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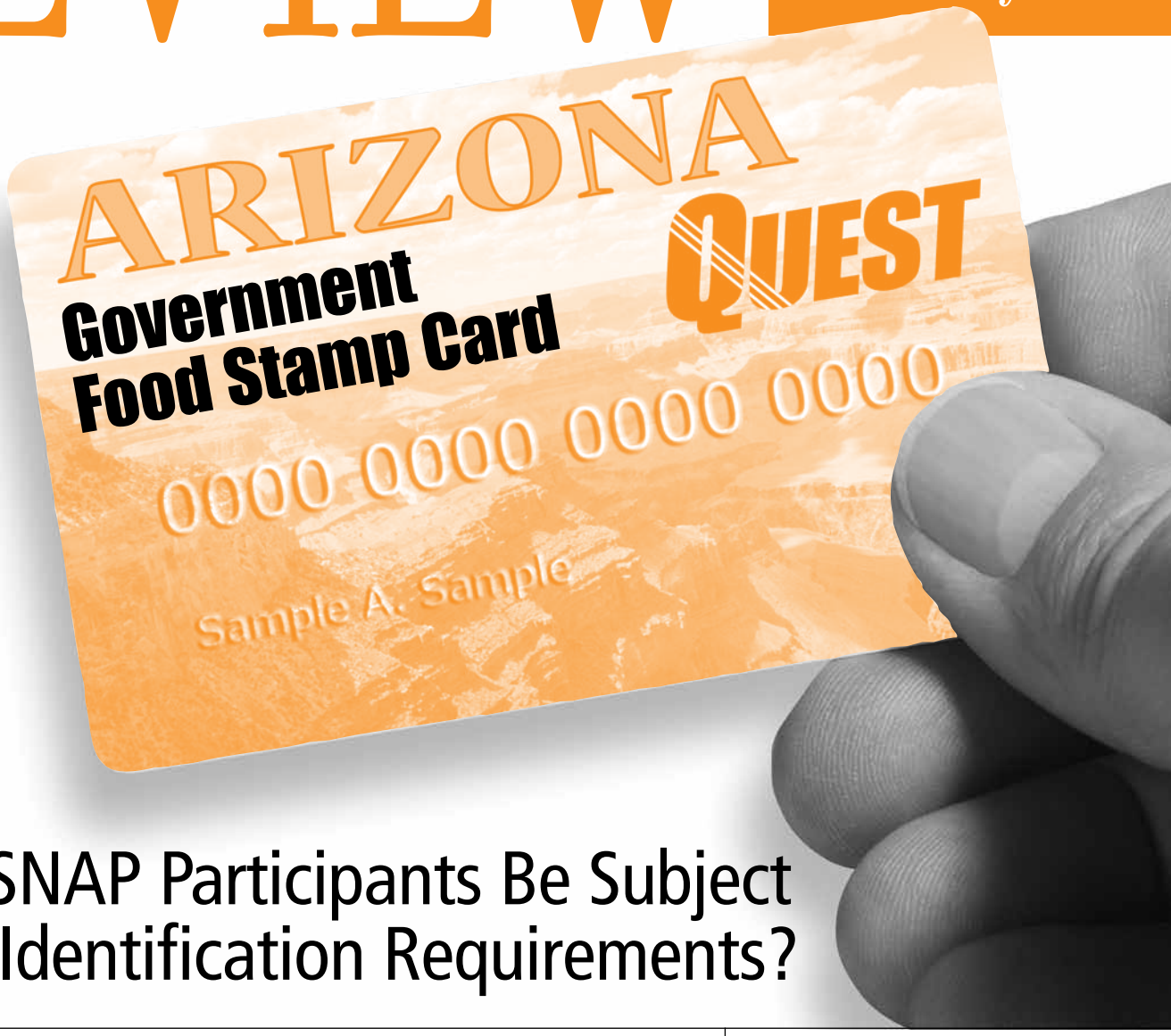

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How the Patient Protection and Affordable Care Act Shapes the Future of Home- and Community-Based Services

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The Patient Protection and Affordable Care Act became law on March 23, 2010.[1] Although some of the Act's effects may have been sensationalized in the media, the Act has the potential to be transformative for home- and community-based services in the Medicaid program. Subject to certain eligibility requirements such as an income and asset test, Medicaid assures institutional coverage for individuals who are clinically in need of institutional care and unable to live at home unassisted due to age or disability. Before 1981, there were few alternatives to institutionalization for these individuals.[2] The Medicaid authority available to states before 1981 was not sufficient in quantity or breadth to meet the needs of this population, which was growing rapidly due to factors such as prolonged life expectancies. The Medicaid program had a pronounced bias in favor of institutionalization, and even individuals who could have remained in their homes with only minor assistance were frequently forced into institutions in order to receive care.[3]

To eliminate this bias, Congress in 1981 added Section 1915(c) to the Social Security Act and thus gave states, instead of paying for institutionalization, the option to run temporary Medicaid "waiver" programs for home- and community-based services to individuals clinically in need of nursing facility care.[4] Over the past three decades

[1]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

[2]When Medicaid began in 1965, institutional care was a mandatory covered service, and home care was only an optional service. By 1981 home health care was a mandatory service, and states had the option to provide personal care services (Steven Lutzky et al., Lewin Group, Review of the Medicaid 1915(c) Home and Community Based Services Waiver Program Literature and Program Data 1–5 (2000)).

[3]In 1980 Medicaid spent about $27 billion on institutional care, compared to only about $1 billion on community-based care (Anita Yuskauskas, Center for Medicare and Medicaid Services, Quality Measures Used in Home and Community Based Services (July 25, 2011) (PowerPoint presentation) (in my files)).

[4]42 U.S.C. § 1396n(c) (2006). These programs are known as "waiver programs" (or simply "waivers") because a state must request and receive an exception to the normal Medicaid rules to run the program; the Centers for Medicare and Medicaid Services must "waive" specific provisions of Medicaid law to make the programs legally permissible.

all states have implemented such waiver programs.[5] These waivers have helped radically redistribute long-term care services toward the community-based environment.[6] Home- and community-based service programs are a boon in that (1) they allow individuals to age in their home and family environments, maximizing their independence and dignity; (2) home services are significantly less expensive for states than institutional care; and (3) aging in a home or community setting promotes better health than the rapid deterioration often associated with institutionalization.[7]

Despite waiver programs having helped reduce Medicaid's bias toward institutions, numerous factors have impeded Medicaid from preventing all unnecessary institutionalizations. For example, the temporary waiver authority that states use to run a home- and community-based services program requires a heavy administrative undertaking that must be repeated every few years. It also is subject to complex requirements such as budget neutrality, which requires a state to show that its waiver program will not cost the federal government more than it otherwise would have spent without the waiver. These types of barriers, along with state financial hesitance to fund these programs, have made waiver programs a useful but imperfect tool for home- and community-based services to those who could benefit from them.

When the Patient Protection and Affordable Care Act was passed, three issues plagued Medicaid long-term care. First, the bias in favor of institutions persisted, although it had been reduced by waiver programs. Second, the major vehicle for home- and community-based services was temporary waiver authority. Third, the piecemeal development of home- and community-based service options had created an additional uniformity problem for Medicaid long-term care and caused administrative nightmares for individuals and providers as well as state and federal authorities. The various options that had developed over time had been implemented with different standards, administration, and definitions of support services and, perhaps most fundamental, different and evolving concepts of how individuals should participate in their own care. For example, some home- and community-based programs had developed consumer-directed delivery models, but even these models were inconsistent from program to program. The Act deals with these three key problems through a slew of provisions expanding access to home- and community-based services.

First, the Act strives to "rebalance" Medicaid long-term care away from the historical push for institutions and toward more home- and community-based benefits. This rebalancing is explicitly set forth by Section 10202, offering states incentive payments for expanding Medicaid access to home- and community-based services.[8] The rebalancing priority is also advanced through Section 2401, the Community First Choice Option.[9]

Second, the Act creates and expands state options for home- and community-based

[5]Almost all states use Medicaid waiver authority under Section 1915(c) to run their home- and community-based programs. Arizona and Vermont run equivalent programs through a conceptually similar authority, Section 1115 demonstration authority, which also requires obtaining waivers of various Medicaid provisions (see Terence Ng et al., Kaiser Commission on Medicaid and the Uninsured, Medicaid Home and Community-Based Service Programs: Data Update 4 (Feb. 2011), http://bit.ly/nscsr6).

[6]By 2005 Medicaid was spending $59 billion on institutional care, compared to $35 billion in community-based care (Yuskauskas, *supra* note 3).

[7]See Tamar Heller et al., *Nursing Home Reform: The Impact of Moving out of Nursing Homes on People with Developmental Disabilities*, Policy Research Brief (Jan. 1995), http://bit.ly/qt3qJK.

[8]Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 10202, 124, Stat. 119, 923–27 (2010). For additional guidance on the Balancing Incentive Payments Program, see Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, CFDA 93.543, Patient Protection and Affordable Care Act Section 10202 State Balancing Incentive Payments Program Initial Announcement (n.d.), http://go.cms.gov/nzNBYh; Letter from Cindy Mann, Director, Center for Medicaid, CHIP, and Survey and Certification, to State Medicaid Directors (n.d.), http://go.cms.gov/r04Xms.

[9]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2401, 124 Stat. 119, 297–301 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1205, 124 Stat. 1029, 1056 (2010) (codified as amended at Social Security Act § 1915(k), 42 U.S.C. § 1396n(k)).

services as a standard Medicaid state-plan benefit, as opposed to relying on waiver authority.[10] Under Section 2401 states have a second and independent way to design a state-plan home- and community-based services benefit.

Third, the Act explicitly charges the U.S. Department of Health and Human Services (HHS) and other agencies to develop coordinated procedures, standards, and uniformity for home- and community-based programs, with a particular emphasis on consumer-centered program design. Not only is HHS required by Section 2402(a) to develop regulations that promote uniformity, but also this priority is being advanced through related regulations that HHS is developing for other home- and community-based services provisions in the Act and in Medicaid.

Rebalancing Between Institutional Care and Home- and Community-Based Services

The Patient Protection and Affordable Care Act's provisions on home- and community-based services are a step in rebalancing Medicaid long-term care away from unnecessary institutionalization and toward home- and community-based care. New program options for Medicaid home- and community-based services will give states more flexibility and will result in more individuals accessing such services. However, the Act goes beyond just making new options available and explicitly promotes rebalancing by offering states enhanced funding opportunities for pursuing such services.

State Balancing Incentive Payments Program. The principal and explicit rebalancing provision is the State Balancing Incentive Payments Program, created by Section 10202 of the Act. This optional program offers states enhanced federal Medicaid matching funds if they increase spending on noninstitutional long-term care and agree to make certain structural changes in their home- and community-based programs.[11] The enhanced matching funds are available for all home- and community-based services offered through both Medicaid state-plan and waiver programs and thus create a financial incentive for states to engage in rebalancing.[12] However, the enhanced matching funds are available only during the rebalancing period, October 1, 2011 through September 30, 2015.[13] They must be reinvested in Medicaid home- and community-based services.[14] The program is capped at a maximum of $3 billion of federal spending.[15]

Under this program, "noninstitutional" long-term care includes home- and community-based services, home health services, personal care services, the All-Inclusive Care for the Elderly program, and self-directed personal assistance.[16] By contrast, nursing homes and intermediate care facilities for persons with mental retardation are given as examples of "institutional" settings.[17]

To be eligible for the enhanced matching funds, a state must apply by August 1, 2014, to HHS with "a proposed budget that details the State's plan to expand and diversify medical assistance for non-institutionally-based long-term

[10]Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 2402(b) , 124 Stat. 119, 302–3 (2010) (codified as amended at 42 U.S.C. § 1396n).

[11]The federal medical assistance percentage is a preset figure representing a state's Medicaid spending percentage that the federal government will pay; the higher the "match," the more federal dollars a state gets for each dollar it is willing to spend.

[12]Patient Protection and Affordable Care Act § 10202(f)(1)(B). The enhanced match would not apply to spending under the Community First Choice Option (see New Medicaid State-Plan Options to Provide Home- and Community-Based Services *infra*).

[13]*Id.* § 10202(f)(2).

[14]*Id.* § 10202(c)(4).

[15]*Id.* § 10202(e)(2).

[16]*Id.* § 10202(f)(1). This includes the major Medicaid home- and community-based services programs created under Sections 1115 and 1915(c), (d), and (i) of the Social Security Act.

[17]Patient Protection and Affordable Care Act § 10202(f)(1).

services and supports" and "achieve [a] target spending percentage" on long-term services and supports.[18] States currently spending less than 25 percent of their long-term care dollars on noninstitutional care must spend at least 25 percent on such care to receive a 5 percent increase in federal Medicaid matching funds.[19] States spending between 25 percent and 50 percent of their long-term care dollars on noninstitutional care have a target of 50 percent and are eligible to receive a 2 percent increase in federal Medicaid matching funds.[20] These increases total millions of dollars. One clear enforcement concern raised by the Balancing Incentive Payments Program is the lack of a correction or penalty methodology if a state collects enhanced matching funds but fails to meet its percentage target.

To participate in the program, a state must take six actions (the first three termed "structural changes") in its delivery system for home- and community-based services:

- develop a "no wrong door" way so that individuals can access all home- and community-based services through a single entry point;
- develop conflict-free case management services to initiate a service plan;
- develop core standardized eligibility and planning assessment instruments;
- collect services data on a per-beneficiary basis from all home- and community-based providers;
- develop population-specific outcome measures; and
- collect core quality data based on population-specific outcome measures.[21]

The Centers for Medicare and Medicaid Services will assign states "milestones" to implement these changes in their work plans, and states will continue to be eligible for rebalancing payments if they demonstrate progress toward achieving these goals.[22] If a state expands access to home- and community-based services and meets these requirements, it is eligible to receive the enhanced matching funds.

Community First Choice Option. The Community First Choice Option, discussed in greater detail below, is a second and independent effort under the Act to rebalance Medicaid long-term care toward noninstitutional care by offering enhanced matching funds for expanding home- and community-based services.[23] This option offers states a 6 percent increase in federal Medicaid matching funds for services in a new Medicaid state-plan option for home- and community-based services.[24]

The sheer number of provisions aiming to expand Medicaid home- and community-based options and the explicit efforts to promote rebalancing through enhanced

[18]*Id.* § 10202(c)(1)(A). A "maintenance of eligibility" provision in the Balancing Incentive Payments Program prohibits states from using eligibility standards or procedures for home- and community-based services that are more restrictive than those they had in place on December 31, 2010 (*id.* § 10202(c)(3)).

[19]*Id.* § 10202(c)(2). Spending for this purpose is calculated in the Balancing Incentive Payments Program by using the states' 2009 fiscal year spending on long-term care. The only state spending less than 25 percent of its long-term care dollars on noninstitutional care is Mississippi (see Centers for Medicare and Medicaid Services, *supra* note 8, attachment C).

[20]Patient Protection and Affordable Care Act § 10202(c)(2). Thirty-seven states spend between 25 percent and 50 percent of their long-term care dollars on noninstitutional care and could be eligible for the 2 percent increase, while twelve states and the District of Columbia spend more than 50 percent of their dollars on noninstitutional care and therefore are not eligible for the program (see Centers for Medicare and Medicaid Services, *supra* note 8, attachment C).

[21]Patient Protection and Affordable Care Act §§ 10202(c)(5)–(6). A state has six months to implement the structural changes.

[22]See Centers for Medicare and Medicaid Services, *supra* note 8, at 17.

[23]Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2401, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1205, 124 Stat. 1029 (2010) (codified as amended at Social Security Act § 1915(k), 42 U.S.C. § 1396n(k)).

[24]42 U.S.C. § 1396n(k)(2).

matching funds for these services through the Balancing Incentive Payments Program and the Community First Choice Option demonstrate a clear commitment to move Medicaid long-term care away from institutions and toward home- and community-based care.

New Medicaid State-Plan Options to Provide Home- and Community-Based Services

Medicaid home- and community-based services are offered most frequently through waiver programs instead of state plans, despite the numerous disadvantages to waiver programs and their administration. The Patient Protection and Affordable Care Act, however, gives states new Medicaid state-plan options for home- and community-based services to reverse this trend.

Changes in the Section 1915(i) Benefit. The Social Security Act § 1915(i) state-plan option is not new. Since its creation in the Deficit Reduction Act of 2005, states have had the option of home- and community-based services in their state plans using Section 1915(i) authority.[25] Unlike Medicaid waiver programs, the Section 1915(i) benefit authorizes states to offer home- and community-based services to individuals who are not clinically in need of institutional care. Because the Section 1915(i) benefit had not been widely adopted by states, the Patient Protection and Affordable Care Act changed the benefit to stimulate state election of the option.[26] The Section 1915(i) changes went into effect on October 1, 2010.[27]

The Patient Protection and Affordable Care Act expanded the Section 1915(i) benefit by making it more comparable to waiver programs. The Act raised the income limit for the Section 1915(i) program from 150 percent of the federal poverty level to 300 percent of the Supplemental Security Income benefit level (roughly 225 percent of the federal poverty level).[28] This matches the maximum income limit that states are permitted to use for waiver programs. The Act also authorizes states to include new services through their Section 1915(i) programs for which they were not able to receive federal funding.[29] This expanded set of services now puts the Section 1915(i) state-plan option on par with waiver programs in terms of services.

The Act made other structural changes in the Section 1915(i) benefit. Under the Act, states are now prohibited from placing enrollment caps on their Section 1915(i) programs or targeting specific geographic regions.[30] Under the Act states now may target the Section 1915(i) benefit to specific populations and vary it with population.[31] Although states are no longer allowed to impose enrollment caps, they are allowed to tighten eligibility standards if projected enrollment targets are exceeded.[32] If states choose to tighten eligibility standards, they must grandfather in current enrollees (unless enrollees' conditions change).[33] Although the enhanced structural flexibility may encourage states to expand home- and community-based services, it could also be used by states to cut these services to select populations.

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[25]Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (codified as amended at 42 U.S.C. § 1396n(i) (2006)).

[26]Patient Protection and Affordable Care Act § 2402(b).

[27]Although an exact reading of Section 2402(g) of the Patient Protection and Affordable Care Act would make April 1, 2010, the effective date, the Centers for Medicare and Medicaid Services' interpretation is to make October 1, 2010, the effective date (see Letter from Cindy Mann, Director, Center for Medicaid, CHIP, and Survey and Certification, to State Medicaid Directors (Aug. 6, 2010), http://1.usa.gov/pvx0Gr).

[28]Patient Protection and Affordable Care Act § 2402(b) (codified as amended at 42 U.S.C. § 1396n(i)(6)(A)).

[29]*Id.* § 2402(c) (codified as amended at 42 U.S.C. § 1396n(i)(1)).

[30]*Id.* § 2402(e)(1) (codified as amended at 42 U.S.C. § 1396n(i)(1)(C)) (prohibiting enrollment caps), § 2402(f) (codified as amended at 42 U.S.C. § 1396n(c)(3)) (prohibiting targeting geographic regions).

[31]*Id.* § 2402(b) (codified as amended at 42 U.S.C. §§ 1396n(i)(6)(C) and (i)(7)), § 2402(f) (codified as amended 42 U.S.C. § 1396n(i)(3)).

[32]42 U.S.C. § 1396n(i)(1)(D)(ii).

[33]Patient Protection and Affordable Care Act § 2402(e)(2) (codified as amended at 42 U.S.C. § 1396n(i)(1)(D)(ii)(II)).

The Patient Protection and Affordable Care Act makes one more remarkable change in the Section 1915(i) provision. As originally designed in the Deficit Reduction Act, Section 1915(i) allowed states to create a new Medicaid home- and community-based *service*, meaning it enabled states to offer such a service to individuals already eligible for Medicaid. The Patient Protection and Affordable Care Act continues to allow states to operate Section 1915(i) as a service option. However, the Act also authorizes states to use Section 1915(i) as a categorical basis for *eligibility*, meaning states may use it to make people eligible for Medicaid, above and beyond providing the particular Section 1915(i) services.[34] States may use this new category of eligibility to cover individuals up to 150 percent of the federal poverty level with full-scope Medicaid.[35] Although states already have authority to create categorical eligibility through waiver programs up to a higher level (300 percent of the Supplemental Security Income benefit), this Section 1915(i) option gives states new plan flexibility similar to that of waivers.

Community First Choice Option: The New Section 1915(k) Benefit. The Patient Protection and Affordable Care Act creates an entirely new pathway for state-plan coverage of home- and community-based services in Social Security Act § 1915(k), known as the Community First Choice Option.[36] This optional program allows states to offer home- and community-based services through their state plans to individuals already eligible for Medicaid; it does not create a new basis for Medicaid eligibility. States may use the Community First Choice Option for home- and community-based services to individuals who had no such services or to transition current waiver populations to this option. States gained authority starting October 1, 2011, to file state-plan amendments implementing the program.

The incentive to deliver new and current home- and community-based services through the Community First Choice Option is a 6 percent increase in federal Medicaid matching funds for these services.[37] With enhanced federal funding, this program has the potential to be one of the most cost-effective ways for a state to provide home- and community-based services. Along with the boost in federal matching funds, however, states taking the option must maintain spending levels through the end of the first full fiscal year after adopting the Community First Choice Option.[38]

Eligibility for the Community First Choice Option is complex. The standard income limit for the program is 150 percent of the federal poverty level, but the state must set the limit at 300 percent of the Supplemental Security Income level (about 225 percent of the federal poverty level) if the state has already chosen to use that higher level for its long-term care eligibility.[39] Regardless of the income limit, there is an additional two-tiered level of need eligibility require-

[34] *Id.* § 2402(d) (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(ii)).

[35] *Id.* The 150 percent income limit is based on the eligibility standards under Section 1915(i) of the Social Security Act.

[36] *Id.*, Pub. L. No. 111-148, § 2401, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1205, 124 Stat. 1029 (2010) (codified as amended at Social Security Act § 1915(k), 42 U.S.C. § 1396n(k)).

[37] 42 U.S.C. § 1396n(k)(2).

[38] *Id.* § 1396n(k)(3)(C). The Patient Protection and Affordable Care Act applies this "maintenance of effort" requirement to all spending on older adults and individuals with disabilities. This is overly broad since much of that general spending would fall outside the domain of spending under the Community First Choice Option. Recent proposed regulations on Community First Choice, however, have swung the pendulum too far in the other direction, suggesting that the maintenance-of-effort requirement should be applied only to personal care services—a definition that would be too narrow considering all of the home- and community-based services for which the program could account. The Centers for Medicare and Medicaid Services' review of comments on the proposed regulation is under way, and a final interpretation of the maintenance-of-effort requirement is pending.

[39] 42 U.S.C. § 1396n(k)(1). Ambiguity in the Community First Choice statute and proposed regulation has made unclear whether states would be *required* to set their income limits at 300 percent of the Supplemental Security Income level—the interpretation favored by the Centers for Medicare and Medicaid Services. The Centers for Medicare and Medicaid Services could change this policy in the final Community First Choice regulations and give states the *option* to use the higher limit.

ment.[40] At up to 150 percent of the federal poverty level, the state is not required to apply an eligibility test of being clinically in need of institutional care, but the state may choose to do so. However, at above 150 percent of the federal poverty level, the state must apply this standard for eligibility.

The Patient Protection and Affordable Care Act details mandatory, optional, and prohibited services for state Community First Choice programs.[41] The optional services include a range of transition services, such as rent or utility deposits, which are a useful expansion of home- and community-based services. The Act also contains a wealth of consumer-centered requirements such as those related to person-centered care planning, integrated settings, and consumer-directed delivery models.[42] In fact, states must implement the Community First Choice Option in collaboration with a stakeholder council that includes consumers.[43]

Whether the enhanced matching funds will lead many states to offer new home- and community-based services through the Community First Choice Option or shift some current services to this program remains to be seen. Whether the Section 1915(i) changes will attract more state interest in that benefit is also unknown. What is clear is that the Patient Protection and Affordable Care Act includes a concerted effort—through the Section 1915(i) changes and the Community First Choice Option—to offer states more opportunities to provide home- and community-based services through their Medicaid state plans as opposed to the waivers that currently dominate Medicaid delivery of home- and community-based services.

Uniformity in Consumer-Focused Standards for Home- and Community-Based Services

Program alternatives for Medicaid delivery of home- and community-based services have developed in a piecemeal manner, resulting in a "system" that is fragmented, with a significant lack of uniformity regarding key definitions and standards around critical issues such as services, assessment, and administration. The Patient Protection and Affordable Care Act has prioritized program uniformity in home- and community-based services in both waiver and state-plan programs. The push toward uniformity is critical not only for administrative efficiency but also for the emphasis on high-quality, consumer-focused coordination of home- and community-based services across all programs.

Section 2402(a). The Patient Protection and Affordable Care Act is explicit on Medicaid home- and community-based services uniformity in Section 2402(a), which orders HHS to promulgate regulations to ensure that state service systems "allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports"; "provide the support and coordination needed for a beneficiary in need of such services"; and "improve coordination … of … all providers of such services under federally and State-funded programs."[44]

The regulations will thus need to be extremely broad in scope and consider programs run through Medicaid, Medicare, the Administration on Aging, and the Substance Abuse and Mental Health Administration, among others. HHS

[40] *Id.* This issue has also been the source of some confusion because the statutory language in the Patient Protection and Affordable Care Act on this point is poorly drafted and open to alternative interpretations. My description here matches the interpretation that appears in the proposed regulation on the Community First Choice Option.

[41] *Id.*

[42] See *id.* § 1396n(k)(1)(A), (k)(3)(B).

[43] *Id.* § 1396n(k)(3)(A).

[44] Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 2402(a), 124 Stat. 119, 301–2 (2010).

indicated that numerous federal offices were coordinating to develop the regulation and that it might be issued in the second half of 2011.[45]

Although Section 2402(a) is brief, it does offer some additional guidance about the priorities that the uniform system of home- and community-based services should handle. Conceptually Section 2402(a) emphasizes consumer-centered care. For example, Section 2402(a) specifically requires the regulation to promote "strategies for beneficiaries receiving such services to maximize their independence" and "individualized, self-directed, community-supported life."[46] It also seeks to establish "more consistent administration of policies and procedures across programs" and better oversight of programs, including assessment, grievance, quality, and workforce development systems.[47]

Rulemaking and Guidance. While the regulations required by Section 2402(a) raise hopes for more coordinated and consumer-focused systems for home- and community-based services, they created a paradox for the HHS' Centers for Medicare and Medicaid Services. Waiting until the Section 2402(a) regulation is promulgated would delay implementing the new home- and community-based service programs, but at the same time implementing these programs without the Section 2402(a) uniformity regulation only furthers the fragmentation problem. The Centers for Medicare and Medicaid Services' solution to this quandary has been to move forward with the necessary program regulations while developing and refining the uniformity principles with each iteration of guidance. The forthcoming Section 2402(a) regulations might best be thought of as the culmination of what has been advanced with each piece of guidance from the Centers for Medicare and Medicaid Services:

- On August 6, 2010, the Centers for Medicare and Medicaid Services wrote to state Medicaid directors about implementing the enhanced Section 1915(i) benefit, focusing on its technical rules.[48] While explicitly mentioning the need for integrated settings and *Olmstead* compliance, the letter did not advance uniformity of consumer-centered principles.[49]
- On February 25, 2011, the Centers for Medicare and Medicaid Services issued a proposed regulation implementing the Community First Choice Option.[50] The regulation specifically notes the attempt to develop systemwide uniformity of key standards. For example, it cites the difficulty in defining an "integrated setting" and attempts to identify settings that might technically be "noninstitutional" but that are not truly integrated and stresses the need for uniformity in this standard in a future Section 1915(c) regulation.[51]
- On April 15, 2011, the Centers for Medicare and Medicaid Services issued a proposed regulation on the Section 1915(c) waiver program (a reissued regulation completely unrelated to the Patient Protection and Afford-

[45]U.S. Department of Health and Human Services, Briefing and Discussion, Section 2402(a) of the Affordable Care Act: Oversight and Assessment of Home and Community Based Services (June 17, 2011) (unpublished PowerPoint presentation in my files).

[46]Patient Protection and Affordable Care Act § 2402(a).

[47]*Id.*

[48]Mann, *supra* note 27.

[49]The *Olmstead* principle maintains that providing services in a way that forces individuals with disabilities into institutions violates the Americans with Disabilities Act. In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court held that two women with developmental disabilities and mental illness were victims of discrimination based on their disabilities when they were institutionalized against their will. *Olmstead* has been used to prevent states from cutting home or personal care services that might force individuals with disabilities into institutions.

[50]Medicaid Program; Community First Choice Option, 76 Fed. Reg. 10736 (Feb. 25, 2011) (to be codified at 42 C.F.R. pt. 441).

[51]*Id.* at 10741.

able Care Act).[52] The Section 1915(c) waiver regulation technically modified Section 1915(c) but also promoted uniform standards on several consumer-centered topics such as person-centered plans of care, public input requirements, and integrated settings. The Section 1915(c) regulation implements the Community First Choice language of "integrated settings" with some further refinements.

The Centers for Medicare and Medicaid Services' accomplishment through regulations has been to refine standards for home- and community-based services—such as "integrated setting"—to develop uniform definitions for a coordinated system that better serves the consumers of the many home- and community-based programs. This progress toward uniformity, driven by the Patient Protection and Affordable Care Act, will ultimately be memorialized in the Section 2402(a) regulation explicitly promoting uniformity and consumer-centered standards and procedures.

■ ■ ■

The Patient Protection and Affordable Care Act represents a real opportunity for states to better the lives of millions of individuals by providing them with Medicaid home- and community-based alternatives to institutions. The Act creates numerous new home- and community-based options for states and shifts the Medicaid services delivery system by incentivizing rebalancing, creating state-plan options, and promoting uniformity in consumer-centered standards.

[52]Medicaid Program: Home and Community-Based Services (HCBS) Waivers, 76 Fed. Reg. 21311 (April 15, 2011) (to be codified at 42 C.F.R. pt. 441).

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- ☐ None of the above

What is the size of your organization?

- ☐ 100+ staff members
- ☐ 51–99 staff members
- ☐ 26–50 staff members
- ☐ 1–25 staff members
- ☐ Not applicable

Please e-mail this form to subscriptions@povertylaw.org.
Or fax this form to Ilze Hirsh at 312.263.3846.

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