the Senate August 19, 2010

\_\_\_\_\_  
*Secretary of the Senate*

\_\_\_\_\_

Passed the Assembly August 16, 2010

\_\_\_\_\_  
*Chief Clerk of the Assembly*

\_\_\_\_\_

This bill was received by the Governor this \_\_\_\_\_ day  
of \_\_\_\_\_, 2010, at \_\_\_\_\_ o'clock \_\_\_\_M.

\_\_\_\_\_  
*Private Secretary of the Governor*

## CHAPTER \_\_\_\_\_

An act to amend Sections 48204, 48645.2, and 56028 of the Education Code, relating to local educational agencies.

## LEGISLATIVE COUNSEL'S DIGEST

SB 1059, Liu. Local educational agencies: districts of residence.

(1) Existing law provides for residency requirements for school attendance, including the requirement that a pupil placed within the boundaries of that school district in a regularly licensed children's institution, a licensed foster home, or a family home pursuant to a placement under a designated statute, is deemed to comply with residency requirements for that district.

This bill would provide that a school district into which a pupil is placed in a regularly licensed children's institution, a licensed foster home, or a family home pursuant to a placement under a designated statute is the district of residence. The bill would further require that this school district of residence would be responsible for providing the pupil with a free appropriate public education, as defined. Because this provision would impose new requirements on school districts, it would constitute a state-mandated local program.

(2) Existing law requires a minor under the jurisdiction of the juvenile court as a consequence of delinquent conduct, in conformity with the interests of public safety and protection, to receive care, treatment, and guidance that is consistent with his or her best interest, that holds the minor accountable for his or her behavior, and that is appropriate for his or her circumstances.

Existing law provides for the establishment of public schools in juvenile halls, juvenile homes, day centers, juvenile ranches, juvenile camps, regional youth educational facilities, or Orange County youth correctional centers, as specified, to provide juvenile court school pupils with quality education and training. Existing law requires a county board of education to provide for the administration and operation of juvenile court schools in the county, either by the county superintendent of schools, as specified, or by contract with the respective governing boards of the

elementary, high school, or unified school district in which the juvenile court school is located.

This bill would require that the county board of education is responsible for providing pupils detained in juvenile halls who are individuals with exceptional needs with a free appropriate public education, as defined. However, if the expanded individualized education program team determines that placement is appropriate, the bill would require the provider of educational services to determine the school district responsible for paying and providing for education placement, pursuant to criteria specified by the bill. Because this provision would impose new requirements on local educational agencies, it would constitute a state-mandated local program.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

*The people of the State of California do enact as follows:*

SECTION 1. Section 48204 of the Education Code, as amended by Section 1 of Chapter 33 of the Statutes of 2007, is amended to read:

48204. (a) Notwithstanding Section 48200, a pupil complies with the residency requirements for school attendance in a school district, if he or she is any of the following:

(1) (A) (i) A pupil placed within the boundaries of that school district in a regularly established licensed children's institution, or a licensed foster home, or a family home pursuant to a commitment or placement under Chapter 2 (commencing with Section 200) of Part 1 of Division 2 of the Welfare and Institutions Code.

(ii) Notwithstanding Sections 48200 and 56028, for any pupil placed pursuant to clause (i), the school district in which the pupil resides is the district of residence, and it is that school district that is responsible for providing the pupil with a free appropriate public

education within the meaning of Section 1412 of Title 20 of the United States Code and Sections 104.33 and 300.104 of Title 34 of the Code of Federal Regulations, as these provisions exist on January 1, 2010, pursuant to residential placement as specified in Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code and Section 60200 of Title 2 of the California Code of Regulations, as it exists on January 1, 2010.

(B) An agency placing a pupil in a home or institution described in subparagraph (A) shall provide evidence to the school that the placement or commitment is pursuant to law.

(2) A pupil for whom interdistrict attendance has been approved pursuant to Chapter 5 (commencing with Section 46600) of Part 26.

(3) A pupil whose residence is located within the boundaries of that school district and whose parent or legal guardian is relieved of responsibility, control, and authority through emancipation.

(4) A pupil who lives in the home of a caregiving adult that is located within the boundaries of that school district. Execution of an affidavit under penalty of perjury pursuant to Part 1.5 (commencing with Section 6550) of Division 11 of the Family Code by the caregiving adult is a sufficient basis for a determination that the pupil lives in the home of the caregiver, unless the school district determines from actual facts that the pupil is not living in the home of the caregiver.

(5) A pupil residing in a state hospital located within the boundaries of that school district.

(b) A school district may deem a pupil to have complied with the residency requirements for school attendance in the district if at least one parent or the legal guardian of the pupil is physically employed within the boundaries of that district.

(1) This subdivision does not require the school district within which at least one parent or the legal guardian of a pupil is employed to admit the pupil to its schools. A school district shall not, however, refuse to admit a pupil under this subdivision on the basis, except as expressly provided in this subdivision, of race, ethnicity, sex, parental income, scholastic achievement, or any other arbitrary consideration.

(2) The school district in which the residency of either the parents or the legal guardian of the pupil is established, or the school district to which the pupil is to be transferred under this

subdivision, may prohibit the transfer of the pupil under this subdivision if the governing board of the district determines that the transfer would negatively impact the court-ordered or voluntary desegregation plan of the district.

(3) The school district to which the pupil is to be transferred under this subdivision may prohibit the transfer of the pupil if the district determines that the additional cost of educating the pupil would exceed the amount of additional state aid received as a result of the transfer.

(4) The governing board of a school district that prohibits the transfer of a pupil pursuant to paragraph (1), (2), or (3) is encouraged to identify, and communicate in writing to the parents or the legal guardian of the pupil, the specific reasons for that determination and is encouraged to ensure that the determination, and the specific reasons therefor, are accurately recorded in the minutes of the board meeting in which the determination was made.

(5) The average daily attendance for pupils admitted pursuant to this subdivision is calculated pursuant to Section 46607.

(6) Unless approved by the sending school district, this subdivision does not authorize a net transfer of pupils out of a school district, calculated as the difference between the number of pupils exiting the district and the number of pupils entering the district, in a fiscal year in excess of the following amounts:

(A) For a school district with an average daily attendance for that fiscal year of less than 501, 5 percent of the average daily attendance of the district.

(B) For a school district with an average daily attendance for that fiscal year of 501 or more, but less than 2,501, 3 percent of the average daily attendance of the district or 25 pupils, whichever amount is greater.

(C) For a school district with an average daily attendance of 2,501 or more, 1 percent of the average daily attendance of the district or 75 pupils, whichever amount is greater.

(7) Once a pupil is deemed to have complied with the residency requirements for school attendance pursuant to this subdivision and is enrolled in a school in a school district the boundaries of which include the location where at least one parent or the legal guardian of a pupil is physically employed, the pupil does not have to reapply in the next school year to attend a school within that district and the district governing board shall allow the pupil to

attend school through grade 12 in that district if the parent or legal guardian so chooses and if at least one parent or the legal guardian of the pupil continues to be physically employed by an employer situated within the attendance boundaries of the district, subject to paragraphs (1) to (6), inclusive.

(c) This section shall become inoperative on July 1, 2012, and as of January 1, 2013, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2013, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 2. Section 48204 of the Education Code, as amended by Section 2 of Chapter 33 of the Statutes of 2007, is amended to read:

48204. Notwithstanding Section 48200, a pupil complies with the residency requirements for school attendance in a school district, if he or she is:

(a) (1) (A) A pupil placed within the boundaries of that school district in a regularly established licensed children's institution, or a licensed foster home, or a family home pursuant to a commitment or placement under Chapter 2 (commencing with Section 200) of Part 1 of Division 2 of the Welfare and Institutions Code.

(B) Notwithstanding Section 56028, for any pupil placed pursuant to subparagraph (A), the school district in which the pupil resides is the district of residence, and it is that school district that is responsible for providing the pupil with a free appropriate public education within the meaning of Section 1412 of Title 20 of the United States Code and Sections 104.33 and 300.104 of Title 34 of the Code of Federal Regulations, as these provisions exist on January 1, 2010, pursuant to residential placement as specified in Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code and Section 60200 of Title 2 of the California Code of Regulations, as it exists on January 1, 2010.

(2) An agency placing a pupil in the home or institution described in paragraph (1) shall provide evidence to the school that the placement or commitment is pursuant to law.

(b) A pupil for whom interdistrict attendance has been approved pursuant to Chapter 5 (commencing with Section 46600) of Part 26.

(c) A pupil whose residence is located within the boundaries of that school district and whose parent or legal guardian is relieved of responsibility, control, and authority through emancipation.

(d) A pupil who lives in the home of a caregiving adult that is located within the boundaries of that school district. Execution of an affidavit under penalty of perjury pursuant to Part 1.5 (commencing with Section 6550) of Division 11 of the Family Code by the caregiving adult is a sufficient basis for a determination that the pupil lives in the home of the caregiver, unless the school district determines from actual facts that the pupil is not living in the home of the caregiver.

(e) A pupil residing in a state hospital located within the boundaries of that school district.

(f) This section shall become operative on July 1, 2012.

SEC. 3. Section 48645.2 of the Education Code is amended to read:

48645.2. The county board of education shall provide for the administration and operation of juvenile court schools established pursuant to Section 48645.1:

(a) By the county superintendent of schools, provided that, in any county in which the board of supervisors is establishing or maintaining juvenile court schools on January 1, 1978, the county superintendent of schools may contract with the board of supervisors for the administration and operation of such schools if agreed upon between the board of education and the board of supervisors. In any event, the county superintendent of schools may contract with other educational agencies for supporting services to the same extent that school districts may contract with other such agencies.

(b) By contract with the respective governing boards of the elementary, high school, or unified school district in which the juvenile court school is located.

(c) This subdivision shall apply solely to pupils detained in juvenile halls pursuant to Article 23 (commencing with Section 850) of Chapter 2 of Part 1 of Division 2 of the Welfare and Institutions Code.

(1) For a pupil in a juvenile hall established pursuant to Section 48645.1, the county board of education is responsible for the provision of a free appropriate public education for individuals with exceptional needs. However, if the expanded individualized

education program (IEP) team determines, pursuant to Sections 7572.5 and 7573 of the Government Code and Sections 104.33 and 300.104 of Title 34 of the Code of Federal Regulations, as those sections exist on January 1, 2010, that residential placement is appropriate, all of the following apply with respect to which school district is responsible for paying and providing for the education placement:

(A) For a pupil who has a parent, as described in paragraph (1) or (4) of subdivision (a) of Section 56028, or who has a legal guardian, the school district where the parent or the legal guardian resides shall be the responsible school district.

(B) For a pupil who has a parent, as described in paragraph (2) or (5) of subdivision (a) of Section 56028, or for a pupil who has a responsible adult appointed in accordance with Section 361 of the Welfare and Institutions Code, the school district where the pupil will be placed for the residential placement shall be the responsible school district, unless the residential placement is out of state, in which case the school district where the child was last enrolled prior to placement in a juvenile hall shall be the responsible school district.

(2) The county office of education shall determine the responsible school district, as described in paragraph (1), and timely notify the responsible school district of its responsibility under this section.

(3) If a pupil is placed at a residential placement as described in this subdivision, the responsible school district, as determined pursuant to paragraph (2), shall remain the district of residence for that pupil throughout the duration of the residential placement, including, as necessary, after disposition of the pupil's juvenile delinquency case.

(4) If a determination is made by a properly constituted individualized education program team that a less restrictive environment is appropriate for the pupil, the responsible school district, as determined pursuant to paragraph (2), shall transition the pupil into a subsequent education placement, including by creating a transition plan as described in paragraph (4) of subdivision (b) of Section 56345. This subsequent education placement may be a public or nonpublic school certified by the State Department of Education.

(5) If a dispute arises regarding responsibility for education placement or services, the responsible school district, as determined by the county office of education where the juvenile hall is located pursuant to paragraph (2), shall implement the individualized education program, including, but not necessarily limited to, paying and providing for the education placement and any other related service, benefit, or aid within the meaning of Sections 7572.5 and 7573 of the Government Code and Sections 104.33 and 300.104 of Title 34 of the Code of Federal Regulations, as those sections exist on January 1, 2010, during the duration of the dispute. A school district impacted by the decision made pursuant to paragraph (2) may appeal to the county board of education where the juvenile hall is located, which shall issue a written decision within 60 days, and that decision shall be final.

(6) The responsible school district, as described in paragraph (2), shall immediately assume responsibility for the educational costs. If the responsible school district fails or refuses to assume the educational costs, the county superintendent of schools may draw a requisition against the funds of the responsible school district in favor of the provider of educational services.

SEC. 4. Section 56028 of the Education Code is amended to read:

56028. (a) "Parent" means any of the following:

(1) A biological or adoptive parent of a child.

(2) A foster parent if the authority of the biological or adoptive parents to make educational decisions on the child's behalf specifically has been limited by court order in accordance with Section 300.30(b)(1) or (2) of Title 34 of the Code of Federal Regulations.

(3) A guardian generally authorized to act as the child's parent, or authorized to make educational decisions for the child, including a responsible adult appointed for the child in accordance with Sections 361 and 726 of the Welfare and Institutions Code.

(4) An individual acting in the place of a biological or adoptive parent, including a grandparent, stepparent, or other relative, with whom the child lives, or an individual who is legally responsible for the child's welfare.

(5) A surrogate parent who has been appointed pursuant to Section 7579.5 or 7579.6 of the Government Code, and in accordance with Section 300.519 of Title 34 of the Code of Federal

Regulations and Section 1439(a)(5) of Title 20 of the United States Code.

(b) (1) Except as provided in paragraph (2), the biological or adoptive parent, when attempting to act as the parent under this part and when more than one party is qualified under subdivision (a) to act as a parent, shall be presumed to be the parent for purposes of this section unless the biological or adoptive parent does not have legal authority to make educational decisions for the child.

(2) If a judicial decree or order identifies a specific person or persons under paragraphs (1) to (4), inclusive, of subdivision (a) to act as the “parent” of a child or to make educational decisions on behalf of a child, then that person or persons shall be determined to be the “parent” for purposes of this part, Article 1 (commencing with Section 48200) of Chapter 2 of Part 27, and Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code, and Sections 361 and 726 of the Welfare and Institutions Code.

(c) “Parent” does not include the state or any political subdivision of government.

(d) “Parent” does not include a nonpublic, nonsectarian school or agency under contract with a local educational agency for the provision of special education or designated instruction and services for a child.

(e) For a pupil placed pursuant to subparagraph (A) of paragraph (1) of subdivision (a) of Section 48204, the school district of residence is the school district wherein the pupil resides. The residence of the person or persons listed in paragraph (5) of subdivision (a), or paragraph (2) of subdivision (b), of this section does not determine the school district of residence.

SEC. 5. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.



## COUNCIL AGENDA ITEM DETAIL SHEET

**BILL NUMBER/ISSUE:** Assembly Bill (AB) 170

**BILL SUMMARY:** This bill seeks to enact legislation that would divide Inland Regional Center, which serves Riverside and San Bernardino counties, into two separate regional centers that independently serve their communities.

**BACKGROUND:** This bill does not include information regarding the reason for the split; however, it is most likely due to the recent investigation and surrounding issues of Inland Regional Center.

**ANALYSIS/DISCUSSION:** Currently, there is one regional center, Inland that serves the San Bernardino and Riverside areas and about 21,200 individuals in a 28,000 mile area. By comparison, Lanterman Regional Center serves approximately 7,000 individuals and Alta Regional Center serves approximately 17,000 individuals.

It is assumed that by dividing the regional center, more oversight and accountability can be provided to two smaller offices; however, this may not be the case. There has been no information provided regarding increased oversight. Also, the division may create significant increased overhead costs.

A more appropriate approach may be for a review of the entire regional center system in the southern California to determine how best to meet the needs of each community. In addition, emphasis should be directed on oversight and accountability without increasing overhead costs.

**COUNCIL STRATEGIC PLAN OBJECTIVE:** Shape public policy that positively impacts Californians with developmental disabilities and their families.

**PRIOR COUNCIL ACTIVITY:** On February 17, 2011, the LPPC took action to recommend that the Council watch this bill. While the Committee did not suggest dividing IRC into two regional centers; based on the very limited information provided in the bill, a watch position was recommended.

**RECOMMENDATION(S):** Watch AB 170

**ATTACHMENT(S):** AB 170

**PREPARED:** Melissa C. Corral, February 24, 2011

**ASSEMBLY BILL**

**No. 170**

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**Introduced by Assembly Member Jeffries**

January 20, 2011

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An act relating to developmental services.

LEGISLATIVE COUNSEL'S DIGEST

AB 170, as introduced, Jeffries. Developmental services: regional centers: Inland Regional Center.

Under existing law, the Lanterman Developmental Disabilities Services Act, the State Department of Developmental Services is authorized to contract with regional centers to provide support and services to individuals with developmental disabilities.

This bill would state the intent of the Legislature to enact legislation that would divide the Inland Regional Center, which serves Riverside and San Bernardino counties, into 2 separate regional centers that independently serve their respective communities.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. It is the intent of the Legislature to enact
- 2 legislation that does all of the following:
- 3 (a) Rectifies the level of accountability and the quality of
- 4 services provided to consumers of the regional center in Riverside
- 5 and San Bernardino counties.

- 1 (b) Increases local involvement and ensures that consumers at
- 2 the regional center in Riverside and San Bernardino counties are
- 3 given the individual attention and service they deserve.
- 4 (c) Divides the Inland Regional Center, which serves the
- 5 Riverside and San Bernardino counties, into two separate regional
- 6 centers that independently serve their respective communities in
- 7 order to address the concerns in subdivisions (a) and (b).

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## COUNCIL AGENDA ITEM DETAIL SHEET

**BILL NUMBER/ISSUE:** Assembly Bill (AB) 154 (introduced last session as AB 1600)

**BILL SUMMARY:** This bill seeks to expand health care coverage to include the diagnosis and treatment of a mental illness of a person of any age and would define mental illness for this purpose.

**BACKGROUND:** During the last legislative session, Assemblymember Beall introduced a similar bill which was not passed; however, the Legislative and Public Policy Committee reviewed the bill thoroughly and although supported, the former bill created a "two-tier system" that was criticized. AB 154 includes the same provisions.

**ANALYSIS/DISCUSSION:** Currently, most health plans operate by allowing the consumer to select a primary care physician who coordinates the consumer's medical care; however, consumers must contact the health plan directly to receive prior authorization to obtain mental health services. This is especially problematic for people with disabilities or people who are aging because it makes access to services more difficult.

AB 154 seeks to make the process much simpler; this bill would mandate that mental health services are treated the same way as physical health services. This process would make it much easier for individuals to receive the mental health care services they need and also coordinated by their primary care physician.

The issue that remains in the bill is the "two tier system." The bill specifically leaves out people who are covered by the Public Employees Retirement System (State workers among them.) In addition, Medicare supplement plans are also excluded which may be a concern. Although most individuals on Medicare purchase a Health Maintenance Organization (HMO) or gap plan, others purchase supplemental plans since they offer better coverage, but those individuals would not be covered by this bill.

**COUNCIL STRATEGIC PLAN OBJECTIVE:** Shape public policy that positively impacts Californians with developmental disabilities and their families. (H.E. 1.1)

**PRIOR COUNCIL ACTIVITY:** The Council sent a letter regarding AB 1600 which supported the bill and encouraged amendments. On February 17, 2011, the LPPC took action to recommend that the Council support this bill with amendments. Specifically, the recommendation is to eliminate the two-tier system.

**RECOMMENDATION(S):** Support AB 154 with amendments to eliminate the two-tiered system established in the bill.

**ATTACHMENT(S):** AB 154

**PREPARED:** Melissa C. Corral, February 24, 2011

**ASSEMBLY BILL**

**No. 154**

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**Introduced by Assembly Member Beall**

January 18, 2011

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An act to add Section 22856 to the Government Code, to add Section 1374.74 to the Health and Safety Code, and to add Section 10144.8 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 154, as introduced, Beall. Health care coverage: mental health services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health care service plan contract and a health insurance policy are required to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age. Existing law does not define "severe mental illnesses" for this purpose but describes it as including several conditions.

This bill would expand this coverage requirement for certain health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2012, to include the diagnosis and treatment of a mental illness of a person of any age and would define mental illness for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual of Mental Disorders IV, including substance abuse but excluding nicotine dependence and specified diagnoses defined in the manual, subject to regulatory revision,

as specified. The bill would specify that this requirement does not apply to a health care benefit plan, contract, or health insurance policy with the Board of Administration of the Public Employees' Retirement System unless the board elects to purchase a plan, contract, or policy that provides mental health coverage.

Because this bill would expand coverage requirements for health care service plans, the willful violation of which would be a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

1 SECTION 1. Section 22856 is added to the Government Code,  
2 to read:

3 22856. The board may purchase a health care benefit plan or  
4 contract or a health insurance policy that includes mental health  
5 coverage as described in Section 1374.74 of the Health and Safety  
6 Code or Section 10144.8 of the Insurance Code.

7 SEC. 2. Section 1374.74 is added to the Health and Safety  
8 Code, to read:

9 1374.74. (a) A health care service plan contract issued,  
10 amended, or renewed on or after January 1, 2012, that provides  
11 hospital, medical, or surgical coverage shall provide coverage for  
12 the diagnosis and medically necessary treatment of a mental illness  
13 of a person of any age, including a child, under the same terms  
14 and conditions applied to other medical conditions as specified in  
15 subdivision (c) of Section 1374.72. The benefits provided under  
16 this section shall include all those set forth in subdivision (b) of  
17 Section 1374.72.

18 (b) (1) "Mental illness" for the purposes of this section means  
19 a mental disorder defined in the Diagnostic and Statistical Manual  
20 of Mental Disorders IV, published by the American Psychiatric  
21 Association, and includes substance abuse, but excludes treatment  
22 of the following diagnoses, all as defined in the manual:

- 1 (A) Noncompliance With Treatment (V15.81).
- 2 (B) Partner Relational Problem (V61.1).
- 3 (C) Physical/Sexual Abuse of an Adult (V61.12).
- 4 (D) Parent-Child Relational Problem (V61.20).
- 5 (E) Child Neglect (V61.21).
- 6 (F) Physical/Sexual Abuse of a Child (V61.21).
- 7 (G) Sibling Relational Problem (V61.8).
- 8 (H) Relational Problem Related to a Mental Disorder or General
- 9 Medical Condition (V61.9).
- 10 (I) Occupational Problem (V62.29).
- 11 (J) Academic Problem (V62.3).
- 12 (K) Acculturation Problem (V62.4).
- 13 (L) Relational Problems (V62.81).
- 14 (M) Bereavement (V62.82).
- 15 (N) Physical/Sexual Abuse of an Adult (V62.83).
- 16 (O) Borderline Intellectual Functioning (V62.89).
- 17 (P) Phase of Life Problem (V62.89).
- 18 (Q) Religious or Spiritual Problem (V62.89).
- 19 (R) Malingering (V65.2).
- 20 (S) Adult Antisocial Behavior (V71.01).
- 21 (T) Child or Adolescent Antisocial Behavior (V71.02).
- 22 (U) There is not a Diagnosis or a Condition on Axis I (V71.09).
- 23 (V) There is not a Diagnosis on Axis II (V71.09).
- 24 (W) Nicotine Dependence (305.10).

25 (2) Following publication of each subsequent volume of the  
26 manual, the definition of “mental illness” shall be subject to  
27 revision to conform to, in whole or in part, the list of mental  
28 disorders defined in the then-current volume of the manual.

29 (3) Any revision to the definition of “mental illness” pursuant  
30 to paragraph (2) shall be established by regulation promulgated  
31 jointly by the department and the Department of Insurance.

32 (c) (1) For the purpose of compliance with this section, a plan  
33 may provide coverage for all or part of the mental health services  
34 required by this section through a separate specialized health care  
35 service plan or mental health plan and shall not be required to  
36 obtain an additional or specialized license for this purpose.

37 (2) A plan shall provide the mental health coverage required by  
38 this section in its entire service area and in emergency situations  
39 as may be required by applicable laws and regulations. For  
40 purposes of this section, health care service plan contracts that

1 provide benefits to enrollees through preferred provider contracting  
2 arrangements are not precluded from requiring enrollees who reside  
3 or work in geographic areas served by specialized health care  
4 service plans or mental health plans to secure all or part of their  
5 mental health services within those geographic areas served by  
6 specialized health care service plans or mental health plans.

7 (3) In the provision of benefits required by this section, a health  
8 care service plan may utilize case management, network providers,  
9 utilization review techniques, prior authorization, copayments, or  
10 other cost sharing to the extent permitted by law or regulation.

11 (d) Nothing in this section shall be construed to deny or restrict  
12 in any way the department's authority to ensure plan compliance  
13 with this chapter when a plan provides coverage for prescription  
14 drugs.

15 (e) This section shall not apply to contracts entered into pursuant  
16 to Chapter 7 (commencing with Section 14000) or Chapter 8  
17 (commencing with Section 14200) of Part 3 of Division 9 of the  
18 Welfare and Institutions Code, between the State Department of  
19 Health Care Services and a health care service plan for enrolled  
20 Medi-Cal beneficiaries.

21 (f) This section shall not apply to a health care benefit plan or  
22 contract entered into with the Board of Administration of the Public  
23 Employees' Retirement System pursuant to the Public Employees'  
24 Medical and Hospital Care Act (Part 5 (commencing with Section  
25 22750) of Division 5 of Title 2 of the Government Code) unless  
26 the board elects, pursuant to Section 22856 of the Government  
27 Code, to purchase a health care benefit plan or contract that  
28 provides mental health coverage as described in this section.

29 (g) This section shall not apply to accident-only, specified  
30 disease, hospital indemnity, Medicare supplement, dental-only, or  
31 vision-only health care service plan contracts.

32 SEC. 3. Section 10144.8 is added to the Insurance Code, to  
33 read:

34 10144.8. (a) A policy of health insurance that covers hospital,  
35 medical, or surgical expenses in this state that is issued, amended,  
36 or renewed on or after January 1, 2012, shall provide coverage for  
37 the diagnosis and medically necessary treatment of a mental illness  
38 of a person of any age, including a child, under the same terms  
39 and conditions applied to other medical conditions as specified in  
40 subdivision (c) of Section 10144.5. The benefits provided under

1 this section shall include all those set forth in subdivision (b) of  
2 Section 10144.5.

3 (b) (1) "Mental illness" for the purposes of this section means  
4 a mental disorder defined in the Diagnostic and Statistical Manual  
5 of Mental Disorders IV, published by the American Psychiatric  
6 Association, and includes substance abuse, but excludes treatment  
7 of the following diagnoses, all as defined in the manual:

- 8 (A) Noncompliance With Treatment (V15.81).
- 9 (B) Partner Relational Problem (V61.1).
- 10 (C) Physical/Sexual Abuse of an Adult (V61.12).
- 11 (D) Parent-Child Relational Problem (V61.20).
- 12 (E) Child Neglect (V61.21).
- 13 (F) Physical/Sexual Abuse of a Child (V61.21).
- 14 (G) Sibling Relational Problem (V61.8).
- 15 (H) Relational Problem Related to a Mental Disorder or General  
16 Medical Condition (V61.9).
- 17 (I) Occupational Problem (V62.29).
- 18 (J) Academic Problem (V62.3).
- 19 (K) Acculturation Problem (V62.4).
- 20 (L) Relational Problems (V62.81).
- 21 (M) Bereavement (V62.82).
- 22 (N) Physical/Sexual Abuse of an Adult (V62.83).
- 23 (O) Borderline Intellectual Functioning (V62.89).
- 24 (P) Phase of Life Problem (V62.89).
- 25 (Q) Religious or Spiritual Problem (V62.89).
- 26 (R) Malingering (V65.2).
- 27 (S) Adult Antisocial Behavior (V71.01).
- 28 (T) Child or Adolescent Antisocial Behavior (V71.02).
- 29 (U) There is not a Diagnosis or a Condition on Axis I (V71.09).
- 30 (V) There is not a Diagnosis on Axis II (V71.09).
- 31 (W) Nicotine Dependence (305.10).

32 (2) Following publication of each subsequent volume of the  
33 manual, the definition of "mental illness" shall be subject to  
34 revision to conform to, in whole or in part, the list of mental  
35 disorders defined in the then-current volume of the manual.

36 (3) Any revision to the definition of "mental illness" pursuant  
37 to paragraph (2) shall be established by regulation promulgated  
38 jointly by the department and the Department of Managed Health  
39 Care.

1 (c) (1) For the purpose of compliance with this section, a health  
2 insurer may provide coverage for all or part of the mental health  
3 services required by this section through a separate specialized  
4 health care service plan or mental health plan and shall not be  
5 required to obtain an additional or specialized license for this  
6 purpose.

7 (2) A health insurer shall provide the mental health coverage  
8 required by this section in its entire in-state service area and in  
9 emergency situations as may be required by applicable laws and  
10 regulations. For purposes of this section, health insurers are not  
11 precluded from requiring insureds who reside or work in  
12 geographic areas served by specialized health care service plans  
13 or mental health plans to secure all or part of their mental health  
14 services within those geographic areas served by specialized health  
15 care service plans or mental health plans.

16 (3) In the provision of benefits required by this section, a health  
17 insurer may utilize case management, managed care, or utilization  
18 review to the extent permitted by law or regulation.

19 (4) Any action that a health insurer takes to implement this  
20 section, including, but not limited to, contracting with preferred  
21 provider organizations, shall not be deemed to be an action that  
22 would otherwise require licensure as a health care service plan  
23 under the Knox-Keene Health Care Service Plan Act of 1975  
24 (Chapter 2.2 (commencing with Section 1340) of Division 2 of  
25 the Health and Safety Code).

26 (d) This section shall not apply to accident-only, specified  
27 disease, hospital indemnity, or Medicare supplement insurance  
28 policies, or specialized health insurance policies, except behavioral  
29 health-only policies.

30 (e) This section shall not apply to a policy of health insurance  
31 purchased by the Board of Administration of the Public Employees'  
32 Retirement System pursuant to the Public Employees' Medical  
33 and Hospital Care Act (Part 5 (commencing with Section 22750)  
34 of Division 5 of Title 2 of the Government Code) unless the board  
35 elects, pursuant to Section 22856 of the Government Code, to  
36 purchase a policy of health insurance that covers mental health  
37 services as described in this section.

38 SEC. 4. No reimbursement is required by this act pursuant to  
39 Section 6 of Article XIII B of the California Constitution because  
40 the only costs that may be incurred by a local agency or school

1 district will be incurred because this act creates a new crime or  
2 infraction, eliminates a crime or infraction, or changes the penalty  
3 for a crime or infraction, within the meaning of Section 17556 of  
4 the Government Code, or changes the definition of a crime within  
5 the meaning of Section 6 of Article XIII B of the California  
6 Constitution.

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## COUNCIL AGENDA ITEM DETAIL SHEET

**Bill NUMBER/ISSUE:** 2011-12 Budget Trailer Bill Language

**BILL SUMMARY:** Proposed legislative changes to California statutes addressing various proposals in the 2011-12 Governor's Budget

**BACKGROUND:** There are generally budget changes proposed by the Governor or the Legislature which necessitate changes to existing law in order to implement the budget changes. If this is the case, separate bills are introduced to implement the change. These budget implementation bills are called "trailer bills" and are heard concurrently with the Budget Bill. By law, all proposed statutory changes necessary to implement the Governor's Budget were due to the Legislature by February 1.

**ANALYSIS/DISCUSSION:** The 2011-12 Governor's Budget proposes several major fiscal reductions and changes that necessitate changes to existing law in order to be implemented, thus a series of trailer bills have been introduced to make these statutory changes.

Specifically the Governor proposed, however the Legislative Budget Committee has not necessarily agreed, to the following:

- Add Section 14131.05 to the Welfare and Institutions Code (WIC) to place a specific dollar cap on Medi-Cal spending per year for hearing aids, durable medical equipment, incontinence medical supplies, urological medical supplies, and wound care supplies. The bill also outlines what services are not affected by the proposed caps. (RN 1102261)
- Add Section 12200.03 to WIC to reduce SSI/SSP payments to the minimum amount required by the federal Social Security Act. (RN 1101850)
- Add Article 6, Chapter 8.7 of Part 3, Division 9 of WIC to eliminate adult day health care services to the extent allowed under federal law. (RN 1102269)
- Add Section 4629.5 to WIC to require 85% of regional center funds be spent on direct services and defines "administrative services". (RN 1103216)
- Amend Section 4639 and add Section 4652.5 WIC to prohibit regional centers from using the same accounting firm for more than 5 years in every 10 years; and requires any entity receiving regional center funds, with some exceptions, to

contract with an independent auditing firm for an audit or review of its financial statements. (RN 11007837)

- Amend Section 14133.32 WIC to place a limit on prescription drugs covered by Medi-Cal to 6 per month and defines some exceptions to this requirement. (RN 1107749)
- Amend Sections 4626 and 4627 WIC addressing the conflict of interests related to regional center board members and employees. (RN1107802)
- Add Section 14131.07 WIC to limit the number of physician visits paid for by Medi-Cal to 10 per fiscal year with some exceptions. (RN 1102263)
- Amend Section 12301 WIC to eliminate domestic services for In-Home Supportive Services (IHSS) recipients who live with a housemate unless the housemate is physically or mentally impaired thus prevented from performing these tasks. (RN 1108109)
- Amend Section 12300 WIC to eliminate domestic services for IHSS recipients who are children living with their parent(s) unless the parent(s) is physically or mentally unable to perform the tasks. (RN 1108110)
- Amend Section 12301.03, 12301.05 and 12301.06 WIC to reduce the amount of IHSS hours to a recipient by 3.6 percent **permanently** and further reduce them in 2011-12 by an additional 8.4 percent for a combined total of a 12% reduction. (RN 1108144)
- Amend Section 12301 WIC to require IHSS applicants or recipients to obtain a certificate from a licensed physician or other appropriate medical professional indicating that due to functional limitations, the person is unable to perform the IHSS independently **and** without IHSS is a risk of placement in out-of-home placement. (RN 1107849)
- Add Section 4648.8 WIC to require the Department of Developmental Services (DDS) to develop purchase of services standards for use by regional centers when purchasing services for consumers and families. (RN 1107836)
- Add Article 2.6, commencing with Section 4659.10, to Chapter 5 of Division 4.5 WIC to establish procedures authorizing DDS or regional centers to institute legal proceedings against a third party or insurance carrier when services are provided or will be provided to a consumer or a child under 36 months of age who is eligible for the California Early Intervention Program (Early Start) as a result of an injury for which the third part is liable; recover the reasonable value of services provided from the person who has brought an action or claim against a third party

who may in this situation; and establish procedures for the enforcement of a lien perfected by DDS or a regional center upon a judgment or award in favor of a child or consumer for a third party injury and other related provisions. (RN 1107840)

- Amend Section 4474.5 WIC to clarify that consumers transitioning from Agnews Developmental Center (ADC) be served by the county organized Medi-Cal managed health care system or a local initiative, if consumers choose to enroll; and require consumers transitioning from Lanterman Developmental Center (LDC) to receive Medi-Cal managed care health plan services from any plan operating in various counties if the consumer chooses to enroll; that managed care plans enrolling LDC consumers will be reimbursed by a supplemental capitation payment for specified services, but not for LDC staff, and defines reasonable cost and reasonable net cost. (RN 1107838)
- Add Sections 4622.5, 4629.5, 4648.12 and 4648.14 WIC to require regional centers to annually submit to DDS documentation demonstrating that the composition of their boards are in compliance with the law; require regional center boards to adopt a written policy requiring any contract over \$350,000 to be approved by the board; require the policy be posted on the center's web site; require DDS establish a transparency portal on its web site and link to the regional centers' sites; and require that persons or entities that have been convicted of prescribed crimes or have been found liable for fraud or abuse in any civil proceeding or have entered into as settlement in lieu of conviction of fraud or abuse in any government program within the previous 10 years be ineligible to be a regional center vendor. (RN 1107801)
- Amend Section 14132 WIC to, in the Medi-Cal program, require enteral nutrition products for persons 21 years or older be limited to those products administered through gastric, nasogastric or jejunostomy tube. (RN11 02272)
- Amend Section 14132 WIC to provide that over-the-counter cough and cold products would **not** be covered by Medi-Cal. (RN 1102247)
- Amend and repeal Section 14134.1 and amend, repeal and add Section 14134 WIC to revise the copayment rates, expand services requiring co-payments and reduce the amount of payment to providers by the amount of co-payments from the recipients in the Medi-Cal program. (RN 1102248)

**COUNCIL STRATEGIC PLAN OBJECTIVE:** Shape public policy that positively impacts Californians with developmental disabilities and their families.

**PRIOR COUNCIL/COMMITTEE ACTIVITY:** On February 8, 2011, the Executive Committee adopted positions on fiscal proposals in the Governor's 2011-12 Budget which correspond to these proposed statutory changes.

**LPPC RECOMMENDATION(S):** Based upon the Executive Committee actions relative to the fiscal proposals, LPPC recommends the following actions related to the associated statutory proposals:

- **All proposals must include a process for exceptions and appeals; not place the health and safety of Californians at risk; not result in Californians receiving services and supports in more restrictive environments/settings; and sunset on June 30, 2012 consistent with the term of the budget**
- **Oppose** language to establish a specific dollar cap on Medical spending per year for hearing aids, durable medical equipment, incontinence medical supplies, urological medical supplies, and wound care supplies. (RN 1102261)
- **Oppose** language to reduce SSI/SSP payments to the minimum amount required by the federal Social Security Act. (RN 1101850)
- **Oppose** language to eliminate adult day health care services to the extent allowed under federal law. (RN 1102269)
- **Support** language to require 85% of regional center funds be spent on direct services and defines "administrative services". **Request** amendments that more clearly define which staff, using the core staffing formula, provides direct services as opposed to administrative services to assure statewide continuity of implementation. (RN 1103216)
- **Support** language to prohibit regional centers from using the same accounting firm for more than 5 years in every 10 years; and requires any entity receiving regional center funds, with some exceptions, to contract with an independent auditing firm for an audit or review of its financial statements. (RN 1107837)
- **Oppose** language to place a limit on prescription drugs covered by Medi-Cal to 6 per month. (RN 1107749)
- **Support** language addressing the conflict of interests related to regional center board members and employees **however subsequent regulations must place the responsibility for review and approval with the Department of Developmental Services and not involve the offices of the State Council.** (RN 1107802)

- **Oppose** language to limit the number of physician visits paid for by Medi-Cal to 10 per fiscal year. (RN 1102263)
- **Oppose** language to eliminate domestic services for In-Home supportive Services (IHSS) recipients who live with a housemate. (RN 1108109)
- **Oppose** language to eliminate domestic services for IHSS recipients who are children living with their parent(s). (RN 1108110)
- **Oppose** language to reduce the amount of IHSS hours to a recipient by 3.6 percent **permanently** and further reduce them in 2011-12 by an additional 8.4 percent for a combined total of a 12% reduction. **Request language be amended to retain the current 3.6% reduction for 2011-12.** (RN 1108144)
- **Oppose** language to require IHSS applicants or recipients to obtain a certificate from a licensed physician or other appropriate medical professional indicating that due to functional limitations, the person is unable to perform the IHSS independently **and** without IHSS is a risk of placement in out-of-home placement. (RN 1107849)
- **Oppose** language to require the Department of Developmental Services (DDS) to develop purchase of services standards. **Once this open-ended statutory change is made, categorical reductions and elimination of services could be implemented, standards could be added or changed by the department in the future, and the values of the system could be reduced to protecting health and safety and the ability to access Medicaid waiver funds, as oppose to enhancing the independence, productivity, inclusion and self-determination of those served in the system.** (RN 1107836)
- **Support** language to establish procedures authorizing DDS or regional centers to institute legal proceedings against a third party or insurance carrier when services are provided or will be provided to a consumer or a child under 36 months of age who is eligible for the California Early Intervention Program (Early Start) as a result of an injury for which the third part is liable and other related provisions. (RN 1107840)
- **Seek clarification** on language that consumers transitioning from Agnews Developmental Center (ADC) be served by the county organized Medi-Cal managed health care system or a local initiative, if consumers choose to enroll; and require consumers transitioning from Lanterman Developmental Center (LDC) to receive Medi-Cal managed care health plan services from any plan operating in various counties if the consumer chooses to enroll; that managed care plans enrolling LDC consumers will be reimbursed by a supplemental capitation payment for specified services, but not for LDC staff, and defines

reasonable cost and reasonable net cost. **How does this proposal coordinate with implementation of the new Medicaid managed Care waiver that requires Medi-Cal recipients to be enrolled in managed care in most instances? Why this language is needed except to obtain the proposed supplement capitation rates and why are these rates needed for this portion of the population?** (RN 1107838)

- **Support** language to require regional centers to annually submit to DDS documentation demonstrating that the composition of their boards are in compliance with the law; require regional center boards to adopt a written policy requiring any contract over \$350,000 to be approved by the board and related provisions. (RN 1107801)
- **Oppose** language to, in the Medi-Cal program, requiring enteral nutrition products for persons 21 years or older be limited to those products administered through gastric, nasogastric or jejunostomy tube. (RN 1102272)
- **Oppose** language to provide that over-the-counter cough and cold products would not be covered by Medi-Cal. This could lead to increased emergency room visits and hospitalizations due to the lack of less intrusive treatment options. (RN 1102247)
- **Oppose** language to revise **copayment rates** and expand the services for which co-payments are due for Medi-Cal services. (RN 1102248)

**ATTACHMENT(S):** None

**PREPARED:** Carol J. Risley, February 28, 2011



## COUNCIL AGENDA ITEM DETAIL SHEET

**ISSUE:** Extension and Expansion of Project SEARCH (Employment)

**BACKGROUND:** During Program Development Grant (PDG) Cycle 32, the Council provided funding to East Bay Innovations (EBI) and WorkLink to develop and strengthen Project SEARCH sites and create awareness and interest in the Project SEARCH model statewide. Funding from October 1, 2009 to September 30, 2010 was \$200,000; project was then extended thru March 30, 2011 and \$50,000 was added with that extension.

**ANALYSIS/DISCUSSION:** At presentation to the Council, EBI and WorkLink reported that Kaiser Permanente is interested in expanding Project SEARCH statewide within their facilities, however funding to support the project was ending as of March 30, 2011.

On February 8, 2011, the Council Executive Committee discussed the Project SEARCH presentation, noting it has exceeded the original goals and is on the brink of expansion statewide through a major medical care provider. The Committee requested that additional information be obtained from EBI and WorkLink to determine the level of resources needed to extend the project, at least until September 30, 2011 with the goal of advancing the Kaiser Permanente's statewide rollout of Project SEARCH, as well as improving and strengthening the existing sites.

In response to the Executive Committee's direction, EBI and WorkLink were requested to provide the Council with information to achieve this expansion and the cost. Because the Council did not run a PDG process this federal fiscal year, but opted to utilize funds on Council identified projects, monies are available, if the Council opted to provide additional time and funding for this project.

**COUNCIL STRATEGIC PLAN OBJECTIVE:** Promote the full inclusion in all chosen aspects of community life for California with developmental disabilities and their families.

**PRIOR COUNCIL ACTIVITY:** As noted above, the Council funded this project in PDG Cycle 32.

**RECOMMENDATION(S):** The Council Executive Committee recommends that the contract with EBI/WorkLink be extended until September 30, 2011 and \$37,000 be added for the expansion of Project SEARCH.

**ATTACHMENT(S):** Request from EBI/WorkLink detailing progress on goals to date and a request for additional time and funding for expansion (per the Executive Committee's request).

**PREPARED:** Carol J. Risley, March 1, 2011

## **Request to the State Council on Developmental Disabilities:**

### **Continued Funding for the California Project SEARCH Initiative**

#### ***I. SUCCESS OF CALIFORNIA PROJECT SEARCH INITIATIVE TO DATE***

Cycle 32 funding enabled East Bay Innovations (EBI) and WorkLink to effectively develop and strengthen Project SEARCH sites and to create awareness of and interest in the Project SEARCH model statewide.

- ✓ The California Project SEARCH Initiative exceeded its proposed goal of developing five new Project SEARCH sites. Seven new programs were established.

Kaiser – San Francisco; the County of Alameda; UCLA Medical Center; Mercy Hospital in Bakersfield; Monterey Park Family Courthouse; Alhambra Superior Courthouse; and, UCSF Medical Center all became operational Project SEARCH sites. Kaiser-Sacramento and San Mateo Medical Center have also established programs. The Sacramento program starts February 28th and San Mateo will have interns on site by March 14<sup>th</sup>.

- ✓ There are a total of 18 Project SEARCH sites with enrolled interns in California.

In addition to developing new sites, the California Project SEARCH Initiative provided extensive technical assistance to existing, but fledgling Project SEARCH sites and partner agencies to ensure their sustainability. In 2008 there were only six Project SEARCH sites in California.

- ✓ Informational presentations and meetings took place with a wide range of prospective employers, educational entities, and public and non-profit agencies in California.

In addition to holding monthly consortium (with service providers and educational partners) meetings in the Bay Area and LA, EBI/WorkLink met face to face with representatives of: The Recording Academy (Grammy's); Social Security Regional Office – Richmond; SF Unified School District; Transition Taskforce of Contra Costa County; San Mateo School District; Medtronic; Kaiser Department Managers in SF; Area Board 5; North Region SELPA; Kaiser Vacaville Medical Center; Lawrence Berkeley Laboratory; Pacific Gas and Electric; Wells Fargo Bank; Jewish Vocational Services of SF; Jewish Vocational Services of LA; California Disabilities Services Association; Fresno School District and local service providers; Kaiser – Sacramento, San Diego School District; Toward Maximum Independence; San Jose/Santa Clara Schools; Mayor's Breakfast in San Mateo; Tierra del Sol; Hospital Association of Southern California; LA County; Cal State Northridge Medical Center; Association of Hospital Administrators; Superintendents of Los Gatos/Saratoga Unified School Districts; Union Bank; Futures Explored; Fremont Unified School District; Progressive Employment Concepts; HOPE Community Services, San Juan Unified School District; Alta Regional Center; Department of Rehabilitation – Sacramento Region; Jay Nolan Community Services; South East LA Arc; Area Board 10; Capistrano Unified School District; DeAnza Community College; Pathpoint; Toolworks, Contra Costa Arc, Solano

Diversified Services; Arc San Francisco; Assembly Select Committee on Workforce Issues in the Developmental Disabilities Services Field; San Mateo Medical Center; California Department of Education – Transition Conference; and, Kaiser Medical Center - North Sacramento.

- ✓ Today, 118 interns are enrolled in Project SEARCH sites in California.

Project SEARCH programs in California are providing the training and support individuals need to obtain more career oriented positions that pay a liveable wage.

- ✓ In 2010, 100% of EBI Project SEARCH consumers received benefits through their jobs. (By comparison, 64% of EBI's consumers in Supported Employment received benefits as a result of their employment).
- ✓ Only 17% of EBI's Project SEARCH consumers were placed in janitorial, retail, or food service jobs in 2010. (In contrast, 67% of EBI's consumers in Supported Employment were employed in these settings in 2010).
- ✓ EBI's Project SEARCH consumers were employed, on average, 30 hours per week, in 2010. (EBI's Supported Employment consumers were employed, on average, 23 hours per week during the same period).
- ✓ EBI's Project SEARCH consumers earned an average wage of \$16.40 per hour in 2010. (EBI's Supported Employment consumers earned an average hourly wage of \$10.90 in 2010).
- ✓ One hundred percent of EBI/Children's Hospital and San Juan Capistrano's 2009 Project SEARCH graduates were placed in jobs.

## ***II. PLAN TO EXPAND THE PROJECT SEARCH INITIATIVE***

To further advance the goal of the California Project Search Initiative –increasing and improving career-oriented employment opportunities for individuals with developmental disabilities – EBI and WorkLink are proposing to accomplish the objectives, described below, over a twelve month period. Funding for the three month period, from July 1, 2011 through September 30, 2011 will enable EBI and WorkLink to set in place the first phase of this expansion.

### **1) Continue to work with Kaiser Permanente to promote a strategic “rollout” of Project SEARCH at Kaiser facilities throughout California.**

Five additional Project SEARCH Kaiser sites will become operational (Vacaville, Irvine, Harbor City, Santa Clara, and Roseville). EBI and WorkLink will provide technical assistance to ensure their successful start-up and implementation.

EBI and WorkLink will assist Kaiser Permanente in developing policies and procedures to establish and support Project SEARCH sites within its medical centers statewide. Project SEARCH-CA will also assist Kaiser to recruit partners (educational and adult service providers) for targeted areas. Kaiser Permanente's National Director of Recruitment, Operations, Yvette Crespo, supports expansion of the Project SEARCH model. In her words:

*"Good corporate citizenship and social responsibility benefit our communities and are part of our hospital's legacy. At Kaiser Permanente, we see Project SEARCH as a way to achieve our objectives, while developing candidates for our workforce. To me, this is a win-win situation. Diversity, inclusion and culturally competent medical care are defining characteristics of the Kaiser Permanente organization. Project SEARCH is an extension of these principles into our training and recruitment efforts of people with disabilities. Project SEARCH gives us the framework and support we need to add individuals with disabilities to our workforce."*

**2) Oversee the stability and sustainability of the 18 existing Project SEARCH sites.**

EBI and WorkLink will continue providing technical assistance to support their ongoing effectiveness and, where possible, encourage expansion to accommodate more interns, and improve placements and employment outcomes.

**3) Develop eight new Project SEARCH sites.**

EBI and WorkLink will expand Project SEARCH to two additional regions in California -- Amador and San Diego Counties -- by conducting outreach and education to prospective employers, identifying and cultivating educational and agency partners, and providing intensive training and support to newly forming collaborations.

EBI and WorkLink will explore development of Project SEARCH sites in industries beyond healthcare, such as Wells Fargo Banks in Contra Costa and San Francisco Counties, Pacific Gas & Electric in San Francisco, and Medtronic in Santa Ana and Santa Rosa, Facebook and/or Apple in Mountain View.

Additional Kaiser sites, not currently under development, will also be explored and established.

**4.) Ensure that at least 16 new placements are made.**

Sixteen individuals will be hired in career path jobs and be working at least part-time, earning a living wage, and accessing benefits through their employment.

*III. FUNDING REQUESTED TO CONTINUE EXPANSION OF PROJECT SEARCH STATEWIDE*

The California Project SEARCH Initiative is experiencing great momentum today as a result of the activities made possible with Cycle 32 support from the State Council. EBI is seeking funding in the amount of \$36,419.00 from the State Council to continue the planned expansion of the Initiative for the period from July 1, 2011 through September 30, 2011. Activities to be

conducted will not only advance Kaiser Permanente's Project SEARCH "rollout," but will also improve and strengthen existing Project SEARCH sites. The California Project SEARCH Initiative will also work to establish programs in underserved geographic areas. Many more individuals with developmental disabilities in California will have opportunities to be gainfully employed in the near future and, given the anticipated Project SEARCH growth trajectory, this number will continue to grow.

Personnel Services

Executive Director	\$3,000
Director of Employment Services	\$7,500

Consultants

WorkLink CPSI Coordinator	\$25,350
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Travel

Airfare	\$ 275
Mileage	\$ 94
Hotels	\$ 100
Per Diem	\$ 100

February 28, 2011

Ms. Carol Risley  
State Council on Developmental Disabilities  
Sacramento, CA

Dear Ms. Risley,

I am writing to ask for the continued support of the State Council to replicate Project SEARCH in California.

Kaiser Permanente has been a leader in the Healthcare industry for more than fifty years and has demonstrated a strong commitment to providing high-quality, culturally sensitive medical services, supporting its patients and building strong communities. Through its innovative recruitment initiatives and diversity policies, Kaiser has created a workforce that strongly reflects the communities we serve. It is because of Kaiser's efforts and commitment to building a diverse workforce, that we have implemented Project SEARCH in the organization's recruitment and diversity strategy.

Thanks to a grant from the council, Tom Heinz of East Bay Innovations and Sara Murphy of WorkLink has been available to assist me and the Kaiser Permanente Medical Centers to pilot Project SEARCH programs in three Northern California sites (Vallejo, San Francisco and Sacramento).

Due to the overwhelming success of these programs, Kaiser is now interested in expanding the program system-wide. My goal for 2012 is to start at least two sites in Kaiser's Southern California region (Harbor City and Irvine) and three additional sites in Northern California (Roseville, Vacaville and Santa Clara).

Sara and Tom have played a crucial role in these efforts. They have assisted in the marketing of the program to senior leadership and managers. As partners, we have developed a strategic roll-out plan and are working to recruit educational and adult service partners in our targeted areas-- and throughout the state.

With an additional year of support from the council, Sara and Tom will be able to continue working with me to create training and employment opportunities for transition aged youth and adults with disabilities. I am very proud and excited about what we have accomplished this year. Should Sara and Tom continue to assist, I am confident we will be able to expand this worthwhile program throughout the state and all Kaiser Permanente regions. Thank you in advance for your support.

Sincerely,

Yvette Crespo  
Director of Recruitment Operations  
National Recruitment Services  
Kaiser Permanente



## AGENDA ITEM DETAIL SHEET

### **ISSUE: EXECUTIVE DIRECTOR FINAL EVALUATION TOOL**

**BACKGROUND:** During the 2010 Executive Director selection process both the Selection and Executive Committees took action to direct staff to develop a draft evaluation tool for the 2011 Executive Director evaluation.

On December 14, 2010, staff provided a draft to the Executive Committee. The committee took action to approve the draft tool and provide it to the full Council in January 2011 for discussion and input.

On January 19, 2011, the revised draft was provided to the full Council with a request to submit comments to the Executive Committee by February 4, 2011. Comments received were: 1) include the Executive Director in the evaluation process, 2) convert the tool to plain language, and 3) two items were added addressing the state strategic plan goals and objectives.

On February 8, 2011, the Executive Committee revised the draft and took action to recommend that the Council approve the attached final draft tool and process.

**ANALYSIS/DISCUSSION:** The final draft is presented to the Council for action.

**COUNCIL STRATEGIC PLAN OBJECTIVE:** CC 1.1

**PRIOR COUNCIL ACTIVITY:** The Council received a revised draft during the January Council meeting and made three comments which were incorporated into the final draft reviewed and approved during the February Executive Committee Meeting.

**RECOMMENDATION(S):** The Executive committee recommends the Council approve the attached executive director evaluation tool and process.

**ATTACHMENT(S):** Draft executive director evaluation tool and process.

**PREPARED:** Melissa C. Corral, February 8, 2011





# STATE COUNCIL ON DEVELOPMENTAL DISABILITIES EXECUTIVE DIRECTOR EVALUATION

## ***I. PROCESS***

The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (federal DD act), requires that the Executive Director of the Council be evaluated on an annual basis.

The process for evaluating the Executive Director is:

1. The Chairperson of the Council coordinates the Executive Director Evaluation. He/she distributes the Performance Evaluation Form.
2. Each Council member must complete the Performance Evaluation Form. Once completed, the form must be returned to the Chairperson.
3. Staff members will be sent Narrative Questions only. These must be returned to the Chairperson.
4. The Executive Director will complete the Performance Evaluation Form for herself/himself and discuss her/his self evaluation with the Chairperson.
5. Each Performance Evaluation Form is logged onto a worksheet and summarized.
6. A final summary report is produced.
7. The Executive Director Evaluation will be on the September Council Meeting agenda as a closed session item.
8. In open session, the Executive Director and Council then meet to discuss salary/bonus, etc.
9. This information is then processed through the Council Personnel Department.

## II. INSTRUCTIONS

Please use the rating levels: “N/I” (Needs Improvement) “A” (Meets Standards/Acceptable), or “O” (Exceeds Standards/Outstanding). If you do not know about a particular area, mark **Do Not Know**.

<b>Rating Factor</b>	<b>Needs Improvement (N/I)</b>	<b>Meets Standards Acceptable (A)</b>	<b>Exceeds Standards Outstanding (O)</b>
Work quantity	Executive Director does not produce enough work.	Executive Director produces the proper amount of work.	Executive Director produces a lot of work.
Work Quality	Executive Director does not have work skills.	Executive Director has the work skills and works accurately.	Executive Director's work is always accurate and orderly and works with superior skill.

### III. EXECUTIVE DIRECTOR EVALUATION

<b>ASSISTANCE TO COUNCIL MEMBERS</b>	<b>Don't Know</b>	<b>Needs Improvement</b>	<b>Acceptable</b>	<b>Outstanding</b>
Assists the Council in scheduling, planning and preparing for Council and committee meetings.				
Assists the Council in the development of agency policy, organizational goals, objectives and budgets.				
Assists the Council in the development of policy decisions regarding issues that affect the rights and interests of persons with disabilities.				
Assists the Council in making sure that the Council follows all federal and state laws and regulations, including providing and interpreting information.				
Assists the Council in the development of the goals and objectives of the Council's 5 year state and strategic plan.				
Provides regular reports to the Council on the state and strategic plan and emerging issues and provides recommendations.				

<b>PERSONNEL</b>	<b>Don't Know</b>	<b>Needs Improvement</b>	<b>Acceptable</b>	<b>Outstanding</b>
Assures that staff are supervised and coordinated effectively in order to carry out all of the Council's goals and objectives.				
<b>BUDGET</b>				
Develops, implements and manages the Council approved budget.				
Ensures that budget is legal and uses acceptable accounting and fiscal management practices.				
Assures that the Council receives budget information.				
Makes contracts on behalf of the Council consistent with approved goals, objectives, plans and budget actions.				

<b>PUBLIC AND AGENCY LIAISON</b>	<b>Don't Know</b>	<b>Needs Improvement</b>	<b>Acceptable</b>	<b>Outstanding</b>
Maintains effective relationships between the Council, the federal Administration on Developmental Disabilities and State funding agencies.				
Maintains effective relationships and works with other advocacy organizations with similar goals and objectives.				
Maintains effective relationship and liaison with the National Association of Councils on Developmental Disabilities (NACDD).				
<b>ADAPTABILITY RATING</b>				
Able to assume a variety of roles and responsibilities related to the position and perform with required knowledge/skills.				
Able to respond well to changing job requirements and work conditions, including unanticipated/exceptional administrative and/or programmatic events.				

<b>EXPRESSION</b>	<b>Don't Know</b>	<b>Needs Improvement</b>	<b>Acceptable</b>	<b>Outstanding</b>
Able to clearly/concisely convey information (e.g., interpreting regulations, presenting reports, articulating needs/priorities, giving instructions) orally and in writing.				
Able to organize coherent presentations and effectively highlight/summarize key points and issues.				
<b>INTERPERSONAL RELATIONS</b>				
Demonstrates sensitivity and good judgment.				
Is helpful and friendly.				
Resolves conflicts in an objective manner.				

**IV. NARRATIVE QUESTIONS**

1. What impressed you the most about the Executive Director's performance this year?
  
2. In what areas has the Executive Director shown exceptional improvement?

3. What specific recommendations do you have for the Executive Director?
  
4. What should be the priorities for the Executive Director over the next year?
  
5. Do you have any additional comments regarding the Executive Director's performance?

\_\_\_\_\_

Council Member Signature

\_\_\_\_\_

Date

## **EXECUTIVE DIRECTOR EVALUATION 2011 TIMELINE**

December 14, 2010	Provide a draft evaluation tool to the Executive Committee Meeting for revision.
January 19, 2011	Provide the revised draft tool from the Executive Committee to the full Council for comments and revision.
February 8, 2011	Executive Committee will review the comments and suggested revisions and incorporate/revise the tool as appropriate
March 16, 2011	Final evaluation tool submitted to the full Council for approval.
June 14, 2011	Executive Committee will select one person to coordinate the evaluation which will be sent to all Council members and staff, as appropriate.
June 15, 2011	Evaluation will be sent out to all appropriate persons with a return date of July 30, 2011 to the evaluation coordinator.
August 9, 2011	Evaluation coordinator will present the evaluation materials, statistical data and all information to the Executive Committee during a closed session.
September 20 -21, 2011	Executive Committee will present the evaluation and their recommendation to the full Council during a closed session.



**Executive Committee Meeting Minutes**  
February 8, 2011

**Attending Members**

Jennifer Allen  
Michael Bailey, Chairperson  
Ray Ceragioli  
Shirley Dove  
Marcy Good  
Olivia Raynor  
Leroy Shipp

**Members Absent**

Jorge Aguilar  
Lisa Cooley  
Kerstin William

**Others Attending**

Melissa Corral  
Mike Danti  
Robin Maitino  
Carol Risley

1. **Call to Order**

Michael Bailey, Chairperson called the meeting to order at 1:05 p.m.

2. **Establishment of Quorum**

Michael Bailey established that a quorum was present.

3. **Introductions**

Members and staff introduced themselves.

4. **Approval of December 14, 2010 Meeting Minutes**

It was moved, seconded (Good/Dove), and carried to approve the December 14, 2010 minutes as presented.

5. **Public Comments**

There were no public comments.

6. **Financial Update**

Michael Danti provided an updated 2010-11 expenditure report, stating that aside from the Area Board 3 and 9 discrepancies, we are currently fiscally sound. Danti has addressed the discrepancies and expects them to be corrected by his next report.

Carol Risley reported on funding for the Councils expect to be reduced with the release of the 2012 federal budget. There was some discussion on how we would distribute funds in the event of a reduction.

## 7. Committee Updates

### a. Strategic Planning

Olivia Raynor reported on the progress of the State Strategic Plan noting that hearings have proven to be very interesting. A question that is coming up is what role the Council plays in providing services. There seems to be some disconnect as to “who” the Council is and “what” they do. There was discussion around how to go about educating the community on the Council’s purpose and the method to use in getting that message out.

There was discussion regarding the composition of the Strategic Planning Subcommittee noting that ideally the subcommittee should be composed of the chairpersons of all the other Council committees to assure continuity of activities consistent with the State Strategic Plan. The final decision was a recognition that the subcommittee is actually part of the Executive Committee, thus the makeup will be consistent with this goal and the Council by-laws. Time will be set aside at Executive Committee meetings, as needed, for the Subcommittee to meet and confer.

### b. Employment First

Michael Bailey reported on the January 7, 2011, Employment First Committee meeting. They reviewed and discussed the draft policy, flushed out recommendations that were made by the five subcommittees, and sent a final draft back to the subcommittees for review and approval. The Committee is expecting to review and approve the final draft of the policy and reports on goals, objectives, and strategies at the March meeting.

### c. Legislative and Public Policy

Carol Risley gave the Legislative and Public Policy report in Jorge Aguilar’s absence. On January 27, 2011, the Committee met and took action to recommend that the Executive Committee take positions on specific proposed budget items that impact individuals with

developmental disabilities. It was moved/seconded (Shipp/Allen) and carried to adopt positions on proposals in the Governor's 2011-12 Budget as reflected in the attachment to the minutes.

#### 8. Draft Executive Director Evaluation

Melissa Corral presented the revised draft Executive Director Evaluation Instrument as discussed at the January 2011 Council meeting.

Melissa reviewed each change with the Executive Committee. After some discussion, one minor change was made on page 3, Section III – Assistance to Council Members, question 5. It was moved, seconded (Good/Dove) and carried to approve the draft as amended and recommend adoption by the Council at the March 2011 meeting.

#### 9. Personnel Update

Carol Risley gave an update on the staffing challenges at headquarters. The Governor's Office has not yet acted upon the three requests for appointment of Council staff.

Carol has made a tentative offer, contingent upon approval of the freeze exemption and appointment, to the Legislative Specialist position and resubmitted packages on the two vacant Deputy Director positions for the third time.

SCDD has also started receiving and reviewing applications for an Associate Information Systems Analyst and expects to start interviewing shortly.

#### 10. Chairperson's Report

Leroy Shipp warned against volunteer burnout and over stretching yourself.

#### 11. Agenda for March Council Meeting

The Committee discussed the following suggested agenda items for the March Council meeting:

- Project Search – additional funding to expand services
- Health Insurance Reform
- PDF Grant Presentation by Grantee

- Committee Reports
  - Strategic Planning
  - Employment First
  - Legislative and Public Policy
  - Executive
  - Consumer Advisory

## 12. **Adjournment**

It was moved, seconded (Bailey/Dove), and carried to adjourn at 4 p.m.

**State Council on Developmental Disabilities  
Positions on 2011-12 Governor's Budget  
Adopted February 8, 2011**

**Basic Principles**

- ▶ *The Council recognizes the magnitude of California's fiscal crisis and that all Californians will be impacted by balancing the budget, thus individuals with developmental disabilities must share in this correction, but should not be expected to assume an inequitable portion of the burden.*
- ▶ *While budget proposals may define and refine the level of entitlement to services and supports in the developmental services system, they must not eliminate the entitlement to access, and to be served by the system for eligible individuals and families.*
- ▶ *Budget proposals must not result in people with developmental disabilities having their health and safety negatively impacted, jeopardize their inclusion in the community, force them to become less productive, and/or reduce their ability to direct their own lives and make choices.*
- ▶ *Budget proposals must not violate the basic tenet of the developmental services system as a civil/social rights model rather than medical model, nor reduce the quality of available services.*
- ▶ *Budget proposals must examine the entire system to seek administrative efficiencies, including but not limited to consolidation of administrative structures and costs, and economies of scale, not just impact direct services.*
- ▶ *Budget proposals must not violate the basic underpinnings of existing federal and state statutes and court decisions that serve to assure the provision of quality services and supports and protect basic human rights of individuals with developmental disabilities.*

## Department of Developmental Services (DDS)

- ▶ *Any budget reductions must be shared by the entire developmental services system, not solely applied to community services, and more specifically purchase of services and supports for individuals with developmental disabilities.*

### Community Services Program

- Proposed \$149.7 million increase in Purchase of Services (POS) and Prevention Program due to increased caseload and utilization.
  - ▶ *Support*
- \$0.5 million decrease due to the delayed implementation of the Self-Directed Services.
  - ▶ *Support, although the Council is extremely frustrated with the continued delay with implementing this option in California.*
- \$13.0 million increase in regional center operations costs primarily due to caseload increases and additional Home and Community-Based Services (HCBS) waiver enrollments.
  - ▶ *Support*
- Increase of \$134.1 million in General Fund and corresponding decrease in reimbursements due to the end of federal stimulus funding.
  - ▶ *Support*
- Continuation of the 4.25 percent payment reduction in 2011-12. The reduction impacts both regional center operations and POS for a total decrease of \$165.5 million (\$91.5 million General Fund). There is an incremental decrease from 2010-11 of \$2.8 million due to the reduced total funding level in 2011-12.
  - ▶ *Request proposal be reduced to 3% to mitigate the overall impact reduction has had on the availability and quality of*

*services particularly when taking into consideration the cumulative effect of historic rate freezes and other reductions in services and supports over the past five years. See attached chart illustrating this cumulative effect.*

- Continue reimbursement funding from the California Children and Families Commission (Proposition 10) in 2011-12, resulting in a General Fund savings of \$50 million.

▶ *Support*

- \$27.2 million decrease in 2011-12, as the 2010-11 budget included costs associated with retroactive processing of claims for 2007-08 through 2010-11 (four years) that is not required in the budget year. These costs related to increasing Federal Financial Participation (FFP) for day treatment and transportation costs for residents of Intermediate Care Facilities for individuals with developmental disabilities (ICF-DD). The 2011-12 budget retains \$9.5 million for budget year claims.

▶ *Support*

- \$1.7 million increase to establish Financial Management Services (FMS) as an option for vouchered respite, transportation, and day care services consistent with federal requirements to renew the HCBS waiver.

▶ *Request additional explanation as to whom or what will provide these services, how \$1.7 million be used and what are consumer/family protections related to this service.*

- \$70.1 million increase to reflect the impact of service reductions proposals in Medi-Cal and SSI/SSP programs that will increase regional centers POS costs in 2011-12.

▶ *Support and request similar provision for individuals with developmental disabilities who will experience a decrease in needed In-Home Supportive Services (IHSS).*

- Increased accountability and transparency and system-wide cost containment measures to generate significant General Fund savings necessary to achieve the balance of overall required reduction of \$750 million.
  - ▶ *Support of increased accountability and transparency.*
  - ▶ *Request that prior to direct service limitations/reductions, DDS identify areas for increased administrative efficiencies and economies of scale within the system infrastructure.*
  - ▶ *While not supportive of service and support reductions to individuals with developmental disabilities and their families, the Council recognizes the system will share in the budget burden and any proposals put forth must include a input from the impacted parties, particularly the underserved and people of color, and accurate analysis of the potential impact on the continued ability of persons to increase or retain their independence, productivity, self-direction and inclusion.*

## **Developmental Centers**

- The Department will pursue additional federal funds for treatment services provided to individuals residing in the secure facility at Porterville Developmental Center. It is anticipated this will result in General Fund savings of \$10 million in 2011-12.
  - ▶ *Support*
- The capital outlay budget includes \$2.0 million General Fund to design and install automatic fire sprinklers in 13 buildings that house Nursing Facility and General Acute Care consumers at the Fairview, Porterville and Sonoma Developmental Centers.
  - ▶ *Support*
- Budget proposes the reappropriation of funding for an addressable fire alarm system, already approved by the Legislature, in consumer utilized buildings at Fairview Developmental Center. This project

continues to be a critical safety improvement, licensing and code compliance need for Fairview's consumers, staff, and visitors.

▶ *Support*

- "... construction phase for a new piping system, already approved by the Legislature, to supply additional oxygen, medical air and suction, and a new oxygen storage tank at the Johnson/Ordahl building at Sonoma Developmental Center.

▶ *Support*

## **DEPARTMENT OF SOCIAL SERVICES (CDSS)**

### **Supplemental Security Income/State supplementary Payment (SSI/SSP)**

- The Governor's Budget proposal would reduce monthly SSP grants for individuals to the federally required minimum payment standard. Under this proposal, the maximum monthly SSI/SSP cash grant for individuals would be reduced by \$15 per month (from \$845 to \$830), beginning June 1, 2011. SSP grants for couples were previously reduced to the federal minimum in November 2009.
  - ▶ *Oppose. This decrease will negatively impact the ability of persons to live in the community. While individuals with developmental disabilities, served by the regional center system, will have their reduction backfilled (see proposal under DDS), others on SSI/SSP will not.*

### **In-Home Supportive Services (IHSS)**

- Budget proposed an 8.4percent reduction to assessed hours for all IHSS recipients for General Fund savings of \$127.5 million in 2011-12. This proposal, combined with the 3.6percent reduction enacted in 2010-11, would bring the total across-the-board reduction in assessed hours for IHSS recipients to 12 percent.

- ▶ *Oppose increase of 8.4 % across-the-board reduction and substitute an individualized review and, if appropriate, reduction in assessed hours.*
- Proposal would eliminate domestic and related services (which include housework, shopping for food, meal preparation and cleanup, and laundry) for consumers living with their provider. IHSS applicants/recipients who have a need for domestic and/or related services that cannot be met in common due to a medically verified condition of other members of the shared living arrangement could be authorized hours for any of these services that meet the need assessment metrics. Minor recipients are living with their parent(s), the need is being met in common; hence, the need for domestic and related service hours would no longer be allowed. The parent would be presumed available to perform these tasks unless the parent could provide medical verification of his/her inability to do so.
  - ▶ *Oppose*
- Requires the provision of IHSS services to be conditioned upon a physician's written certification that personal care services are necessary to prevent out-of-home care.
  - ▶ *Oppose. IHSS is not a medical model program and physicians are not trained to assess a person's ability to live in the community. Continued certification of need for services should be completed by an entity that is qualified and uses a standardized assessment tool and process throughout California.*

## **DEPARTMENT OF AGING (CDA)**

- Multipurpose Senior Centers (MSSP) provide case management services for elderly clients who qualify for placement in a nursing facility but who wish to remain in the community. This proposal would eliminate these services for a savings of \$19.9 million General Fund in 2011-12.

- ▶ *Oppose. Closure of MSSP sites are designed to keep people included in communities and such inclusion is less costly to the taxpayers than placement in skilled nursing facilities.*

## **DEPARTMENT OF HEALTH CARE SERVICES (DHCS)**

- ▶ *All efforts must be made to access and maximize other sources of income including but not limited to:*
  - *Issuing directions to counties regarding the use of state and local funds for Medi-Cal share of costs for California Children's Services (CCS).*
  - *Require that the Consolidated Omnibus Budget Reconciliation Act (COBRA) notices be issued in California to provide information about the Health Insurance Premium Payment Program (HIPP) for coverage of premium costs of COBRA benefits; and information that receiving an extension of the 11-month disability extension does not require a person to qualify for Social Security benefits.*
  - *Examine other states' successes in ensuring that costs of long-term care are not prematurely shifted from Medicare to Medi-Cal.*
  - *Seek payments by health plans to cover their obligations to children with disabilities covered under their parent's group plans.*
  - *Require private insurance plans to cover the full cost of wheelchairs and other durable medical equipment.*
  - *Actively promote the coverage of children under 26 years old on their parent's private insurance.*
  - *Pursue federal financial participation for the costs of veterans pharmacy benefits.*

### **Medi-Cal**

- **Proposal establishes utilization controls at a maximum annual benefit dollar on hearing aids (\$1,510), durable medical equipment (\$1,604), incontinence supplies (\$1,659), urological supplies (\$6,435), and**

wound care (\$391), limits prescriptions (except life-saving drugs) to six per month, and limits the number of doctor visits to ten per year.

- ▶ *Oppose. Decisions about the level of medical services required should be made on an individualized basis. The potential impact of a formula could be to jeopardize the health and safety of individuals with developmental disabilities.*
- Co-payments would become mandatory. This proposal includes a \$5 co-payment on physician, clinic, dental, and pharmacy services (\$3 on lower cost preferred drugs) for savings of \$294.4 million in 2011-12.
  - ▶ *Oppose. However if adopted, request a process be established to grant exceptions from the increased level or entire co-pay requirement if the co-pay will reduce access to necessary medical care services. With the decrease in SSI/SSP, less cash is available to people who access both publically funded supports, thus the impact of coupling these proposals is results in a disproportionate reduction to this population as compared to other publically funded services.*
- Budget proposal would also eliminate the optional Adult Day Health Care program for savings of \$1.5 million in 2010-11 and \$176.6 million in 2011-12.
  - ▶ *Oppose. This will impact people with developmental disabilities and their ability to remain included in their communities.*
- Budget proposes to reduce provider payments by 10 percent for physicians, pharmacy, clinics, medical transportation, home health, Adult Day Health Care, certain hospitals, and nursing facilities.
  - ▶ *To the extent that this would reduce the availability of medical care to persons with developmental disabilities, the proposal would add to the disproportionate share of reductions they would experience.*

- The Budget proposes to use \$1 billion in Proposition 10 funds to fund Medi-Cal services for children through age five.

- ▶ *Support*

- The Budget proposes to extend the fee through June 31, 2011, which will save \$160 million in Medical. Fee revenue is used to leverage federal funding to provide supplemental payments to hospitals for the provision of Medi-Cal services and to offset General Fund costs to a lesser degree.

- ▶ *Support*



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**Developmental Services Quality Review Consolidation Project**  
**Reduces Duplication of Quality Review Requirements for Providers of Services, Preserves State Funds and**  
**Simultaneously Improves the Lives of People with Developmental Disabilities in California**

California has, through the Lanterman Act (Welfare & Institutions Code §§ 4500 et seq), created a service system for people with developmental disabilities intended to provide services and supports to enable these individuals to live independent, productive and normal lives in their home communities. As part of the desire to ensure quality services are being provided, systems were put in place to monitor the delivery of these services. As the entire system has grown, so has the complexity of the quality review process. At present, many different entities review the quality of various programs. In many situations, several of these entities monitor the same service provider. With the number and complexity of the review systems, there is overlapping, duplication and in some instances, contradictory standards in measuring quality. This leaves the individuals being served, service providers, regional center staff and others often in situations that are non-productive and take away from the resources that should be used to provide even better services.

The California Department of Developmental Services (DDS), together with the 21 Regional Centers, has responsibility for a variety of monitoring requirements of thousands of service providers that support the 270,000 people who receive services through the regional center system. A large number of the service providers provide group or individual living and day activities or work services, and often provide a combination of supports. When services are grouped in a building, regulations require that services be licensed and monitored as well by Department of Social Services Community Care Licensing (CCL). Some living arrangements are licensed and monitored by the Department of Public Health. Many other entities also have monitoring responsibilities. As a result service providers must interface with a variety of requirements, licensures, accreditations and additional funding streams depending on the combination of services they offer. While review is welcomed in the ongoing pursuit of quality service, duplicating review efforts does not benefit people with developmental disabilities and wastes valuable resources.

In these fiscally challenging times people with developmental disabilities and their families want to ensure that state funding resources are dedicated to providing the services they need and are not wasted in duplicative and process oriented monitoring efforts. Service providers and regional centers share this desire. Because of this, the following unification of key quality assurance functions and simultaneous refocusing of the quality assurance system is proposed:

- Place under the DDS all licensing, certification and quality assurance functions regarding the health, welfare and safety of people with developmental disabilities. The quality assurance and improvement tasks would be held by DDS with some tasks delegated to regional centers.
- Expand the focus of quality standards to address individual outcomes for people served such as community inclusion, empowerment and choice as well as health and safety.
- Shift the focus of quality efforts to a service enhancement model that encourages and rewards service provider improvements.
- Department of Social Services will maintain enforcement responsibilities including fingerprinting processing and legally representing the State of California in the most serious of incidents.

This proposal will save limited state general fund dollars, simplify the lives of service providers and enhance the effectiveness of quality assurance efforts – thus it will improve the lives of people with developmental disabilities in California.

The grid that follows provides an overview of the duplication of monitoring functions with a focus on licensed facilities. Attached is a reference document that lists the statutes and regulations in place for the complex system of service provision for people with developmental disabilities in California.

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*Note: A key follows the table that describes the regulations and statutes referenced in the material.*

<p><b>Developmental Services System – Lanterman Act (WIC), California Regulations Title 17</b></p>	<p><b>Community Care Licensing System and Health Care Licensing -- Health and Safety Code, California Regulation Title 22, Code of Federal Regulation</b></p>	<p><b>Other Entities</b> For Employment Services - Department of Rehabilitation; For affordable housing - HUD</p>
<p><b>Needs Assessment</b> Purchase of service is regulated by individual consumer need/choice for self sufficiency (WIC 4648.1); Regional centers vary in practice as to whether overall needs information available</p>	<p>Requires Needs and Services Plan for each person entering the facility (T22 80068.2, 85068.2)</p>	<p>HUD Development requires need assessment. Department of Rehabilitation needs assessments are completed through District Offices. (Rehabilitation Act of 1973)</p>
<p><b>Vendor Application</b> Regional center system focuses on service/program design elements. There are a variety of requirements based on service type. (T 17 Sec 54310, 56013, 56712)</p>	<p>Licensing focuses on operations plan, fire clearance, criminal records clearance (T22 80017-46) An 8 hour orientation required before submission of application (T22 Sec. 80001c)</p>	<p>Department of Rehabilitation initial certification prior to CARF accreditation (Title 9, California Code of Regulations [CCR], Division 3, Chapter 11, Section 7331)</p>
<p>Regional centers must respond to applications within 45 days of submission (T17 54320)  The regional center shall provide a residential services orientation for all persons who wish to become vendorized to provide services orientation by prescribed topics no less than every six months (T17 56003)</p>	<p>For day programs and residential facilities, the typical application timeline is: - A response is sent within 90 days that the application is received; provisional license will be granted if application complete; visit made within 12 months for license For health care facilities – ICF Intermediate Care Facilities: - A response is sent within 90 days that the application is received; a visit is made - 90 days after the visit the license may be granted</p>	<p>Administrators must complete testing or coursework before the application can be processed; For health facilities a federally required qualified staff (QMRP) must be certified. (T22 Sec. 85064, CFR W 158 Sec 483.430)</p>

<p><b>Developmental Services System -- Lanterman Act (WIC), California Regulations Title 17</b></p>	<p><b>Community Care Licensing System and Health Care Licensing -- Health and Safety Code, California Regulation Title 22, Code of Federal Regulation</b></p>	<p><b>Other Entities</b> For Employment Services -Department of Rehabilitation; For affordable housing - HUD -</p>
<p><b>Vendor Ongoing Operations</b></p> <p><b>Incident Reporting</b></p> <p><i>Note: Slight variations in definitions and processes</i> Report to RCGs w/in 24 hrs; written report in 48 hrs (T17 Sec 54327) RCs report to DDS w/in 48 hrs (T17 Sec 54327.1)</p>	<p>Vendor reports w/in 24 hrs; written report in 7 days (T22 Sec 80061) ICF Abuse Reporting Procedures [CFR 483.420(1)(6); (d)(2); (d)(4)]</p>	<p>Additional reporting for abuse (WIC 15600-01) Overlying requirements for mandated reporters (WIC 15630)</p>
<p><b>Monitoring</b></p> <ul style="list-style-type: none"> <li>- Quarterly visits to residence to review consumer funds and the facility (T17 Sec. 56047)</li> <li>-Annual monitoring visit by regional center (T 17 Sec. 56078)</li> <li>- ICF Quarterly Monitoring Requirements (T17 Sec 56103)</li> <li>- Allows for regional center review of programs as needed (WIC 4648.1)</li> </ul>	<ul style="list-style-type: none"> <li>- Unannounced annual visits (HSC 1534)</li> <li>-Visits in response to reported violations (HSC 1538)</li> <li>-Plan of correction follow-up (T22 Sec. 80053)</li> <li>- ICF survey – is often annual for 3 days (CFR 483)</li> </ul>	<p>Monitoring and Evaluation of Habilitation Program Services requiring CARF accreditation: Requires reviews 1-3 years depending on conditions of last accreditation. (T17 Sec 58850)</p> <p>For HUD funding, requires annual Management Occupancy Reviews and REAC Inspections every 1-3 yrs depending on the last score</p>
<p><b>Personnel Requirements</b> – variety of requirements by service type</p> <p>Requirement References: T17 Sec. 56722, 56724-56754, 56752, 56037, 56038, 56040</p>	<p>Requirement References: Title 22 Sec. 80065 For ICFs: T 22 Sec.76913, 76891, 76878, 76905, 76863, 76872(k); HSC 1267.11</p>	<p>CARF Recruitment, retention, and qualifications (Section 1 Part I Standards 1-4)</p>
<p><b>Physical Plant</b></p> <p>Regional Center assignment of Facility Liaison for Quality Assurance Monitoring of the Facility (T17 Sec 56048)</p>	<p>Fire Marshall Annual inspections for “protection of residents”, protection of fire workers. Local offices make specific recommendations based on general requirements. Physical plant reviews are part of the annual visits (HSC 1534)</p>	<p>CARF Requirements for accessibility and architectural design (Section 1 Part 2 Standard 2A); HUD Inspection of all aspects of physical plant</p>

<p><b>Developmental Services System – Lanterman Act (WIC), California Regulations Title 17</b></p>	<p><b>Community Care Licensing System and Health Care Licensing -- Health and Safety Code, California Regulation Title 22, Code of Federal Regulation</b></p>	<p><b>Other Entities</b> For Employment Services -Department of Rehabilitation; For affordable housing - HUD -</p>
<p><b>Vendor Ongoing Operations, cont.</b> <b>Staff Training –</b> variety of requirements by service type Requirement References: T17, Sec. 56003, 56033-38, 56723</p>	<p>Requirement References: T22 Sec. 80065 ICF Staff Training Requirements, Medication Training (T22 Sec. 76873(c)-76873(c)(19); Abuse Training [CFR 76876(f)(1)(a-k)]</p>	<p>CARF for Employment: Orientation requires training in 12 different topic areas</p>
<p><b>Program Plan Requirements</b> T17 Sec. 4646 (all) Individual Program Plan/Individual Service Plan requirements for each consumer T17 Sec. 58812 Individual Habilitation Services Plan (IHSP) for work programs</p>	<p>Expectation that the Needs and Services Plan used for service planning (T22 80068.2, 85068.2) ICF Consumer Assessment Process [T22 76859(a)(1)-76859(c)(4)] ICF Consumer Assessment process [CFR 483.440(c)(4)(i)- 483.440 (c)(4)(v)]</p>	<p>Individual Plan for Employment required for employment services funded through Department of Rehabilitation (CCR Title 9)</p>
<p><b>Record Keeping –</b> variety of requirements by service type Requirement References: T 17 Sec. 50603-6, 56059, 56710, 56728, 56730, 56732, 58831, 58811, 58822, 58831, 56714, 56059</p>	<p>Requirement References: T 22 Sec. 54326, 80070; CFR 483.410(c)(1)-483.410(c)(6)</p>	<p>CARF Consumer Records Review and cross references to other CARF Standards (Section 2 Part A Standard 1.1) HUD Review of administrative and client records for accuracy and conformity to federal laws, e.g. fair housing, admissions/discharges, medical procedures, health and safety/crisis procedures, etc.; Review of administrative and client records for accuracy and conformity to federal laws, e.g. fair housing, admissions/discharges, medical procedures, health and safety/crisis procedures, etc.</p>

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<p><b>Developmental Services System – Lanterman Act (WIC), California Regulations Title 17</b> <i>Vendor Ongoing Operations, cont.</i></p>	<p><b>Community Care Licensing System and Health Care Licensing -- Health and Safety Code, California Regulation Title 22, Code of Federal Regulation</b></p>	<p><b>Other Entities</b> For Employment Services -Department of Rehabilitation; For affordable housing - HUD -</p>
<p>Medication Review</p>	<p>T22 Sec. 80075 Requirements for records of medications, physicians and instructions for medications; Sec. 76878(b) 76876(a) ICF Registered Nurse authority requirements</p>	<p>CARF Section 2 Part C Standards 1-4</p>
<p>T17 Sec 4646 Individual Program Plan Review</p>		

**Key:**

California Code of Regulations Title 17: Contains regulations promulgated under the Lanterman Act by the Department of Developmental Services affecting specific providers of services to people with developmental disabilities.

California Code of Regulations Title 22: Contains regulations promulgated by Department of Social Services which apply to all community care facilities regulated by the Community Care Licensing Division. Also contains regulations promulgated by the Department of Public Health which apply to Intermediate Health Care residential facilities.

Lanterman Act, California Welfare and Institutions Code: defines the rights of persons with developmental disabilities and establishes how services will be delivered.

CARF: A private national monitoring entity. Department of Rehabilitation requires CARF accreditation for vendors

HUD: Housing and Urban Development regulates funded affordable housing.

Code of Federal Regulation: codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government.

Rehabilitation Act of 1973: authorizes grants to States for vocational rehabilitation services, with special emphasis on services to those with the most severe handicaps

California Health and Safety Code: Contains the state code covering the subject areas of health and safety including the Departments of Social Services and Public Health.

**ATTACHMENT**  
**Reference Document**

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**Table of statutes & regulations affecting service provider agencies in the Department of Developmental Services (DDS) system RECORD REVIEW**

Requirement Source	Sections	Information Required
Title 17 – Administrative	50603-6	Descriptions of Service Provider accountability and requirements
	56013, 56712	Program Design requirements
	56036	Training Plans required
	56059	Residential Services Records
	56047	Quarterly visits w consumer re IPP progress includes review of facility notes and reports on consumer and permits review of facility records and accounts re consumer cash and property.
Title 17 – Consumer	56048	Facility Liaison Quality Assurance (QA) Monitoring of the Facility
	56710	General requirements for non-residential programs
Title 22 – Administrative	56728	Program record requirements
	56730	Consumer record requirements
	56732	Requires conducting own effectiveness review which includes record reviews
	58615	Description of record requirements for Supported Living Services
	58831, 58811	Description of record requirements for Habilitation services
Title 22 – Administrative	58822	Description of record requirements for Work Activity Programs
	58831	Description of record requirements for Supported Employment
	56714	Description of record requirements for Day Programs
	56084	Description of record requirements for Family Home Agencies
	80022	Plan of Operation provides description of record requirements
CARF	Section 1 Part M Standards 1-4	Description of demographic information and business functions
HUD	Management Occupancy Review	Review of administrative and client records for accuracy and conformity to federal laws, e.g. fair housing, admissions/discharges, medical procedures, health and safety/crisis procedures, etc.
Health and Safety Code	56048	Facility Liaison Quality Assurance (QA) Monitoring of the Facility
	56059	Residential Services Records
Title 22	1268.6	ICF orientation requirement
	76857-76857(a)(11)(C)	ICF Program Plan Requirements
Code Federal Regulation	76859(a)(1)-76859(c)(4)	ICF Consumer Assessment Process
	483.440(c)(4)(i)- 483.440(c)(4)(v)	ICF Consumer Assessment process
Code Federal Regulation	483.410(c)(1)-483.410(c)(6)	ICF: Description of Consumer Records

**RECORD REVIEW (CONTINUED)**

Title 17	54326	General Requirements for Vendors including records
Title 22 – Consumer	80070	Record requirements for personnel, Needs and Services Plan, Registry of Clients, Plan of Operation, Eviction Notice, Admissions Agreement, Safeguarding cash, etc.
CARF	Section 2 Part A Standard 11	Consumer Records Review and cross references to other CARF Standards
HUD	Management Occupancy Review	Review of administrative and client records for accuracy and conformity to federal laws, e.g. fair housing, admissions/discharges, medical procedures, health and safety/crisis procedures, etc.
Lanterman Law	4648.1 (a) & (b)	DDS & RCs involved in monitoring or auditing services provided to the regional centers' consumers by a service provider shall have access to the provider's grounds, buildings, and service program, and to all related records.

**VISITS/REVIEW PROCESSES**

Title 17	56047	Requires RC quarterly visits with consumer to review the consumer's progress towards achieving IPP objectives – at least two of these meetings must take place at the consumer's residence to review consumer funds and the facility
	56078	Requires an annual monitoring visit by regional center
	50821-3	Requires review of any Behavior Plans that could cause pain, trauma or involve ECT
	58850	Monitoring and Evaluation of Habilitation Program Services
	56095	Monitoring and sanctions of Family Home Agencies
	56103	Intermediate Care Facility (ICF); ICF/Developmentally Disabled (ICF/DD); ICF/DD-Habilitative (ICF/DD-H); ICF/DD-Nursing (ICF/DD-N); Skilled Nursing Facility (SNF) Monitoring Requirements
	58680(a)(2)	Requires at least quarterly face-to-face meeting with each SLS consumer and, when appropriate, the consumer's personal advocate. The meeting shall occur in the consumer's home, except when the consumer withholds permission;
Health and Safety Codes	1526.5	Requires a visit for pre-licensing and post licensing (within 90 days)
	1534	Requires annual visit
	1538	Requires a visit within 10 days of a complaint
Title 22	80053	Requires a visit for follow up on Plan of Correction and for a case management visit as needed
CARF	58850	Monitoring and Evaluation of Habilitation Program Services requiring CARF accreditation. Requires reviews from every year to once in three years depending on conditions of last accreditation.
Lanterman Law	4648.1	Allows for regional center review of programs as needed - with or without prior notice. Also requires that not less than two of the required (Title 17 56047) four monitoring visits to consumers in licensed long-term health care or community care facility or family home agency home each year shall be unannounced.

**VISITS/REVIEW PROCESSES (CONTINUED)**

Lanterman Law	4648.1(i)	Effective July 1, 2009, a regional center shall not be required to perform triennial evaluations of community care facilities, as described in Sections 56046, 56049, 56050, 56051, and 56052 of Title 17 of the California Code of Regulations.
Lanterman Law	4684.70	ARFPSHN_ 962 Homes RC licensed registered nurse to make monthly visits
Lanterman Law	4689.1(e)(9)	Family Home Agency homes and Teaching Homes – monthly monitoring visits by the FH Agency social services staff
Lanterman Law	4743	Legislative Intent -- to the greatest extent possible, the staff of the regional center are assigned so as to minimize the number of persons responsible for programs provided in a given facility.
Code Federal Regulation	483.400-483.480	ICF Conditions of Participation
Code Federal Regulation	456.600	ICF Inspection of care: survey details
HUD	Management Occupancy Review and REAC Inspections	For any property with HUD funding, requires annual Management Occupancy Reviews and REAC Inspections (physical) from every year to once in three years depending on the last REAC score
Health and Safety Code	1266.12 (b)	ICF Initial Certification Survey
Code Federal Regulation	442.108-442.109	ICF Certification requirements

**MEDICATION REVIEW**

Title 17	56001	Regional centers use Title 22 as part of Quality Assurance Review regarding medication
Lanterman	56090(b)(5-6)	Medications reviewed annually by regional centers for Family Home Agencies
	4684.5-7	Medications are always reviewed as part of the Individual Program Plan reviews
Title 22	80075	Medication review for "962" homes
CARF	Section 2 Part C Standards 1-2	Requirements for records of medications, physicians and instructions for medications Medication monitoring
	Standard 3	Information to be provided
	Standard 4	Psychologist needs to review
Title 22	76878(b) 76876(a)	ICF RN authority Requirements

**PHYSICAL PLANT**

Title 17	56001-56060	Quality Assurance reviews based on requirements in Title 22 including physical plant
Title 22	80087	Requirements for Buildings and grounds
	80088	Requirements for fixtures and equipment
	80075	Requirements for first aid kits
CARF	Section 1 Part 2 Standard 2A	Requirements for accessibility and architectural design
	Section 2 Part D Standard 9	Requirements for tools and equipment
HUD	REAC	Inspection of all aspects of physical plant
Fire Marshall		Annual inspections for "protection of residents", protection of fire workers. Local offices make specific recommendations based on general requirements.
Health and Safety Code	1267.8, 1267.13	ICF Fire Safety Standard
NFPA Codes		ICF Required Fire System Maintenance
Code Federal Regulation	483.470(j)	ICF Standard Fire Protection
Code Federal Regulation	483.470(h)	ICF: Standard Emergency Plan and Procedure
Lanterman Law	4648.1 (a) & (b)	DDS & RCs involved in monitoring or auditing services provided to the regional centers' consumers by a service provider shall have access to the provider's grounds, buildings, and service program, and to all related records.

**TRAINING**

Title 17	56033	Direct Care Staff Competency-Based Training and Testing Requirements
	56726	Requirements for new staff training
	56036	Requirements for provider training plan
	56038	Direct Care Staff Qualifications and Continuing Education Requirements
	56037	Administrator Qualifications and Continuing Education
	58650-4	Training requirements for Supported Living Services
	56083	Training requirements for Family Home Agencies
	56774	Training requirements for Infant programs
	56794	Training requirements for respite programs
	56003	Residential services orientation
Title 22	85064	Administrator certification requirements
	80065	Training requirements for on the job
CARF	Sec 1 Pt 1 Std 5	Orientation requires training in 12 different topic areas. Other standards mention training in specific areas.

**TRAINING (Cont.)**

Title 22	76873(c)- 76873(c)(19)	ICF Staff Training Requirements
Title 22	76876(f)(1)(a-k)	ICF Medication Training Program
Code of Federal Regulations	483.420(d)(1) 483.430(e)(1)	ICF Abuse Training
Lanternman Act	4695	Uniform statewide training program for directors or licensees of residential facilities to be offered by DDS w Community Colleges
Lanternman Act	4695.2	Requires direct care staff at CCFs to complete competency based training

**PERSONNEL**

Title 17	56722	Personnel requirements for non-residential services
	56724-56754	Personnel Functions and Qualifications
	56752	Personnel requirements
	56037	Administrator Qualifications and Continuing Education
	56038	Direct Care Staff Qualifications and Continuing Education Requirements
	56040	Consultant requirements
	56784(a)(8)	Personnel requirements for Family Home Agencies
	56790-2	Personnel requirements for In Home Respite providers
	54342	Requirements for Behavior Analyst
Title 22	80065	Personnel requirements
	85065	Audit requirements
	80064	General Requirements
	85064	Community Care Facilities requirements
CARF	Section 1 Part I Standards 1-4	Human Resources – Recruitment, retention, and qualifications
Health and Safety Code	1267.11	ICF Direct Care Staff Requirements
Title 22	76872	ICF ID Team Requirements
Title 22	76913,76891,76878,76905,76863, 3,	ICF Professional staff/Consultant requirements
Federal Regulation	w348,w170,w173,w175,w176,w 177	ICF Consultant requirements
Title 22	76872(k)	ICF Direct Care Staff requirements
H & S code	1267.11	ICF Direct Care Staff requirements

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**INCIDENT REPORTING**

Title 17	54302, 54327	Requirements for reporting for Vendors
	54327.1	Requirements for regional centers reporting to the Department of Developmental Services
	54327.2	Responsibilities of Risk Management Committee regarding Incident Prevention
Title 22	80061	Reporting Special Incidents by Community Care Facilities
Welfare and Institutions Code	15600-01	Requirements for reporting suspected abuse of adults with developmental disabilities (dependent adults)
Penal Code	11164-11174.3	Requirements for reporting suspected abuse of children
CARF	Section 1 Part H Standards 7-8	Procedures for reporting incidents
Health and Safety code	1265.5	ICF Criminal Record oversight
Welfare and Institutions code	15630	Reporting Requirement for Mandated reporter
Code Federal Regulation	483.420(1)(6) 483.420(d)(2) 483.420(d)(4)	ICF Abuse Reporting Guidelines

**COMPLAINT PROCESS**

Title 17	56053	Procedures for Immediate Danger
	56054	Process for Substantial Inadequacies
	56056	Filing a Corrective Action Plan and follow up
	56057	Applying sanctions to service providers
	56104	Suspension of placements
	56105	Termination of Consumer placement
	54370	Termination of Vendorization
	56718	Termination of funding
	56061-7	Vendor appeals for residential
	54380-4	Vendor appeals
	56095	Monitoring and sanctions for Family Home Agencies
	56096	Appeals by Family Home Agencies
Title 22	80040	Denial of application and appeals; citation for noncompliance; revocation of license; probationary status; suspension and immediate revocation
	80054	Civil penalties

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**COMPLAINT PROCESS (Cont.)**

Lanternman Law	4648.1	Providers shall be informed of their rights established in regulations adopted pursuant to Sections 4648.2, 4748, and 4780.5, to appeal actions taken by regional centers or the department as a result of their monitoring and auditing findings.
Lanternman Law	4648.2	DDS shall promulgate regulations with a process for service providers to appeal actions the department takes as a result of its auditing and monitoring activities.
CARF	Section 1 Part K Standards 4-5	Clients rights complaint to the organization; outlines non-accreditation status and accreditation that is less than the 3 year review period; policies and procedures established regarding public information, announced or unannounced visits; modification of accreditation; suspension; appeal
Code Federal Regulation	483.420(a)(3)	ICF Client Right to file complaints





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## FACT SHEET

### DEVELOPMENTAL DISABILITIES ASSISTANCE AND BILL OF RIGHTS ACT (D.D. ACT)

#### **Background**

The Developmental Disabilities Assistance and Bill of Rights Act (DD Act) is the fundamental law supporting and enhancing the lives of people with developmental disabilities and their families. For over 30 years, the DD Act has enjoyed strong bipartisan support. It was last authorized in 2000.

The DD Act focuses on the estimated 5 million children and adults in the United States and territories who have developmental disabilities. The Act provides federal financial assistance to states and public and nonprofit agencies to support community-based delivery of services to persons with developmental disabilities to create and enhance opportunities for independence, productivity, and self-determination. The DD Act consists of four programs that create an intersecting network. Grant funds support initiatives in civil rights protections, education and early intervention, child care, health, employment, housing, transportation, recreation, family support, and other services. The DD Act components are: State Councils on Developmental Disabilities (DD Councils)

Councils on Developmental Disabilities are located in every State and Territory and include volunteers who are appointed by Governors. More than 60% of these volunteers must be people with developmental disabilities or family members. Councils are charged by Federal law to identify the most pressing needs of people with developmental disabilities in their State or Territory and to develop innovative and cost effective ways to address those needs in a manner that upholds the dignity and value of people with developmental disabilities. Councils work to promote the independence and productivity of people with developmental disabilities and promote systems change that will eliminate obvious inequities in areas such as education, access to healthcare and employment.

#### **Protection and Advocacy (P&A) systems**

Under the Protection and Advocacy for Persons with Developmental Disabilities (PADD) program, P&As are required to pursue legal, administrative, and other appropriate remedies under all applicable federal and state laws to protect and advocate for the rights of individuals with developmental disabilities. Collectively, the P&A network is the largest provider of legally based advocacy services to people with disabilities in the United States. The federally mandated P&As serve individuals with a wide range of disabilities by guarding against abuse; advocating for basic rights; and ensuring accountability in health care, education, employment, housing, transportation, and within the juvenile and criminal justice systems. University Centers for Excellence in Developmental Disabilities (UCEDDs)

The DD Act authorizes core funds to 67 UCEDDs, at least one in every state and territory, that are components of a university system or are public or not-for-profit entities associated with universities. UCEDDs provide interdisciplinary training to students and professionals, engage in cutting-edge research, provide technical assistance, and direct services and supports to people with disabilities of all ages and their families. UCEDDs share information and research findings.

#### **Projects of National Significance (PNS)**

PNS is a discretionary program that focuses on emerging areas of concern. This program supports local implementation of practical solutions and provides results and information for possible national replica-

tion. PNS also supports technical assistance; research regarding emerging disability issues; conferences and special meetings; and the development of federal and state policy. Additionally, funding is provided for states to create or expand statewide systems change.

### **Family Support Programs**

Over 75% of people with ID/DD live with families, often with aging parents. However, families and caregivers often struggle to access any level of formal support. Title II of the DD Act authorizes the Family Support Program to promote and strengthen the implementation of comprehensive State systems for in-home supports for families caring for individuals with disabilities. Family support services are effective in reducing the costs associated with life-long disability, and in preventing the expense of out-of-home placement. The Family Support program should be expanded with a state funding formula based on need.

### **Action Taken by Congress and the Administration**

No bills have been introduced to reauthorize the DD Act to date. The Administration on Developmental Disabilities (ADD) has held nationwide listening sessions to gather input in preparation for the reauthorization. ADD will hold a number of regional summits on self-advocacy this year. The National Council on Disability will soon publish its report on progress made by DD Act programs: *Rising Expectations: The Developmental Disabilities Act Revisited*.

### **Recommendations**

The 112th Congress should work toward timely reauthorization of the DD Act that:

- *Increases the authorization for appropriations for all programs authorized under the DD Act;*
- *Reauthorizes the Title III Program for Direct Support Workers to address the direct support work force shortage and improve the recruitment, training, support, and retention of a qualified direct service professional workforce in each state;*
- *Reauthorizes and funds the Title II Family Support program and provides a formula grant to every state and territory with a separate authorization and appropriation line item;*
- *Protects and expands the authority of Protection and Advocacy Systems to investigate abuse, neglect, and deaths and to pursue class action litigation on behalf of our constituents wherever they live; and*
- *Support federal funding for self-advocacy leadership activities directed by self-advocates with appropriate organizational and infrastructure supports.*

### **Relevant Committees**

House and Senate Appropriations Committees  
House Energy and Commerce Committee  
House Education and Labor Committee  
Senate Health, Education, Labor and Pensions Committee

For more information, please contact The Arc and United Cerebral Palsy Disability Policy Collaboration (202) 783-2229, Association of University Centers on Disability (301) 588-8252, American Association on Intellectual and Developmental Disabilities (202) 387-1968, National Association of Councils on Developmental Disabilities (202) 506-5813 or Self Advocates Becoming Empowered (802) 760-8856.

2/2/2011



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## FACT SHEET EMPLOYMENT

### Background

Working age people with disabilities are among the most unemployed and underemployed segments of our society. The United States Bureau of Labor Statistics (BLS) reported that in January 2010, the percentage of people with disabilities in the labor force was 21.8% compared with 70.1% for persons with no disability. Far too many people with intellectual and developmental disabilities are underemployed, are in segregated settings, and earn very little money. For example, according to the Government Accountability Office, 424,000 people are earning less than the federal minimum wage and of that number about 74% are people with intellectual disabilities. According to the Census Bureau, weekly wages for people with any disability decreased from \$353 in 2000 to \$288 in 2006. Weekly wages for people with an intellectual or developmental disability decreased from \$234 in 2000 to \$188 in 2006. In 2007, the state Developmental Disability Agencies provide day or employment supports to an estimated 566,895 individuals yet only 115,239 individuals were supported in integrated employment. The reasons for these problems are complex, often tied to limited exposure to the workforce, reduced expectations, lack of access to jobs and competing federal policies regarding the employment potential for persons with disabilities.

The state vocational rehabilitation (VR) program is significantly under-funded to meet the employment needs of hundreds of thousands of individuals with significant disabilities who need these services to obtain and retain employment. Many individuals with disabilities could also greatly benefit from the employment and training services delivered through the Workforce Investment Act (WIA) One-Stop system. However, physical and programmatic access to WIA services is inconsistent for individuals with disabilities, despite Federal requirements that such services be accessible.

Even given the current economic downturn, with the declining birth rate as well as the aging of the current workforce, it has become more apparent that there will be a shortage of workers to meet employer demands in the coming decade. We must ensure that all people who want to work have the training and support they need to be employed.

In each of the past three Congresses, bills to reauthorize WIA and VR have been introduced or discussed. A number of good provisions were included in these bills, namely strengthening transition services for special education students, expanding supported employment services and improving physical and programmatic access to one-stops.

### Action Taken by Congress and the Administration

Legislation to reauthorize WIA and Vocational Rehabilitation has yet to be introduced in the 112th Congress. It was last reauthorized in 1998.

### Recommendations

The 112th Congress should:

- Place a high priority on reauthorizing the Workforce Investment Act (WIA) and the Rehabilitation Act;
- Expand supported employment services and create a new competitive grant program for youth with the most significant disabilities;

- Support innovative strategies to assist persons with developmental and other significant disabilities in entering competitive, integrated employment with appropriate supports and services;
- Improve transition services by strengthening the VR role in the transition from school to adult life for students with disabilities, particularly requiring VR counselors to actively participate in the IEP (Individualized Education Program) process.
- Assure that people with disabilities have physical and programmatic access to the WIA system;
- Support employment first strategies, policies and practices that target integrated employment at minimum wages or above for all individuals with developmental and other significant disabilities
- Support the utilization of national and community service opportunities in transition and vocational planning for individuals with disabilities as a gateway to integrated employment.
- Ensure that people with disabilities are fully included in any efforts to create jobs and stimulate the economy.

### Relevant Committees

House Appropriations Committee  
House Education and Labor (WIA and VR)  
Senate Appropriations Committee  
Senate Health, Education, Labor and Pensions (WIA and VR)

For more information, please contact The Arc and United Cerebral Palsy Disability Policy Collaboration (202) 783-2229, Association of University Centers on Disability (301) 588-8252, American Association on Intellectual and Developmental Disabilities (202) 387-1968, National Association of Councils on Developmental Disabilities (202) 506-5813 or the Self Advocates Becoming Empowered (802) 760-8856.

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## FACT SHEET EDUCATION

### Background

The U.S. Congress may complete work on two key education laws in 2011: the Elementary and Secondary Education Act (known as No Child Left Behind) and legislation to limit the use of restraint and seclusion in schools. Both pieces of legislation impact the education of students with disabilities.

### Elementary and Secondary Education Act

The Elementary and Secondary Education Act (ESEA), called "No Child Left Behind" in its last reauthorization, requires that all students in elementary and secondary schools be assessed to determine educational progress by individual schools and school systems. The disability community continues to support ESEA because the law requires the inclusion of all students with disabilities in the student achievement system. ESEA's authority expired in September 2007, and Congress is expected to begin work on reauthorization this year.

There has been much controversy about how to measure educational progress for students with disabilities, a population that is frequently blamed by educators for their schools' poor test scores. The Bush Administration responded to these criticisms by adopting two regulations aimed exclusively at certain students with disabilities. The first rule allows up to 1% of all students (10% of special education students) with significant cognitive impairments to be assessed using alternate assessments based on alternate standards. The other rule, not yet fully implemented, allows for assessments based on modified achievement standards aligned to the general curriculum for those students with disabilities (up to 20%) who can make progress toward, but may not reach, grade-level achievement standards in the same time frame as other students. The U.S. Department of Education has also allowed the states to employ so-called "growth models" to assess student performance by measuring a student's progress within a certain time-frame.

The Obama Administration released its blueprint for ESEA reauthorization in March 2010; it proposes providing incentives for states to adopt academic standards that prepare students to succeed in college and the workplace and create accountability systems that measure student growth toward meeting the goal that all children graduate and succeed in college or the workplace. Although the Administration acknowledges that the primary funding for programs that support students with disabilities is through the Individuals with Disabilities Education Act (IDEA), it promises that its ESEA proposal will "increase support for the inclusion and improved outcomes of students with disabilities".

### Restraint & Seclusion

Both chambers introduced legislation to limit the use of restraint and seclusion in schools during the last Congress. Research and recent reports show that restraint and seclusion in education are often unregulated and used disproportionately on children with disabilities, frequently resulting in injury, trauma, and even death. In January 2009, the National Disability Rights Network issued a report detailing the harmful use of these interventions in over two-thirds of states, involving children as young as three years old in both public and private school settings. Following that report, the Government Accountability Office (GAO) conducted an investigation finding no federal laws restricting the use of these interventions in schools, and that state laws vary widely if they exist at all.

Restraint and seclusion are often used for behaviors that do not pose danger or threat of harm and implemented by untrained school personnel. Students are not the only ones injured by restraint and seclusion; school personnel have suffered significant injuries while implementing these techniques. The use of restraint and seclusion can be traumatizing for everyone involved, including the students who witness it. Numerous alternatives to restraint and seclusion exist, including positive behavioral interventions and supports and other de-escalation techniques that could prevent the need for these dangerous interventions in many circumstances.

The Keeping All Students Safe Act (H.R. 4247, S. 3895) was passed by the House of Representatives in March 2010 but was never considered in the Senate. New legislation must be introduced in the 112th Congress, and the issue could be addressed within the reauthorization of ESEA.

The previously-introduced versions of the bill were very similar. They aimed to establish federal minimum safety standards to limit the use of restraint and seclusion in public and private early childhood, elementary and secondary schools that receive support from federal education funds, as well as Head Start programs. The bills would have banned the use of the worst types of restraints and limited the use of restraint and seclusion to emergency situations where physical injury is imminent and less restrictive interventions would be ineffective in controlling the student's behavior. Additionally, the bills would have required continuous monitoring of students while being restrained or secluded, parental notification any time restraint and seclusion are used, and training and certification of school personnel who implement these techniques to do so safely and use alternative interventions when possible.

#### **Action Taken by Congress and the Administration**

House and Senate leaders have not introduced any bills to reauthorize ESEA and no hearings have been scheduled.

#### **Recommendations**

The 112th Congress should:

##### **Elementary and Secondary Education Act (ESEA):**

- *Ensure that any changes to ESEA do not negatively impact students with disabilities, such as using the student's IEP for purposes of assessing adequate yearly progress;*
- *Require closer coordination of ESEA and IDEA policies;*
- *Substantially increase authorized funding for teacher preparation in the ESEA.*

##### **Restraint and Seclusion legislation:**

- *Pass legislation limiting the use of restraint and seclusion in schools, including personnel training and certification requirements, parental notification requirements, and bans on the most dangerous types of restraint.*

#### **Relevant Committees**

House Education and Workforce Committee

Senate Health, Education, Labor and Pensions (HELP) Committee

For more information, please contact The Arc and United Cerebral Palsy Disability Policy Collaboration (202-783-2229), Association of University Centers on Disabilities (301-588-8252), American Association on Intellectual and Developmental Disabilities (202-387-1968), or National Association of Councils on Developmental Disabilities (703-739-4400).

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## FACT SHEET HOUSING

### Background

Being part of the community and living as independently as possible are among the most important values and goals shared by people with disabilities, their families, and advocates. People with developmental and related disabilities face a severe crisis in the availability of decent, safe, affordable, and accessible housing. Today many still live in large congregate facilities or other inappropriate places like institutions. Over 700,000 people with developmental disabilities live with aging parents (one of whom is over age 65). For people who use wheelchairs or other mobility devices, finding housing with even basic accessibility features (e.g. an entrance with no steps) ranges from daunting to impossible.

The affordability gap for people with disabilities has exponentially worsened in recent years. According to Priced Out in 2008, on a national average, over 4 million Americans with disabilities who rely on federal monthly Supplemental Security Income (SSI) of \$674 for all their basic needs would have to pay 112.1 percent of their entire monthly income to rent a modest one-bedroom unit. The cost of renting a smaller studio/efficiency unit is 99.3% of monthly SSI.

In a huge victory for the disability community, the Frank Melville Supportive Housing Investment Act (The Melville Act) was enacted on January 4, 2011. The Melville Act makes a number of important changes designed to streamline the Housing and Urban Development (HUD) Section 811 program in order to increase the supply of integrated supportive housing opportunities for people with disabilities. Lead co-sponsors of this overwhelmingly bi-partisan legislation included Representative Christopher Murphy (D-CT) and Representative Judy Biggert (R-IL) as well as Senator Bob Menendez (D-NJ) and Senator Mike Johanns (R-NE).

### The Melville Act Improves the Section 811 program.

The reformed Section 811 program will be able to create thousands more units of integrated permanent supportive housing every year by:

- Streamlining the administrative processes for non-profit housing developers.
- Creating a new "Project Rental Assistance Contract (PRAC) only" option within 811 that will allow states to use project-based assistance to integrate supportive housing into larger rental housing developments. (The PRAC ensures affordability by paying the housing operating costs (maintenance, insurance, certain utilities, etc) that are not covered by tenant rents.)
- Allowing 811 capital financing and project-based operating subsidies to be used in multifamily developments, and
- Authorizing a shift of funding for renewal of 811 "mainstream" tenant-based rental assistance out of 811 into the Section 8 account.

### Section 8 Rental Assistance – The Housing Choice Voucher Program

The Section 8 Housing Choice Voucher program bridges the gap between income and rent by paying the difference between what a very low-income household can afford (e.g., 30 percent of income) and modest rental housing costs. An estimated 2.1 million Housing Choice Vouchers have been created by Congress since the program began in the mid-1970s. However, as many as 2.4 million non-elderly adult

renter households with disabilities are currently paying more than 50 percent of their income for housing and/or are living in substandard housing. Hundreds of thousands of other individuals with disabilities are living unnecessarily in institutional settings or are at-risk of institutionalization because they live at home with aging parents. These individuals need a Housing Choice Voucher to afford safe, decent housing of their own in the community.

### **The National Affordable Housing Trust Fund Act**

This 2008 law was enacted to develop 1.5 million new units of rental housing affordable to very low-income and extremely low-income households. It creates the first new federal housing production program specifically targeted to extremely low income households since the Section 8 Housing Choice Voucher program was created in 1974. It has not yet received any appropriations.

### **Action Taken by Congress and the Administration**

No bills have been introduced and no hearings have been held.

### **Recommendations**

- *Support the full implementation of the Frank Melville Supportive Housing Investment Act which reforms the HUD Section 811 Supportive Housing for Persons with Disabilities program. Provide at least level funding of \$300 million for the FY 2012 Section 811 program, which will create as many as 3,000 new supportive housing units – triple the number created during the last competitive funding round.*
- *Provide full funding for the Housing Choice Voucher program in FY 2011 to ensure that all Housing Choice Vouchers can be renewed and that no tenants are displaced.*
- *Provide \$30 million in funding for new Housing Choice Vouchers targeted to non-elderly people with disabilities who are institutionalized or at-risk of institutionalization.*
- *Provide \$1 billion for the National Affordable Housing Trust Fund.*

### **Relevant Committees**

House & Senate Appropriations Committees  
House Financial Services Committee  
Senate Banking Committee

For more information, please contact The Arc and United Cerebral Palsy Disability Policy Collaboration (202) 783-2229, Association of University Centers on Disability (301) 588-8252, American Association on Intellectual and Developmental Disabilities (202) 387-1968, National Association of Councils on Developmental Disabilities (202) 506-5813 or the Self Advocates Becoming Empowered (802) 760-8856.

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## FACT SHEET MEDICAID AND MEDICARE

### Background

The federal/state Medicaid program provides critical health and long term services and supports for people with severe disabilities. The federal Medicare program provides health insurance to approximately 8 million Americans with disabilities under the age of 65. Combined, these two programs provide health coverage and long-term services and supports to roughly one-third of the estimated 53 million people with intellectual, developmental, physical, and/or mental disabilities in the United States. In addition, Medicaid and Medicare providers employ many professionals, paraprofessionals, and direct support workers throughout our nation.

### Federal Medical Assistance Percentage (FMAP)

States across the country are facing huge budget deficits due to the economic downturn of the last few years. Many states are required by their own laws to balance their budgets and, as a result, have cut many human services programs. Almost all states have chosen to cut Medicaid services for people with disabilities. For example, many states have reduced the number of hours for home health aides for people with developmental disabilities. In February 2009, the American Recovery and Reinvestment Act (ARRA - known as the economic stimulus bill) was enacted. It included a two-year \$87 billion increase in the federal share of Medicaid spending (known as the FMAP). This temporary FMAP increase has provided needed relief to state Medicaid programs, averting more severe cuts in health care and other critical services that allow people with disabilities to live in their communities. In August 2010, the FMAP increase was extended at gradually reducing levels for an additional six months until June 30, 2011.

### Maintenance of Effort on eligibility

One legislative battle this year will involve the maintenance of effort on eligibility requirements for the Medicaid program established by the Affordable Care Act (ACA), otherwise known as "health reform". The ACA requires states to maintain at least their current Medicaid eligibility criteria through 2014 (when the health reform law's Medicaid expansion and higher federal Medicaid matching payments will take effect). Recently, every Republican governor signed a letter to President Obama and to the Congressional leadership calling for an end to this provision.

### Deficit Reduction

Several proposals to reduce the federal deficit have included a number of entitlement cuts which would have had a very negative impact on people with disabilities. The National Commission on Fiscal Responsibility and Reform (often referred to as the "Deficit Commission") proposed several cuts to Medicaid. These included: eliminating the provider tax payment method used by states to increase the federal Medicaid match; cuts to administrative services reimbursement; placing dual Medicaid and Medicare eligibles in managed care; and the possibility of a Medicaid block grant. The Deficit Commission also proposed significant cuts to the Medicare program and increased cost-sharing for beneficiaries. These recommendations are premised on the belief that Medicare beneficiaries use too much health care and need to pay more for it.

Finally, there have been proposals to put global caps on federal expenditures for health care spending. If such caps were imposed, they would likely put pressure on these programs to move away from an individual entitlement. They could also result in a block grant for Medicaid and health care vouchers to replace Medicare. This is a fundamental shift in our health and long term services and supports system from services mostly based on eligibility to services based on a set budget.

### **Action Taken by Congress and the Administration**

The House of Representatives passed H.R. 2 to repeal the ACA in January. It is unlikely that the Senate will pass similar legislation. It is expected that the House will pass bills to repeal various sections of the ACA this session of the 112th Congress.

### **Recommendations**

The 112th Congress should:

- *Protect the individual entitlement to Medicare and Medicaid.*
- *Extend the temporary FMAP increase until 2014 when the new Medicaid expansion takes effect.*
- *Ensure that cost savings proposals such as reducing Medicaid spending and raising Medicare cost-sharing do not have a disproportionate impact on people with disabilities.*
- *Oppose removing the maintenance of effort on eligibility provision in the ACA for Medicaid.*

### **Relevant Committees**

House and Senate Budget  
House Ways and Means and Energy and Commerce  
Senate Finance

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## FACT SHEET SOCIAL SECURITY

### Background

Social Security provides benefits to over 53 million individuals, including at least 11 million people with disabilities, their spouses, and children. Any changes in Social Security will affect everyone who receives benefits. While most people think of Social Security only as a retirement program, over one-third of people who receive monthly checks are not retirees.

People with disabilities receive benefits from all three programs commonly called "Social Security" - the Old Age, Survivors, and Disability Insurance (OASDI) programs established in Title II of the Social Security Act. These are insurance programs covering people who retire, die, or become disabled. The benefits are designed to insure against poverty in retirement years and when disability may limit the ability to work and to protect dependent survivors. When workers become disabled, retire or die, their spouses and children receive benefits based on the earnings record of their parent or spouse. People with disabilities and their families who receive Social Security include a wide range of individuals:

- *Disabled workers and their dependents,*
- *Retirees with disabilities (not counted in the 11 million),*
- *Disabled dependents of retirees,*
- *Disabled survivors, and*
- *Disabled adult children and disabled widow(ers).*

Funding for the OASDI Social Security programs comes from two Trust Funds which are funded with payroll taxes (FICA taxes) paid by employees and employers. The goal is for the Social Security Trust Funds to be able to pay benefits over the long term – to be solvent for at least the next 75 years.

Future Challenges for the Trust Funds: Social Security is currently running a planned surplus to address the retirement and disability needs of the baby boom generation. According to the Social Security Trustees 2010 Report, the surplus is at \$2.6 trillion and is expected to grow to \$4.2 trillion by the end of 2024. To meet all financial obligations over the next 75 years, the Trust Funds show a projected short-fall of less than one percent of the Gross Domestic Product (GDP). Previous Trustee forecasts made similar projections. In later years, when the surplus has been spent, Social Security will be able to pay reduced benefits from the taxes it collects. According to a July 2010 Congressional Budget Office Report, Social Security can pay full scheduled benefits until 2039; 80 percent of scheduled benefits in 2040; and 76 percent in 2084. Social Security will not be bankrupt: the program is not in crisis and no drastic changes are needed now.

As a result of the current deep recession, Social Security's income is down. However, this is not expected to have a long term effect on the program's solvency.

People with disabilities and their families have an enormous interest in any proposed Social Security changes. These issues are bipartisan; all policymakers must address the concerns of people with disabilities and their families.

Improvements Needed to Supplemental Security Income (SSI) and Social Security Disability Programs: There remain many issues in the SSI and Social Security disability programs which need to be addressed in order to make the programs work better to meet the needs of people with disabilities. These include: increasing the substantial gainful activity (SGA) level for people who are disabled (currently \$1,000 per month)

to the level for people who are blind (currently \$1,640 per month); increasing, and indexing for inflation, the asset limits and income exclusions for SSI; eliminating marriage penalties for people with disabilities; eliminating the two-year waiting period for Medicare; making needed improvements to work incentives; and addressing policy issues which have a harsh impact on people eligible for Title II benefits as disabled adult children.

In its quest to find solutions to the federal fiscal crisis, the National Commission on Fiscal Responsibility and Reform has made a number of recommendations for changes to the Social Security system, despite the fact that the Social Security system has accumulated a significant surplus. In addition, a number of private commissions and Members of Congress have also put forward several proposals to make changes to the Social Security programs. The various proposals include combinations of eligibility and benefits changes and revenues increases. Many of the proposals would be harmful to people with disabilities and their families.

### **Action Taken by Congress and the Administration**

In his State of the Union speech, President Obama called for finding a bipartisan solution to strengthen Social Security for future generations without putting at risk current retirees, the most vulnerable, or people with disabilities; without slashing benefits for future generations; and without subjecting Americans' guaranteed retirement income to the whims of the stock market. Members of Congress have begun debate on Social Security issues in floor statements.

### **Recommendations**

- *Congress should ensure the long term solvency of the Social Security Trust Funds by making modest adjustments that spread the costs widely while preventing privatization or depletion of the Social Security Trust Funds.*
- *Congress should request a beneficiary impact statement on every major component of proposals to change Social Security. For a program that affects millions of individuals of all ages, it is essential to look beyond the budgetary impact to understand the actual impact on people's daily lives now and in the future.*
- *Congress should address the many areas in which improvements are needed in the SSI and Social Security disability programs.*

### **Relevant Committees**

House Ways and Means Committee  
Senate Finance Committee

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## FACT SHEET

### FEDERAL BUDGET AND APPROPRIATIONS FOR FY 2011 AND 2012

#### Background

#### FY 2011 Funding

The outlook for various federal programs and systems of supports for citizens with disabilities looks grim at the outset of the 112th Congress as leaders lay out proposed strategies for reducing the federal deficit, shrinking the size of government, and slashing federal spending.

With none of the 12 annual appropriations bills for the current year (Fiscal Year 2011) signed into law, Congress extended the current funding levels for federal programs in a Continuing Resolution (CR) through March 4th. House Republican leaders plan to use the next CR as a vehicle to impose deep cuts in domestic discretionary programs and to defund implementation of key elements of the health reform law. Appropriators may begin writing a new omnibus appropriations bill for FY 2011 which began October 1, 2010. Whether the House and Senate can negotiate a compromise agreement – and whether the President will veto the appropriations bill if it is too extreme and thereby set up a confrontation over a potential government shutdown – remains to be seen. Other possibilities include a series of short-term continuing resolutions while debate continues or a CR for the remainder of FY 2011, but at levels significantly below the current FY 2010 funding. There is no doubt that these types of cuts will have a serious impact on programs that support people with developmental and other disabilities who are already suffering under deep cutbacks caused by state budget deficits, unemployment, and the recession.

#### Fiscal Commission

On December 1, 2010 President Obama's Commission on Fiscal Responsibility and Reform released its final report *The Moment of Truth* outlining their plans to reduce the deficit and debt. A recent analysis by the Center for Budget and Policy Priorities points out that the plan does not represent a truly balanced approach to bringing deficits under control. Specifically, the plan starts to take effect in fiscal year 2012, which could threaten the fragile economic recovery; it proposes policy steps that would prove a serious hardship for some of the nation's most disadvantaged individuals, such as those with disabilities; it relies far too much on spending cuts as opposed to revenue increases; and it calls for adopting policies that will hold annual revenues and spending to 21 percent of Gross Domestic Product (GDP) in future decades, which is both unrealistic and unwise, according to economic experts at the Center.

While the Commission recommendations did not receive enough votes (14 of 18) to be considered final recommendations, some extremely troubling proposals have emerged based on the recommendations and will be part of the deficit reduction debate. These include imposing multi-year caps on discretionary spending at levels that would require severe cuts in this part of the budget; placing caps on total Medicare and Medicaid expenditures that could lead to converting Medicare to a voucher system and block-granting Medicaid; closing Social Security's shortfall primarily through benefit cuts; and imposing limits on total federal spending and taxes at levels far below what will be needed in coming decades. These limits will continue to require deep cuts in basic programs for years to come.

#### President's Budget Request

President Obama is expected to send the Administration's Budget Request to Congress on February 14. It is expected to be the most austere budget in decades. In his State of the Union address, the President

proposed a five-year freeze on annual domestic spending and acknowledged that such a freeze would require painful cuts. He also mentioned the recommendations of the fiscal commission, including its recommended changes to the Social Security program, stating that "we must strengthen it without putting at risk current retirees, the most vulnerable, or people with disabilities..."

Like all Americans, we want a strong economy. However, a truly strong and secure nation can only be achieved if federal funding decisions and tax policy do not result in a federal budget that is crafted at the expense of people with disabilities. Federal fiscal policy can and should be used to decisively address the crises facing people with disabilities and their families. However, adequate funding for the program services and supports are vital to enable people with disabilities and their families to be productive and fully included in society.

### **Recommendations**

The 112th Congress should:

- *Strengthen, not weaken, vital entitlement programs such as Social Security, Medicaid, Medicare, TANF, and food stamps;*
- *Oppose any process which prevents Members of Congress from exercising their legislative responsibilities to carefully consider and vote on legislative changes;*
- *Address the significant unmet needs of people with disabilities and their families by expanding the federal government's investment in people with disabilities to enable them to live and work as independently as possible in the community with appropriate and flexible long term individual and family supports;*
- *Ensure that any deficit reduction proposals are balanced and do not result in increases in poverty or inequality; and*
- *Address the unmet needs of people with disabilities and their families before making further tax cuts or reforming tax policy in a way that negatively impacts low wage earners and other vulnerable people.*

### **Relevant Committees**

House and Senate Budget Committees  
House and Senate Appropriations Committees  
House and Senate Labor, Health and Human Services Subcommittees

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## FACT SHEET AFFORDABLE CARE ACT

### Background

The Affordable Care Act (ACA) of 2010 will provide access to affordable health insurance for 32 million Americans who are currently uninsured. According to the non-partisan Congressional Budget Office, it will reduce the federal deficit by \$130 billion over the first ten years and \$1.2 trillion over the second ten years. The law represents a sea change in expanding access to affordable, quality health care for persons with disabilities.

The Arc, AAIDD, AUCD, UCP, NACDD and SABE are long standing advocates for universal access to quality, affordable care and fully support funding and implementing the ACA. Our support is not a partisan choice rather it is based on the many provisions that eliminate discrimination against people with health conditions, expand coverage, improve prevention, and expand long term services and supports. The ACA's most critical provisions for people with disabilities are:

#### Insurance Market Reforms

- *Prohibit pre-existing condition exclusions, lifetime and annual caps, discrimination based on disability and health status, and rescission of coverage.*
- *Prohibit consideration of health status when setting premiums.*
- *Require guaranteed issue and renewal of insurance policies.*

#### Expanding Access to Coverage

- *Establish temporary high risk pools to provide coverage to those who are currently uninsured.*
- *Provide significant subsidies to assist low income individuals to purchase coverage in the Exchanges.*
- *Include coverage of dental and vision care for children in the Exchanges.*
- *Include coverage of critical disability-related services, such as mental health services, rehabilitative and habilitative services and devices, in the Exchanges.*

#### Establishing a New Long Term Services and Supports Program

*The Community Living Assistance Services and Supports (CLASS) Act creates a national long-term services insurance program which assists eligible individuals and their families to meet long-term needs with a cash benefit and without forcing them into poverty to receive Medicaid benefits.*

#### Medicaid and Medicare

- *Expands Medicaid eligibility to 133 percent of the federal poverty level with significant federal funding.*
- *Establishes the Community First Choice Option for states to cover comprehensive community attendant services under the state's optional service plan and includes several other provisions to encourage home and community based services.*
- *Improves care coordination for dual eligibles (those who receive both Medicare and Medicaid benefits), eliminates drug coverage (Part D) co-pays for dual eligibles receiving waiver services, and improves access to key medications.*

#### Prevention, Provider Training, Data Collection

- *Eliminates co-pays for critical prevention services.*

- *Creates the Prevention and Public Health Fund to pay for essential prevention programs.*
- *Increases opportunities for training of health care providers, including dentists, on the needs of persons with disabilities, including those with developmental disabilities.*
- *Improves data collection on where people with disabilities access health services and where accessible facilities can be found.*

### **Action Taken by Congress and the Administration**

The partisan disagreements over the law continue in the 112th Congress with multiple strategies to repeal all or portions of the law and other efforts to block implementation and funding for key provisions. Currently, the biggest target is the law's individual responsibility provision (commonly referred to as the "individual mandate") which requires that individuals who can afford to do so maintain a minimum level of health insurance coverage or else pay a tax penalty. This provision, the cornerstone of the ACA, brings down costs by broadening the insurance risk pool to make coverage expansions and consumer protections possible.

On January 19th the House of Representatives voted 245-189 in support of a bill (H.R. 2) to repeal the law. The Senate is not expected to consider the legislation. The House has charged four committee Chairmen - Dave Camp (R- MI) of Ways and Means, Fred Upton (R-MI) of Energy and Commerce, John Kline (R-MN) of Education and the Workforce, and Lamar Smith (R-TX) of Judiciary, to hold oversight hearings and draft bills to replace elements of the ACA. Members of Congress have also begun introducing legislation to repeal or revise specific provisions. The House leadership is also looking at ways to defund the ACA, including eliminating the Prevention and Public Health Fund.

### **Recommendations**

Members of Congress should work with the Administration to ensure that the new health reform law operates as intended for people with disabilities and other Americans.

They should:

- *Oppose full or partial repeal of provisions that are important to people with disabilities.*
- *Provide adequate funding to implement the ACA.*
- *Support the individual responsibility provision as it is key to making sure that insurance risk is shared and premiums do not become cost prohibitive.*
- *Oppose repeal of the CLASS program.*
- *Preserve the Medicaid expansion which can help people with disabilities in the waiting period for Medicare, people who have disabilities that do not meet the standard for Social Security, and people who have too much income or assets to be eligible.*

### **Relevant Committees**

House and Senate Appropriations Committees  
 House Education and the Workforce, Senate Health Education Labor and Pensions  
 House Ways and Means, House Energy and Commerce, Senate Finance  
 House and Senate Budget Committees

For more information, please contact The Arc and United Cerebral Palsy Disability Policy Collaboration (202) 783-2229, Association of University Centers on Disability (301) 588-8252, American Association on Intellectual and Developmental Disabilities (202) 387-1968, National Association of Councils on Developmental Disabilities (202) 506-5813 or the Self Advocates Becoming Empowered (802) 760-8856.

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## FACT SHEET AUTISM SPECTRUM DISORDER (ASD)

### Background

In 2006, President Bush signed into law the Combating Autism Act (CAA, PL 109-416). This law is unique in that it is wide-reaching by targeting and coordinating every available system in order to efficiently and effectively address this developmental disability that now affects one percent of the American population. The law focused on expanding research and coordination at the National Institutes of Health (NIH), increasing awareness and surveillance at the Center for Disease Control (CDC), and expanding the interdisciplinary training of health professionals to identify and support children with ASD and their families. This law is scheduled for reauthorization this year. Due to sunset language this law will expire if it is not reauthorized by September 2011.

According to a recent congressionally mandated report to Congress, in the past four years under the provisions of the CAA, significant advances have been made in our understanding of ASDs. Notably, reliable estimates of the prevalence and a clearer picture of both the opportunities and gaps that exist in ASD research and services are now available. With federal support, researchers continue the crucial task of evaluating interventions that provide lasting, meaningful benefit to people with ASDs. Large-scale efforts in data collection, consolidation, and sharing are empowering researchers and health practitioners with knowledge not available only a few years ago. Within the biomedical research community, there is optimism that a continued rigorous focus on identifying genetic and environmental triggers to ASDs will yield innovative treatment and prevention strategies.

While the median age for ASD diagnosis (approximately 4.5 years of age) appears to be favorably on the decline, new CDC data indicates a critical need for improved access to early evaluation and diagnostic services. The typical time gap from developmental concern to diagnosis is over 2 years but with a continued focus on ASD awareness and training this critical time gap can be lessened. Strategic efforts aimed at underserved populations are under way to encourage awareness, early diagnosis, and intervention, but additional efforts will be needed to provide the necessary evidence base to support a wide variety of new interventions and services and supports for individuals on the autism spectrum. In addition, Federal agencies are actively identifying best practices and implementing programs to increase quality of life for people with ASD. This critical progress must not end.

In addition, services for those already diagnosed with ASD are desperately needed. These services include housing, education, supported employment, family supports, and transition services across the lifespan. Individuals with ASD and their families also continue to need access to accurate information about scientifically-supported interventions. The training of a wide range of interdisciplinary professionals to provide these services must be a top priority. A well-trained workforce will ensure that the findings coming out of our research institutions can be translated and made available to parents and providers across the country, and will ensure that services can be implemented as quickly as possible.

In the 111th Congress, Sens. Durbin (D-IL), Casey (D-PA), and Menendez (D-NJ) introduced the Autism Treatment Acceleration Act. A companion bill was introduced in the House by Reps. Doyle (D-PA) and Smith (R-NJ). This bill would accelerate the development of a service system to meet the needs of individuals with ASD and related developmental disabilities. The House of Representatives also passed the Training and Research for Autism Improvement Nationwide Act in the last Congress. And former Sen. Dodd (D-CT) introduced a bill to reauthorize the Combating Autism Act in the waning days of the 111th

Congress. President Obama has repeatedly pledged support to increase research, training and services for individuals on the spectrum.

Action Taken by Congress and the Administration

No bills have been introduced yet and no hearings have been scheduled.

### **Recommendations**

The 112th Congress should:

- *Reauthorize and fully fund the Combating Autism Act*
- *Support legislation that addresses the direct service and interdisciplinary training needs associated with the increasing number of individuals with Autism Spectrum Disorders.*

### **Relevant Committees**

House and Senate Appropriations Committees

Senate Health, Education, Labor and Pensions Committee

House Energy and Commerce Committee (Subcommittee on Health)

House and Senate Labor, Health and Human Services and Education Appropriations Subcommittees

**For more information, please contact The Arc and United Cerebral Palsy Disability Policy Collaboration (202-783-2229), Association of University Centers on Disabilities (301-588-8252), AAIDD (202-387-1968), or National Association of Councils on Developmental Disabilities (703-739-4400), or Self Advocates Becoming Empowered (802) 760-8856.**

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