

Home and Community-Based Services: Federal Funding to States.

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1. Introduction

This part of the PAS Center website reports ways in which states have obtained grant funding to reform Medicaid home and community-based services (HCBS). This report compliments information on Systems Change Grants ('Federal Systems Change Grants to States and Territories: 2001-2004') because it describes other funding opportunities for states from Federal sources, either within the Health and Human Services Department or in other Government departments. The funding mechanisms in this report either supplement HCBS developments (e.g. housing initiatives) or have been designed to support a specific population group (e.g. older people) to live in the community. Funding mechanisms that focus on other aspects of supporting people to live independently (e.g. employment) are not included in this report.

The support to facilitate community integration provided by Federal sources may pre-date the Supreme Court Olmstead ruling in 1999¹ although there has been an increase in activity post-Olmstead, largely due to the establishment of the New Freedom Initiative in 2001 (see 'Federal Policy Context', below). Federal government departments are also providing assistance to states in other ways, such as technical assistance, training and information. The extent of federal support differs so progress in areas that are key to community integration (e.g. transport) or for some population groups (such as people with mental illness) varies across states. The National Council on Disability has criticized this variation in progress.²

2. Federal Policy Context

On February 1 2001, President Bush announced 'The New Freedom Initiative' (NFI),³ a cross-governmental policy and funding initiative that aims to remove barriers to community living for people with disabilities and provide additional momentum to efforts to comply with the Americans with Disabilities Act (ADA).⁴ Later in 2001, President Bush signed an Executive Order that outlined the Government's commitment to community-based alternatives to institutional care for all people with disabilities.⁵ It directed Federal agencies to work with States to ensure compliance with the ADA integration mandate that had been reinforced by the Olmstead ruling. Subsequently, all Federal Agencies submitted reports regarding their own compliance with the ruling.⁶

The President's proposed 2005 budget makes a commitment to continuing the NFI, including the continuation of the 'Systems Change Grants' provided via the Center for Medicare and Medicaid Services (CMS). Draft legislation was transmitted by the administration in July 2003 to support this budget. The proposed 'New Freedom Initiative Medicaid Demonstrations Act' has provisions to support five demonstration projects funded by competitive grants to states. These are:

- Demonstration on Respite for Caregivers of Adults.⁷ This proposal is for \$449 million over 10 years in grants (\$7million in FY 2004 increasing to \$66 million in FY 2012) to provide assistance to family caregivers of adults with disabilities and test the effectiveness of respite in enabling people to stay in their own home.
- Demonstration of Respite for Caregivers of Children with Substantial Disabilities.⁸ This proposal is for \$118 million of grants over 10 years and has similar aims to the Demonstration on Respite for Caregivers of Adults.
- Money Follows the Individual Rebalancing Demonstration (see details below).
- Demonstration of Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities for Children.⁹ The proposal would authorize \$504 million in grants over 10 years.
- Demonstration to Address Shortages of Community Direct Care Workers (see below). The proposal is for \$3million in FY 2004 for grants to states.

The Bill also includes provisions to allow states the option of permitting presumptive eligibility of some seniors and disabled people to enable them to receive Medicaid HCBS during the time in which they are being assessed for eligibility after being hospitalized as well as a clause to protect the Medicaid insurance coverage of people with disabilities when their spouses return to work. Another piece of legislation affecting HCBS provision that has been proposed (but not by the Government) is the Medicaid Community-Based Attendant Services and Supports Act (S.917/H.R.2032).¹⁰ This proposed legislation (known as MiCASSA) was re-introduced in 2003 after first being introduced before the Olmstead ruling in the 1990s. It aims to eliminate the institutional bias in publicly funded LTC by requiring States to include community-based Personal Assistance Services in their Medicaid plans.

3. Department of Health and Human Services (DHHS)

The DHHS has different offices within it that are working to develop the community integration of people with disabilities. An Office of Disability was created in 2002 to help coordinate these efforts.¹¹

Although many people with disabilities receive HCBS through Medicaid (either under Medicaid waiver, State Plan Personal Care or Home Health programs) some are eligible for Medicare. The DHHS recently announced that as a result of Medicare legislation changes in 2003, 3 states (Missouri, Colorado and Massachusetts) have been awarded 2-year Medicare demonstration projects that will allow a new definition of ‘homebound’.¹² This means people with disabilities receiving home health benefits will not have limitations on their time spent away from home.

3.1 DHHS: Center for Medicare and Medicaid Services (CMS)

CMS is the main agency supporting states to deliver long-term care (LTC) for people with disabilities. There are several ways CMS has promoted changes to increase HCBS. These include new waiver programs (e.g. §1115 ‘Independence Plus’ waivers), providing

grant funding (e.g. Systems Change Grants), promulgating ideas and clarifying and amending policy guidelines to states (e.g. through letters to State Medicaid Directors).¹³

Examples of such policy change and clarification include those regarding Personal Assistance Retainers (PARs) and Targeted Case Management (TCM). States can pay PARs to ‘hold’ HCBS provision for participants who are temporarily placed in institutions. Until the policy change in 2000, retainers could only be paid on behalf of Medicaid waiver recipients who lived in institutions and were temporarily away from the facility. As part of HCBS waiver programs, Medicaid provides for states to plan TCM, which is designed specifically to help people transition out of nursing homes. CMS changed its guidelines in 2000 to allow states to furnish Medicaid-eligible people with TCM during the last 180 days of their institutional stay in order to organize their transition into the community. Previously states could have provided this service but would not have received Federal funds for it. (Another type of case management, HCBS Case Management, can be provided for 180 days before a person moves out of an institution as part of a waiver program but Federal funding is not available until the person has left the institution).¹⁴

3.1.1 CMS Policy Initiatives: Money Follows the Person

Money Follows the Person (MFP) is a term used to describe methods for financing LTC that enable public funds to be used wherever a person receives services. It encapsulates the strategies states use to reduce bureaucratic barriers that inhibit the options for where people receive LTC and primarily describes the financial organization of moving people out of institutions. For example, when a person living in a nursing home funded by the state wishes to move to the community, funding for their care can be transferred from being spent on nursing home care to being spent on HCBS waiver services. MFP therefore describes systems that aim to be responsive to consumer need and preferences.

CMS states that Money Follows the Person systems embrace “self-direction and consumer control” and are based on a “market-based approach that gives individuals more choice over the location and types of services they receive.”¹⁵ CMS suggests that MFP systems tackle four issues; (1) access (e.g. people enter the LTC system through a single agency), (2) responsiveness, (3) quality and (4) co-ordination of funding streams so they appear seamless to consumers.¹⁵ MFP is associated with the concept of ‘rebalancing’ LTC, meaning that there is more HCBS provision and reduced bias towards institutional care.

CMS has encouraged states to rebalance LTC systems and enable money to follow the person through grants to states as well as making policy changes, providing guidance and proposing legislation. For example, recent CMS policy guidance advised on the main features of reformed LTC systems and highlighted examples of state innovation in California, Maine and Nevada.¹⁶ Nine states received ‘Money Follows the Person’ grants in 2003 and 7 states received similar ‘Rebalancing Initiative’ grants in 2004.¹⁷ A recent study notes that states have used three main strategies for rebalancing LTC systems; (1) legislative action (setting policy and creating budgetary mechanisms to enable money to

move around); (2) market-based approaches (giving consumers more information to enable them to make their own choices, therefore creating increased demand for community services); and (3) fiscal and programmatic linkages (improving co-ordination between services and increasing community services). The report notes four states (Michigan, Oregon, Washington and Wisconsin) which have used all three of these strategies to achieve a more balanced LTC system.¹⁸

Texas is an example of a state that has developed MFP legislation to enable this type of systematic LTC reform. In response to Olmstead, the Texas Legislature added a rider to the state Appropriations Bill for the FY 2002-2003 biennium.¹⁹ The Rider states: “It is the intent of the legislature that as clients relocate from nursing facilities to community care services, funds will be transferred from Nursing Facilities to Community Care Services to cover the cost of the shift in services”.²⁰ People receiving Medicaid funded care in nursing facilities who are eligible for the state Medicaid Community Care program are covered by this clause and can transition into the community without joining waitlists for the HCBS program. The Texas Department of Human Services has lead responsibility for Rider implementation and supplied small grants to help participants set up home. The state housing department supported this by setting aside 35 Section 8 housing vouchers, funded through the Federal Project Access grant program (see housing section below). Since August 2003, more than 2000 people have moved out of nursing facilities under the Rider.²⁰ Six other states have used legislation to ‘rebalance’ their LTC system (Utah, Vermont, Missouri, Maryland, Nevada and North Dakota).¹⁸

MFP is included within the ‘New Freedom Initiative Medicaid Demonstration Act of 2003’ (‘Money Follows the Person Rebalancing Initiative’) proposed by the President. The Act proposes \$1.75 billion over five years (\$350 million per year between 2004 and 2008) for competitive grants to states in order to increase the proportion and total amount of Medicaid funds for HCBS.²¹ These grants would reimburse states for one year of Medicaid services for people who move from institutions into the community. After then, states would be required to continue care at the regular Medicaid matching rate.

Another federal legislative proposal is the ‘Money Follows the Person Act’ (S.1394). It was proposed around the same time as the ‘NFI Medicaid Demonstration Act’. However this Act concentrates exclusively on the concept of MFP, it proposes financial incentives for states to balance LTC systems as well as a grant scheme for states.

3.1.2 Other CMS Initiatives: Workforce and Employment

CMS organizes projects to support people with disabilities to join or re-join the workforce. These initiatives (which include grants such as Medicaid Infrastructure Grants) are part of the Ticket to Work and Work Incentives Improvement Act (1999) and are described elsewhere on the PAS Center website.²²

CMS also has an initiative to develop the long-term care workforce called the ‘Demonstration to Improve the Direct Service Community Workforce’. This competitive grant program for states was launched in 2003. The demonstration program aims to help

states develop programs to increase the pool of direct care service workers through recruitment and retention strategies.²³ Five grants were awarded for FY 2003²⁴ and a further five for FY 2004.²⁵ This scheme complements the Robert Wood Johnson Foundation's program 'Better Jobs, Better Care'.^{26,27} Information regarding the Personal Assistance workforce is included in detail elsewhere on the PAS Center website.²⁸

3.2 DHHS: Administration on Aging

The Older Americans Act (OAA) is an important mechanism for providing HCBS for older people and their families it also established the Administration on Aging (AoA) within DHHS. OAA was first enacted in 1965 and was most recently re-enacted in 2000. It covers 50 states, the District of Columbia and 5 Territories²⁹ and has 7 sections (titles) that have the broad aim of ensuring the well being of older people. Title III sets the structure and mechanisms for financing and delivering HCBS programs for older people and is the largest program under the OAA. Whilst funding for the OAA is small compared to the major source of LTC funding (Medicaid) it provides a safety net for people who might otherwise "fall through the cracks" in LTC provision because their income is too large to be Medicaid eligible but they require non-Medical support.³⁰

OAA Title III is split into 5 parts which; (1) set the formula by which funds are allocated to states, (2) provide Supportive Services and Senior Centers (including LTC, healthcare, transport, I&A, housing, legal assistance), (3) provide nutrition programs for homebound older people and those in congregate settings (e.g. senior centers), (4) concern health promotion and illness prevention, and (5) establish the National Family Caregiver Support Program (part 5 was added in 2000).³¹

Unlike Medicaid HCBS waivers, states do not have to apply to receive federal funding, Title III funds are primarily allocated according to the number of people aged 60+ in each state and all people 60 years of age and older are eligible for OAA services. Exceptions to this age limit are the Senior Community Service Employment program (this offers part-or full-time employment to low-income persons who are 55 years of age or older) and the National Family Caregiver Support Program funds (these are allocated through a formula based on the proportion of the state population who is 70 or older).³²

States participating in Title III are required to set up a State Unit on Aging (SUA) to develop a 2-4 year statewide aging plan covering OAA programs. Many states have divided the state into local Area Agencies on Aging (AAAs) to administer OAA programs (13 states and Territories have single planning areas, there are 56 SUAs and 655 AAAs). The SUA develops an intrastate funding formula, reflecting local demographics in order to allocate funds to AAAs. AAAs assess the needs of older people (preference is given to older people with greatest economic and social need) and are expected to spend at least some of the allocated funds on; (1) access (transport, outreach, I&A and case management), (2) in-home services (homemaker, home health aide, chore and supportive services) and (3) legal assistance. In most cases, AAAs subcontract with provider organizations and do not provide direct services.³²

OAA service providers can develop a suggested contribution schedule for services but means tests cannot be used for any services under Title III and services cannot be denied because older people cannot or will not contribute to the cost of the service. States set their own eligibility criteria for Title III services, however are some restrictions on the criteria set: (1) SUAs cannot include a means test in the state eligibility criteria for in-home services (economic need is assessed using the federal poverty guidelines); and (2) they are required to prioritize people 60 or over who are frail (have a physical or mental disability, Alzheimer's disease or a related disorder which restricts normal daily tasks), homebound due to illness or disability.³²

Title III funds are intended to be a catalyst bringing together public and private resources in the community. All services are required to be funded statewide and the non-Federal share of the OAA funding should not be less than 15% (match-funding requirements for AAAs are determined by the SUA). Each state is required to spend at least the average amount of state funds it spent over the last 3 years to avoid a state allotment reduction. A recent study suggests federally appropriated OAA funding has "increased slightly each year but has not kept pace with inflation and the growth of the older population".³⁰

3.2.1 Title III funded HCBS: Table of State expenditure.

The OAA requires states to submit annual State Program Reports (SPRs) to the AoA. These reports contain information on expenditure for 14 services (including personal care) by client groups served and services provided which are funded wholly or partly by OAA. Table 1 presents the data published for HCBS funded under Title III in 2002 by state. It shows that Indiana had the largest total expenditure on personal care through the OAA (\$23 million in 2002) although Massachusetts served the most people under the OAA personal care program (13,000 people). It is important to note that a state's total expenditure on these services may include funds from other sources (including state and other federal sources). Expenditures under the National Family Caregivers Support Program are not included in this table and instead are described below.

3.2.2 OAA Title III funded HCBS: The National Family Caregivers Support Program

Authorized until FY 2005 under the Older Americans Amendments Act 2000, this program aims to stimulate state innovation in assisting families and informal caregivers of older people and seniors who are caregivers.³³ The program has provided over \$400 million to states and territories since 2001.⁶ The Act also established a Native American Caregiver Support Program (a total of \$6.2 million was appropriated for this in FY 2003).

Funds are allocated to SUAs using a formula based on the state's proportion of 70+ years population and are intended to provide direct services to support family caregivers of older adults (and grandparents and relative caregivers of children). Funds must provide five services; (1) information, (2) assistance in accessing services, (3) individual support (e.g. counseling and support groups), (4) respite and (5) supplementary care.³⁴ There is also a competitive grant program for demonstration projects on systems development,

service components, links to special populations and new approaches to support. There are also grants for national projects that contribute to and support state level activities.^{35,36}

Several studies have examined the impact of the NFCSP on state caregiver support systems.^{37,38} Findings include that the design and administration of programs varies between and within states,³⁷ although most HCBS programs are administered by SUAs and are available statewide.³⁸ 36% of states began providing support to caregivers for the first time as a result of NFCSP funds although most state programs have multiple funding sources, the four main sources being state general funds, NFCSP, HCBS waivers and client contributions.³⁸ Limited funding, lack of coordination with other HCBS programs and workforce shortages were identified as major barriers to services, with NFCSP funding too low to meet the varied needs of caregivers.^{37,38}

3.2.3 OAA Title IV funded HCBS: Naturally Occurring Retirement Communities

Authorized under Title IV of the OAA (Training, Research, and Discretionary Projects & Programs), the Naturally Occurring Retirement Communities (NORC) grant program aims to help organizations within states to evaluate new methods for assisting older people who have ‘aged in place’ (rather than moved to senior housing) to remain in the community and avoid unnecessary institutionalization. In common with the prevention program (see below) the focus is on access to and links between services that sustain older peoples’ independence. The program aims to ensure older people (aged 60 or over) can access comprehensive support and healthcare services, including; on-site assessments, information and education, referral services, case management, counseling, transport, shopping, financial management, recreation and socialization programs. Healthcare services may include nursing, health screening, in-home assessment, medication management and physician home visits.

Total value of grants awarded: \$3.7 million (FY 2002),³⁹ \$5.6 million (FY 2003),⁴⁰ \$5.1 million (FY 2004).⁴¹

Approximate amount of award: \$150,000-\$400,000 (per year)

Duration of the grant: at least 12 months

Organizations permitted to apply: Service organizations within States

Number of grant recipients: 22 (16 new in 2004, 6 continuations).⁴¹

3.2.4 Alzheimer’s Disease Demonstration Grants to States

The Alzheimer’s Disease Demonstration Grants to States Program (ADDG) was established under the Public Health Service Act and the Health Professions Education Partnerships Act of 1998.⁴² The program aims to improve HCBS for people with Alzheimer’s disease or related disorders, their families and caregivers.⁴³ The grants have been awarded for some time, most recently offered in FY 2004. Two new requirements were added in 2004 to ensure that; (a) grant recipients link ADDG funded activities to other state LTC systems change efforts and (b) all project proposals were based on research. The current recipients of these grants are shown on Table 1.

Total value of grants awarded: \$8 million (FY01), \$12 million (FY03), \$6.8 million (FY04).⁴⁴

Approximate amount of award: \$150,000-\$400,000 (per year)

Duration of the grant: Mostly 3 years. (2 states received a one-year grant in FY 2004).⁴⁴

Organizations permitted to apply: State governments.

Number of grant recipients: 38 (24 in 2004, 14 continuing from previous years).

Additional information: States are required to provide cash or in-kind contribution equal to at least 25% of the total project cost in the first year, 35% of the cost in the second year and 45% in the third year.⁴⁵ States cannot apply if they have already received an award.⁴⁶

3.2.5 Evidence-Based Disease Prevention Program

Launched in 2003, this grant program is run by the AoA jointly with the Robert Wood Johnson Foundation, the John Hartford Foundation and the Horizon Foundation. AoA provided \$6 million over 3 years to fund 13 local projects⁴⁷ and a national technical assistance center at the National Council on Aging. The program aims to test how recommendations from national research (e.g. from the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality and the National Institute on Aging) can be used in practice through service provider organizations to help prevent disability in older people (e.g. through falls prevention and disease self-management).

3.2.6 Aging and Disability Resource Center Grants

CMS and AoA offered these competitive grants to states in 2003 and 2004. They aim to help states develop 'one-stop shops' at the community level to help people make informed decisions about their support options and provide a single point of entry to LTC. For example, Montana established a public information site in a mall and New Jersey is working on streamlining services reforming LTC financial eligibility and pre-admission screening as well as developing a management information system.⁴⁸

Total value of grants awarded: \$4,910,790 (2003) \$8,970,493 (2004)⁴⁹

Conditions of the grant: Activities must target the elderly and at least one other target population (such as people with serious mental illness).

Range of value of grants: \$200,000 - \$800,000

Duration of grant: up to 36 months

Organization permitted to apply: State agencies (SUAs and Medicaid agencies must be involved).

Number of grant recipients (states): 12 (2003), 12 (2004)

Additional information: This program builds on models in Wisconsin and other states.⁵⁰

3.3 Health Resources and Services Administration (HRSA)

3.3.1 Traumatic Brain Injury (TBI) grants

This grant program is administered through the Maternal and Child Health Bureau in HRSA and was re-authorized in 1996 under the Children's Health Act.^{51, 52} The program

aims to improve access, availability and appropriateness of health care and other services for individuals with traumatic brain injury (TBI) and their families. There are three categories of grants; planning grants, implementation grants and post-demonstration grants. Planning grants and implementation grants were available in 1999-2003, 2004 awards will be announced early in 2005.⁵³ Post-demonstration grants were available in FY 2002-2004. There were also grants for protection and advocacy services for TBI in FY 2002 and FY 2003. Since 1997, 49 States and Territories (including the District of Columbia) have received at least one grant and in FY 2003 TBI program funding was \$9.3 million.⁵⁴ States have to provide 50% match funding for the grants (non-Federal contributions not less than \$1 for each \$2 of Federal funds provided).

TBI Planning Grants⁵⁵

Approximate amount of award: up to \$75,000

Duration of the grant: 2 years

Purpose of the grant: To assist the development of a TBI program infrastructure.

Organizations permitted to apply: State governments are the only eligible applicants

Number of grant recipients: Up to 7 states (FY 2004).

Additional information: States develop 4 elements of a TBI service system; (1) a lead Designated State Agency and a staff person responsible for State TBI activities, (2) a Statewide TBI Advisory Board, (3) a Statewide Resource/Needs Assessment, and (4) a Statewide plan for a comprehensive, community-based system.

TBI Implementation Grants⁵⁵

Approximate amount of award: up to \$200,000

Duration of the grant: 3 years

Purpose of the grant: To help states move toward a statewide system to ensure access to comprehensive coordinated TBI services

Organizations permitted to apply: State governments are the only eligible applicants

Number of grant recipients: Approximately 7 awards (FY 2004).

TBI Post Demonstration Grants⁵⁵

Financial Years awarded: FY 2004

Approximate amount of award: up to \$100,000

Duration of the grant: 1 year

Purpose of the grant: To address issues including capacity building initiatives in the system of community supports.

Organizations permitted to apply: State governments are the only eligible applicants

Number of grant recipients: 11 (FY 2004).⁵²

3.3.2 Medical Home for Children with Special Health Care Needs

Authorized under the Social Security Act, this is part of the NFI and is administered through the Maternal and Child Health Bureau in HRSA. It aims to help states develop and implement a plan for community services for children with special health care needs. Children with special health care needs have or are at risk of “a chronic physical, developmental, behavioral, or emotional condition”.⁵⁶ The program funds: (1) a National

Resource Center on Medical Homes for children with special healthcare needs (\$1million to the American Academy of Pediatrics), (2) four grants (in four different states) to support community primary care practices or networks in order to improve links to early intervention, child care, schools and community programs (\$50,000-\$250,000), (3) a grant to promote partnerships between health services (University of Florida, approx. \$200,000) and (4) a 4 year grant for investigation into early identification and interventions for children with autism (\$200,000 to the University of Wisconsin)^{57, 58}

3.4 Substance Abuse and Mental Health Services Administration (SAMHSA)

As part of the NFI, a national Commission on Mental Health was set up to examine the publicly and privately funded mental health delivery system. In its final report, the Commission noted the complexity of services for people with mental illness and recommended a fundamental change in the way that mental health services are delivered to ensure consumer involvement, patient-centered care, and comprehensive state mental health plans.⁵⁹

Meanwhile, SAMHSA provides states with Mental Health Block Grants and has a ‘Community Action Grant’ program that has been running since before 1999. This covers people with mental health problems or substance use problems. SAMHSA has also developed a networking resource (the ‘Olmstead Community’) to aid states in planning more community-integrated mental health services⁶⁰ and works collaboratively on a long-term care policy academy for states with the AoA and the National Governor’s Association.⁶¹

Recent CMS Systems Change Grants have focused on the needs of children with severe emotional disturbances and the transition between children’s and adult mental health services.¹⁷ However, there has been criticism of pace of development of community-based services for people with mental illness despite state action following Olmstead.⁶²

4. Department of Transportation

Transport is acknowledged as vital to the successful integration of people with disabilities. The funding and support available to states from the Department has been limited though,² as no new funds were appropriated by the Department of Transport to develop programs for people with disabilities.⁶ Nevertheless, some assistance has been provided through the “United We Ride” program that assists in the coordination of human service transport through technical assistance, information dissemination, learning opportunities and small grants.⁶ There is also a federal Community-Based Transportation Planning Grant program to help communities create stakeholder partnerships and plans to expand transport for people with disabilities.⁶

5. Department of Housing and Urban Development (HUD)

HUD has specific information for people with disabilities about housing initiatives including programs to ensure accessibility.⁶³ HUD has three competitive grant programs

specifically aimed at helping people with disabilities. These are: (1) mainstream housing for people with disabilities, (2) rental assistance for non-elderly people with disabilities related to certain developments, and (3) rental assistance for non-elderly people with disabilities in support of designated housing plans.^{64,65} There are also housing programs for low and moderate income persons with disabilities in rural areas.⁶⁶

Housing and related expenses are critical for people who transition out of institutions and CMS has clarified policy for Medicaid beneficiaries moving out of institutions into community housing, as Medicaid cannot cover rent but states can use federal matching funds for Community Transition Services (under HCBS waivers) for one-off expenses (e.g. furniture or utility set-up fees).⁶⁷ In terms of support to help people with disabilities remain in the community, HUD provided \$30 million of grants in FY 2003 to provide Service Coordinators in federally supported housing for low-income seniors and people with disabilities. These coordinators aim to help residents access services such as health care and meals.⁶ However, the National Council on Disability has recommended that more grants should be available to help states offset the one-time costs people incur.²

5.1 Project Access

Established in 2001, this pilot program aims to help nursing home residents move to community-based settings. It is a joint venture between CMS and HUD whereby states are encouraged to apply for section 8 housing vouchers when applying for a nursing home transition grant. The program is limited to people living in nursing homes who are under 65. The Section 8 rental vouchers awarded are in addition to those vouchers awarded to Public Housing Authorities (PHA) as part of their strategic plan. In 2001, HUD made 400 vouchers available to 11 states, with the prediction that this figure would rise to up to 2000 over the project duration.^{68,69}

5.2 Homeownership Voucher Program⁷⁰

This pilot was launched in 2001 and aims to support families with members with disabilities to buy a home. Eligible families are those whose incomes are up to 99% of the area median and who do not own their own home. The pilot aims to help them use Section 8 housing vouchers to buy a home without paying more than 30% of their income. The family minimum income requirement is an annual household income of at least \$10,000 (welfare income may be counted). The program is administered through local PHAs that participate in the Section 8 program although each family is responsible for obtaining the mortgage financing required. If a family defaults on the mortgage, they may be permitted to move to a new unit with continued homeownership assistance if the default is due to catastrophic medical reasons, however if they default for other reasons, they may become ineligible for the pilot.

5.3 Housing and Service co-ordination

HUD provided \$30 million in grants to states in FY 2003 to provide Service Coordinators in federally supported housing for low-income seniors and people with disabilities. These

coordinators aim to help residents to access services such as health care and meals in order to support them to remain in the community.⁶

5.4 Support for people who are homeless

HUD, HHS and the Department of Veterans Affairs developed a \$35 million initiative in 2003 to jointly fund 11 grants for three years to provide services and permanent housing to people with disabilities who are chronically homeless.⁶

5.6 Home Modification Grants

Through the federal Faith-Based and Community Initiative in the Office of Disability Employment Policy (ODEP), working with HUD and the Corporation for National and Community Service, a total of \$700,000 was awarded in 2003 to local faith-based and community organizations. The 8 grants aim to enable organizations to support people with disabilities to remain in their home or to move into accessible homes through making modifications.⁷¹

6. Department of Labor

This paper does not deal extensively with initiatives in the Department of Labor as these are dealt with in other areas of the PAS Center. However, an example of activity undertaken by the Department of Labor that affects HCBS for people with disabilities is the 'Home Modification Grants' program. These grants were administered via the Faith-based and Community Initiative in collaboration with HUD and were awarded in 8 states to help local faith-based and community organizations assist individuals with disabilities to remain in their own homes.⁷²

References

¹ See 'Introduction to Olmstead Lawsuits and Olmstead Plans' on this website.

² Gran, J *et al* (2003) 'Olmstead: Reclaiming Institutionalized Lives' National Council on Disability, Washington DC. At: <http://www.ncd.gov>.

³ NFI information at: <http://www.whitehouse.gov/infocus/newfreedom/>, <http://www.hhs.gov/newfreedom/>.

⁴ Information on the Americans with Disabilities Act (1990) is at <http://www.ada.gov>.

⁵ White House (Jun 2001) Executive Order 13217: Community-based Alternatives for Individuals with Disabilities. <http://www.whitehouse.gov/news/releases/2001/06/print/20010619.html>

⁶ 'Compilation of Individual Federal Agency Reports of Action to Eliminate Barriers and Promote Community Integration' at <http://www.hhs.gov/newfreedom/final/>. The progress reports for 2002 and 2004 are at: <http://www.hhs.gov/newfreedom/prelim/>.

⁷ A CMS grant program for Respite for Adults was available to States in 2003. See 'Federal Systems Change Grants to States and Territories: 2001-2004' on this website.

⁸ A CMS grant program for Respite for Children was available to States in 2003. See 'Federal Systems Change Grants to States and Territories: 2001-2004' on this website.

⁹ A similar CMS grant program, 'Community-Based Treatment Alternatives for Children' was available in 2003. See 'Federal Systems Change Grants to States and Territories: 2001-2004' on this website.

¹⁰ More information on MiCASSA is available at: <http://www.adapt.org/casaintr.htm>.

¹¹ At: <http://www.hhs.gov/od/>

¹² DHHS (2004) *News Release 'HHS identifies States for Medicare demonstration of new, less restrictive homebound definition'*, June 3. <http://www.hhs.gov/news/press/2004pres/20040603.html>.

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- ¹³ CMS published a series of letters following the Olmstead ruling. These were published on January 14 2000, July 25 2000 (2 letters) and January 10 2001 (2 letters). Other relevant letters are State Medicaid Director Letter #02-008 May 9 2002, SMDL #03-006 July 14 2003 and SMDL #02-012 August 13 2003. At: <http://www.cms.hhs.gov/states/letters/>
- ¹⁴ CMS 'Dear State Medicaid Director' letter, Olmstead Update No. 3. July 25, 2003. At: <http://www.cms.hhs.gov/states/letters/smd725a0.asp>
- ¹⁵ CMS 'Dear State Medicaid Director' letter Sep 2003. <http://www.cms.hhs.gov/states/letters>
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- ¹⁷ See 'Federal Systems Change Grants to States and Territories: 2001-2004' on this website
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