



April 2010

The Medicaid Long-Term Services and Supports Provisions in the Health Care Reform Law

Introduction¹

With the enactment of the *Patient Protection and Affordable Care Act* (PPACA) on March 21, 2010, health care reform finally became a reality. This historic legislation will impact virtually every facet of the nation's healthcare system and provides numerous opportunities for millions of individuals to receive services to which they currently lack access. One particular area in which this is the case is in Medicaid's coverage for long-term services and supports (LTSS).

Medicaid is the single largest purchaser of LTSS in the nation, but the program continues to spend more for institutional care than for community-based care for enrollees with LTSS needs. Over the years, Congress has gradually expanded Medicaid's community-based service options, but the balance of expenditures still falls on the side of nursing homes and other facilities. In the PPACA, however, Congress took arguably its most aggressive action toward the "rebalancing" of Medicaid's LTSS spending since it created the Medicaid home and community-based services waiver program in 1981.

Specifically, the PPACA: authorizes a Medicaid "Balancing Incentive Payment Program," under which participating states will receive additional federal financial assistance if they commit to shifting more of their Medicaid LTSS spending toward noninstitutional care; creates a new community-based option for individuals otherwise eligible for Medicaid institutional coverage; enhances the HCBS state plan benefit authorized by the *Deficit Reduction Act of 2005* (DRA);² mandates, at least temporarily, spousal impoverishment protections for spouses of all individuals receiving coverage for HCBS waiver services and certain state plan services; extends authorization of the Money Follows the Person program through 2016; and authorizes additional funding for Aging and Disability Resource Centers.

These new, or in some cases enhanced, services and programs should increase the opportunities for Medicaid enrollees with chronic conditions to receive services in the settings of their choice,

¹ This issue brief is part of a series of issue briefs prepared by NSCLC which discusses the impact of the new law on low-income older adults. The others are: [Health Care Reform & Low-Income Adults: An Overview](#); [Health Care Reform & the Individual Mandate](#); [Health Care Reform & Long-Term Care Facilities](#); [Health Care Reform, Dual Eligibles & Coverage Expansion](#); and [Health Care Reform: "Medical Assistance" as Payment](#). This particular issue brief is a modified version of the NSCLC paper released in January 2010 entitled, "The Medicaid Long-Term Services and Supports Provisions in the Senate's *Patient Protection and Affordable Care Act*." All of our health reform issue briefs are available at www.nslc.org.

² Pub. L. No. 109-171, §6086

a prospect increased by the financial incentives for states that accompany many of the options. What follows is an analysis of these provisions.

State Balancing Incentive Payments Program (Section 10202)

According to data included in a 2008 AARP Public Policy Institute report, only five states directed at least 50% of their total Medicaid LTSS expenditures toward HCBS in 2006 (Oregon, New Mexico, Washington, Alaska, and California).³ When the data was analyzed narrowly for state spending on HCBS for individuals 65 years and older and adults with physical disabilities, it showed only four states spending at least 50% (Oregon, New Mexico, Washington and Alaska), and only 12 others spending at least 25%. While the report noted the progress states have made in providing more HCBS coverage under their Medicaid programs, the data clearly revealed that states still have a long way to go toward “balancing” their Medicaid LTSS expenditures.

Section 10202 of the PPACA, entitled “Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes,” offers states the broad encouragement to shift their Medicaid LTSS spending from institutions to the community through a “Balancing Incentive Payment Program.” Under this program, states that are spending less than 50% of their total Medicaid LTSS dollars on HCBS may be selected to receive an enhanced federal reimbursement rate for *all* HCBS covered under their Medicaid programs during the “balancing incentive period” of October 1, 2011 through September 30, 2015.

A state wishing to be selected must submit a plan to the U.S. Department of Health and Human Services (HHS) that proposes a budget and describes how the state will “expand and diversity” its Medicaid coverage for noninstitutional services, including identifying any new service options it will offer.⁴ A state that devoted less than 25% of its Medicaid LTSS spending on HCBS in fiscal year 2009 must aim to reach 25% (its “targeted spending percentage”) no later than October 1, 2015. If selected by HHS for participation, these states will receive an increase of five percentage points in their federal Medicaid reimbursement rate for the HCBS they provide coverage for during the balancing incentive period.

All other participating states must have a targeted spending percentage of 50% for their HCBS coverage (also to be reached by October 1, 2015). These states will receive an enhanced reimbursement rate of two percentage points for HCBS covered during the balancing incentive period.

Regardless of the reimbursement increase for which they may be eligible, states are limited in the aggregate total of money they may receive through the program to \$3 billion. All participating

³ Enid Kassner, et al., AARP Public Policy Institute, A Balancing Act: State Long-Term Care Reform (2008), available at http://assets.aarp.org/rgcenter/il/2008_10_ltc.pdf. Data from Arizona and Vermont was not included in the report. Additionally, State Medicaid coverage for home health services was not factored into the data.

⁴ A state seeking selection that proposes, as a method of expanding HCBS, the adoption of the HCBS state plan benefit may apply toward the benefit an income eligibility limit of 300% of the Supplemental Security Income federal benefit rate, instead of the 150% of the federal poverty level limit otherwise applicable to the benefit (see below for more information about the HCBS state plan benefit).

states must use the additional funds they receive for new or expanded HCBS services. Additionally, during the balancing incentive period, states may not make more restrictive their eligibility requirements for HCBS services than their requirements are as of December 31, 2010.

Participating states are also required to make, within six months of the submission of their applications, “structural changes” to their LTSS systems that include: the establishment of a “single entry point system” for individuals seeking access to LTSS; conflict-free case management services for individuals eligible for LTSS; and a standardized assessment instrument to be used state-wide for determining eligibility for HCBS.

Comment

This program will hopefully advance state progress in making more community-based opportunities available for individuals with chronic needs. Some states will certainly be interested in participating, given the enhanced federal reimbursement rate that is available. When states were offered a similar incentive upon authorization of the Money Follows the Person program in 2006 (described more fully below), more than 30 states applied for participation.

But key to how the program develops will be the oversight role played by HHS. How states are evaluated for selection or compelled to meet their targeted spending percentage will be almost solely within HHS’ purview to determine—there is no penalty dictated by the statute, for example, for a state’s failure to meet its targeted spending percentage. Thus, the promise the program holds will be largely dependent on the level of HHS’ commitment to the balancing of Medicaid’s LTSS delivery.

Community-Based Attendant Service Option (Section 2401)

State Medicaid agencies generally develop a clinical eligibility standard for Medicaid LTSS coverage. Individuals who meet this standard and also meet Medicaid’s financial eligibility requirements are guaranteed coverage for nursing facility services.⁵ If the individual does not want to be institutionalized, the Medicaid options available may include an HCBS waiver, personal care services, home health services, or HCBS state plan services.⁶ With the exception of home health services, however, it is at the option of the state to offer these services, and with regard to HCBS waiver programs, states are limited in the expenditures they may make.⁷

Section 2401 of the PPACA, entitled “Community First Choice Option,” makes a new service available to the Medicaid LTSS population and offers states the incentive to provide coverage for it. The provision, which adds a new paragraph (k) to 42 U.S.C. §1396n, provides states the

⁵ 42 U.S.C. §§1396a(a)(10)(A), 1396d(a)(4)(A)

⁶ Only the HCBS waiver program requires an individual to meet the state’s Medicaid LTSS clinical standard to receive services. See 42 U.S.C. §1396n(c)(1). Federal law prohibits states from requiring individuals to meet the LTSS standard in order to receive Medicaid home health services or HCBS state plan services. See 42 U.S.C. §1396n(i)(1) (relating to Medicaid HCBS state plan services), and 42 C.F.R. §441.15(c) (relating to home health services).

⁷ 42 U.S.C. §1396n(c)(2)(D)

option to offer community-based attendant services as a state plan benefit to individuals who meet the state's nursing facility clinical eligibility standard. The provision not only frees states from the expenditure caps currently applicable in HCBS waiver programs, it also dictates that states receive an increase in their standard Medicaid reimbursement rate of six percentage points for the services provided through the option.

An income cap is included. States may not offer eligibility to an individual whose income is above 150% of the federal poverty level (FPL), unless the state's nursing facility income eligibility threshold is greater, in which case the state is authorized to apply the latter standard. Federal law authorizes states to adopt a special income eligibility level for individuals seeking coverage for nursing facility services.⁸ This level can be up to 300% of the Supplemental Security Income (SSI) federal benefit rate, which, for a single individual in 2010, is equal to \$2,022 a month (150% of the FPL for a single individual in 2010 is \$1,354 a month). If a state has exercised its authority to apply a special income level for its Medicaid nursing facility population and the state's level is higher than 150% of the FPL, the state may choose to apply the special income level as the eligibility limit for community-based attendant services.

Individuals eligible in states that adopt the option receive coverage for the attendant services necessary to assist with activities of daily living and instrumental activities of daily living. Section 2401 limits coverage to individuals who are not in a "nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded." However, for institutionalized individuals who meet the eligibility requirements for community-based attendant services, the provision authorizes states to provide coverage for costs related to a transition from a facility into the community. Transition costs include: rent and utility deposits; *first month's rent* and utilities; bedding; basic kitchen supplies; and other necessities that would facilitate the individual's transition.⁹

States choosing to adopt the option must establish a Development Implementation Council that includes a majority of members with disabilities, elderly individuals and their representatives, and the state must collaborate with the council in the development and implementation of the state plan amendment. Additionally, the provision directs that the services be available on a "statewide basis" and be provided "without regard to the individual's age, type or nature of disability, severity of disability, or the form of . . . services and supports that the individual requires in order to lead an independent life."

The provision also directs that the community-based attendant services be provided in the "most integrated setting appropriate to the individual's needs." This may ultimately require states to examine the community character of the location in which an individual is receiving community-

⁸ 42 U.S.C. §1396a(a)(10)(A)(ii)(V)

⁹ Coverage for the first month's rent is a noteworthy feature. States are independently authorized to receive federal reimbursement for transition-related services such as rental (e.g., security) *deposits*, but this authority specifically excludes direct payment for rent itself. See Letter from the Center for Medicaid and State Operations to State Medicaid Directors (May 9, 2002), available at <http://www.cms.hhs.gov/smdl/downloads/smdl050902a.pdf>. This limitation was reemphasized in communications sent by the Centers for Medicare & Medicaid Services (CMS) to states that received grants to transition nursing facility residents to the community through the Money Follows the Person program. (Letters on file with author).

based attendant services. In regulations it has proposed for the HCBS state plan benefit, CMS has suggested that, where a prospective recipient is living in a residence with four or more persons unrelated to the proprietor, states evaluate whether the location is a “community” one relative to the person’s needs.¹⁰ CMS has also recently proposed developing regulations that would more specifically define the nature of community-based residences for purposes of all Medicaid HCBS programs and services,¹¹ even though most of the statutory provisions authorizing them only identify what may *not* be a community-based residence (e.g., hospital, nursing facility, or intermediate care facility for the mentally retarded). The specific reference to “most integrated setting” in the provision seems to be in the same vein as the recent CMS proposals.

States that adopt the service must also assist the federal government in evaluating the effectiveness of the program, which includes an analysis of the extent to which recipients of the service have been assisted to “lead an independent life to the maximum extent possible.” While authorization for the service is not time-limited, the Secretary of Health and Human Services will be responsible for providing a report to Congress, based on data sharing provided by participating states, by the end of the calendar 2015 year.

States may begin providing coverage for the Community First Choice Option beginning October 1, 2011.¹²

Comment

Ideally, this would be a mandatory Medicaid benefit that would not have an income limit attached to it. However, its addition to the Medicaid program will still be a significant development, in that a Medicaid enrollee in a state that has adopted the option whose needs are at least equivalent to the state’s Medicaid LTSS standard and who is financially eligible for the service will have the choice between nursing facility care or community-based attendant services. The incentive the provision offers states to adopt the option is also very important. The HCBS state plan benefit that Congress added to Medicaid’s optional services in the DRA did not include a federal match increase, and so far, only four states have added the benefit to their Medicaid programs. On the other hand, the Money Follows the Person that was also authorized by the DRA (see below) did include a federal match increase, and 31 states adopted the program. The addition to Medicaid of the community-based attendant service benefit should therefore be a very valuable addition to the Medicaid program.

¹⁰ 73 Fed. Reg. 18676, 18685 (April 4, 2008).

¹¹ 74 Fed. Reg. 29454 (June 22, 2009).

¹² Certain provisions of the PPACA were modified by the *Health Care and Education Affordability Reconciliation Act of 2010*, Pub. L. No. 111-152 (the “Reconciliation Act”), enacted on March 30, 2010. The PPACA authorized states to begin providing coverage for the Community First Choice option beginning October 1, 2010, but Section 1205 of the *Reconciliation Act* delayed the effective date until October 1, 2011.

Improvements to the HCBS State Plan Benefit (Section 2402)

Historically, Medicaid enrollees who require a package of community-based services to help them stay out of institutions have had to qualify for HCBS waivers, two requirements of which are that the waiver participants have a level of need equal to their state's nursing facility clinical eligibility standard and that the states not spend more on the care for the waiver participants than they would if the participants were institutionalized. The DRA, however, created the HCBS state plan benefit,¹³ which authorizes states to provide packages of HCBS services to individuals who have lower levels of need without the budget neutrality requirement of HCBS waiver programs. Iowa, Nevada, Colorado, and Washington have adopted the option.

Section 2402 of the PPACA, entitled "Removal of Barriers to Providing Home and Community-Based Services," makes a number of changes to the current statutory framework of the HCBS state plan benefit.

The law expands the services available to individuals who qualify for the HCBS state plan benefit. Originally, the statute authorized only a finite number of services that could be included in the benefit, and it expressly denied CMS the authority to permit states to include services that CMS could approve for HCBS waivers.¹⁴ The law removes the limitation on CMS authority and allows states to include, subject to CMS approval, services additional to the ones specifically identified in the statute.

The PPACA also removes the authority for states to limit coverage of the HCBS state plan benefit to certain geographical areas of their states. Additionally, the PPACA removes state authority to cap the number of individuals who receive coverage for the benefit. Conversely, however, the PPACA allows states to elect not to comply with Medicaid's *comparability* mandate in the provision of the HCBS state plan benefit, which will allow states to *target* the benefit to individuals with particular conditions if the state wishes.

The PPACA also protects Medicaid beneficiaries receiving coverage for the HCBS state plan benefit from losing coverage in the event a state modifies its clinical eligibility standard. The hallmark of the HCBS state plan benefit is that the clinical eligibility standard for coverage must be less restrictive than the state's clinical standard for coverage of nursing facility services/HCBS waiver services. The statute, however, permits a state to tighten its clinical standard for the state plan benefit if the state's projected enrollment for the benefit is exceeded.¹⁵ Originally, individuals receiving coverage for the state plan benefit at the time of the modification who failed to meet the modified criteria were grandfathered for only a limited

¹³ Pub. L. No. 109-171, §6086, codified at 42 U.S.C. §1396n(i)

¹⁴ 42 U.S.C. §1396n(i)(1). The only services that originally could be included in the HCBS state plan benefit package were: case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and, for individuals with chronic mental illness, day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services.

¹⁵ In addition to allowing states to limit the number of individuals receiving coverage for the HCBS state plan benefit, the original statute also required that states *project* for CMS the number of individuals who will receive coverage. 42 U.S.C. §1396n(i)(C)(i). The projection requirement remains in the statute.

period of time. The PPACA's amendment to the provision requires that these individuals maintain eligibility for as long as their conditions meet the pre-modified criteria.

The PPACA also authorizes states to make individuals who meet the eligibility requirements for the HCBS state plan benefit an optional categorical eligibility group. Under the statutory framework of the HCBS state plan benefit, some individuals who have incomes under the 150% FPL income cap and who meet the state's clinical eligibility standard cannot access the benefit. For example, states generally must provide Medicaid to Supplemental Security Income (SSI) recipients,¹⁶ whose incomes are, for 2010, approximately 75% of the FPL,¹⁷ while states have the *option* to extend coverage to individuals 65 years old or older or who have disabilities who are not SSI recipients and whose incomes are at or below 100% of the FPL.¹⁸

Thus, a 70 year-old individual whose income is too high to qualify for SSI but below 100% of the FPL and who lives in a state that has not adopted the optional 100% FPL categorical group and does not offer coverage to the medically needy may not access the benefit, because he or she is not otherwise eligible for Medicaid. If this individual's state wanted to allow the individual to access the HCBS state plan benefit, the state has the option to incorporate the 100% FPL category or medically needy category into its state Medicaid program, in which case the state would be required to provide Medicaid to all individuals who meet the financial eligibility requirements for the categories, regardless of whether they require HCBS services.

The PPACA allows states to create *a separate eligibility category* for individuals whose incomes are at or below 150% of the FPL and who meet the states' HCBS state plan benefit clinical eligibility standard. Because all individuals who would qualify under this optional category would be categorically eligible individuals, they would receive, in addition to the services available in the HCBS state plan service package, coverage for all mandatory Medicaid services.

Comment

The PPACA's changes do not eliminate the current statute's income cap, which means some Medicaid enrollees who have a need for the service will be denied access to it.¹⁹ Furthermore, if an income cap is to be imposed, it would make more sense to authorize all states to apply a cap as high as 300% of the SSI FBR, instead of limiting this authority to those states selected for the State Balancing Incentive program who propose adopting it as a method of increasing their HCBS (a possible, although narrow, reading of the language of the balancing incentive provision would deny those states selected for participation the option to choose the 300% SSI FBR if they already have adopted the HCBS state plan benefit).

Nevertheless, the changes will enhance the HCBS state plan benefit. The statute's original limitation on the services that could be included in the benefit package was a barrier to a state's use of this option as an effective tool for delaying or offsetting the onset of an institutional level

¹⁶ A few states, the "209(b)" states, are permitted to apply more restrictive criteria. See 42 U.S.C. §1396a(f).

¹⁷ The SSI monthly federal benefit rate for a single individual in 2010 is \$674.

¹⁸ 42 U.S.C. §1396a(a)(10)(A)(ii)(X)

¹⁹ For example, individuals with incomes above 150% of the FPL who qualify for Medicaid through a state's medically needy category would remain ineligible for the benefit in lieu of the changes.

of need on the part of program enrollees. Removing this barrier by allowing CMS to authorize more services is a critical improvement. The new optional category will also be an important addition to Medicaid, as it would allow, in states that adopt the option, individuals with incomes at or below 150% of the FPL to automatically qualify, where many of these individuals would have to spend down their income on uncovered medical expenses to qualify, or would otherwise not be eligible for Medicaid at all. Mandating the statewide application of the benefit and protecting recipients of the benefit against termination where their states modify the clinical criteria are also valuable changes. Overall, the PPACA's changes to the Medicaid HCBS state plan benefit will make the benefit a better service for Medicaid beneficiaries.

Money Follows the Person (Section 2403)

The DRA authorized \$1.7 billion for the Money Follows the Person program (MFP),²⁰ under which 31 states were awarded grants to transition Medicaid-enrolled nursing facility residents to their homes or other community settings. The “grants” states have received come in the form of an enhanced federal match for the services provided to program participants for the first 12 months after a participant’s transition. Approximately 37,000 individuals were projected to be transitioned under MFP. The DRA authorized MFP through 2011.

Section 2403 of the PPACA, entitled “Money Follows the Person Rebalancing Demonstration,” authorizes continued federal support for MFP through 2016, and also relaxes one of the program’s primary eligibility requirements. The DRA mandated that program participation be available only to Medicaid-enrolled nursing facility residents who have been institutionalized for not less than six months. The law also authorized states to impose a longer minimum residency requirement of between six months and two years. The PPACA reduces the minimum residency requirement from six months to 90 days and eliminates the state authority to impose a longer minimum period. However, any days an individual spends in an institution receiving short-term rehabilitative services will “not be taken into account for purposes of determining the 90-day period” under the law.

Comment

The MFP program is a valuable component of the effort to “balance” Medicaid’s spending for LTSS. While CMS had authorized states before enactment of the DRA to receive federal reimbursement for transition assistance provided to institutionalized individuals moving to the community, the MFP program provided an important incentive to states, and thereby increased the possibility for many institutionalized individuals to return home or to other community settings. The extension of the MFP through 2016 will provide continued encouragement to states to assist institutionalized individuals to accomplish this.

²⁰ Pub. L. No. 109-171, §6071

Temporary Expansion of Spousal Impoverishment Protections (Section 2404)

Federal law requires that the spouse of any Medicaid-enrolled nursing facility resident be allowed to keep a minimum share of the couple's combined income and assets.²¹ For 2010, the "community" spouse is entitled to at least \$1,821 of the couple's combined monthly income, or a maximum of \$2,739, although the amount may be even higher where the community spouse is threatened with "significant financial duress."²² With regard to assets, the community spouse is entitled to either a minimum of \$21,912 (in 2010) or 50% of the couple's combined assets, whichever is greater (up to a maximum in 2010 of \$109,560).

While current federal law requires that states extend the spousal impoverishment protections to the spouses of nursing facility residents, the law makes the extension of the protections to the spouses of HCBS waiver enrollees discretionary for states.²³ Additionally, CMS has recently taken the position that, where a state does choose to include the protections in an HCBS waiver, the spouses of waiver participants who qualify as medically needy are prohibited from being extended the protections.²⁴

Section 2404 of the PPACA, "Protection for Recipients of Home and Community-Based Services Against Spousal Impoverishment," modifies the spousal impoverishment statute to *mandate* that states include the spousal impoverishment protections in their waiver programs, and that the spouses of *all* HCBS waiver participants, including those who qualify as medically needy, have the protections available. Additionally, the PPACA mandates that the protections be extended to the HCBS state plan benefit, as well as the community-based attendant services benefit that is created by the law. All of the changes in this provision, however, will not become effective until January 1, 2014, and will end December 31, 2019, at which point the current language of the statute will become effective again (meaning, that it would no longer be mandatory that states extend the protections to HCBS waiver enrollees, and the protections would not be available to the HCBS state plan service or community-based attendant service recipients).

The application of the spousal impoverishment protections to individuals seeking coverage for a discrete state plan benefit would be new. Generally, the spousal impoverishment protections, at least as they pertain to income, are grafted into the unique post-eligibility income treatment applied by the federal regulations to Medicaid-enrolled nursing facility residents and HCBS waiver enrollees.²⁵ In this evaluation, specific portions of an enrollee's monthly income are allocated between a personal maintenance allowance, a community spouse maintenance allowance, and the enrollee's share of the cost of the covered services. But a Medicaid enrollee not in a nursing facility or HCBS waiver and receiving state plan services, such as the HCBS state plan benefit, may have co-pays for services he or she receives, but will not be subject to the

²¹ 42 U.S.C. §1396r-5. The minimum income and asset allotments are adjusted annually.

²² 42 U.S.C. §1396r-5(e)(2)(B)

²³ 42 U.S.C. §1396r-5(h)(1)

²⁴ The spousal impoverishment statute authorizes states to extend the protections to waiver participants who are referenced in 42 U.S.C. §1396a(a)(10)(A)(ii)(VI), which CMS has opined is limited to waiver participants whose income is within the state's special income level for nursing facility coverage. (CMS letters on file with author).

²⁵ See 42 C.F.R. §§435.725, 726, 733, 735, 832.

same income allocations as nursing facility or HCBS waiver enrollees. Thus, CMS will have to help states walk through this process for the recipients of the state plan benefits referenced in this section.

One clear benefit of extending the spousal impoverishment protections to individuals seeking coverage for HCBS state plan services or community-based attendant services is that the income of the individual's spouse will not be counted in determining eligibility. Generally, the income of a Medicaid applicant's spouse is deemed available to the applicant in evaluating his financial eligibility, but the spousal impoverishment statute mandates that the income of spouses be treated separately.²⁶ Because both the HCBS state plan and community-based attendant service benefits have income ceilings, the separate treatment of income that will apply by virtue of application of the spousal impoverishment protections will benefit an individual whose spouse's income would, if deemed available, otherwise render the applicant ineligible.

Comment

By mandating that states extend impoverishment protections to spouses of institutionalized Medicaid enrollees but not for HCBS waiver enrollees, the current spousal impoverishment statute provides a stark example of Medicaid's institutional bias. The PPACA will therefore take a critical step toward reducing this bias when its spousal impoverishment provisions become effective in 2014. Of equal importance is that the law will ensure that spouses of Medicaid HCBS enrollees who qualify as medically needy are not discriminated against in the extension of the protections in waiver programs, which is the upshot of CMS' current reading of the statute. Finally, by also adding the mandate that spouses of recipients of the HCBS state plan and community-based attendant services receive the protections, the sum of the changes in Section 2404 stand out in their degree of beneficiary friendliness.

The only drawback of the changes in this section is that they would sunset after five years.

Additional Support for Aging and Disability Resource Centers (Section 2405)

For several years, the federal government has been supporting state efforts to establish Aging and Disability Resource Centers (ADRCs). The goal of the ADRC program is to have states create one-stop shops for consumer information on LTSS. In 2006, Congress mandated that the Assistant Secretary on Aging implement an ADRC program in all states for the purpose of having the ADRCs "serve as visible and trusted sources of information on the full range of long-term care options, including both institutional and home and community-based care, which are available in the community."²⁷ Section 2405 of the PPACA, entitled "Funding to Expand State Aging and Disability Resource Centers," authorizes \$10 million in additional support for the ADRC programs from 2010 through 2014.

²⁶ 42 U.S.C. §1396r-5(b)(1)

²⁷ Older Americans Act Amendments of 2006, Pub. L. No. 109-171, §202(b)(8), codified at 42 U.S.C. §3012(b)(8). In FY 2009, the U.S. Administration on Aging provided 46 states and the District of Columbia grants to support ADRCs. See http://www.aoa.gov/AoAroot/AoA_Programs/HCLTC/ADRC/docs/2009/ADRCFundingTable.pdf.

The ADRC program is a valuable AoA initiative that is worthy of the additional support provided by the law.

Summary

The PPACA creates the Community Living Assistance Services and Supports program (the “CLASS” program), which is a national voluntary LTSS program that will provide coverage for a host of community-based services to enrollees who have paid premiums for at least five years. As ambitious as the program is, there is little doubt that Medicaid will maintain a primary role in delivering LTSS coverage to the nation’s seniors now and for the foreseeable future. Given Medicaid’s role, and the vast increase in the chronically ill population that will accompany the surge in the older population in the next thirty years, there was no doubt that an effort to bring about comprehensive health reform required improvements to Medicaid’s LTSS framework.

The PPACA makes a number of critical improvements to Medicaid’s LTSS coverage. Historically, Medicaid has relied on institutions for its delivery of LTSS coverage, but the number of community-based options under Medicaid has grown over the years, and the PPACA continues this necessary trend. As evidenced by the authorization of the Money Follows the Person program, there is broad agreement that there are institutionalized Medicaid enrollees who neither want nor need to be in facilities. Because the Medicaid LTSS provisions contained in the PPACA would increase the Medicaid services available in the community, enhance existing ones, and provide continued support for institutionalized individuals to transition, the law provides much needed progress.

For more information on LTSS provisions in the new health reform law contact Gene Coffey at gcoffey@nsclc.org.