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There's No Place Like Home: How PPACA Falls Short In Expanding Home Care Services To The Elderly

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THERE'S NO PLACE LIKE HOME: HOW PPACA FALLS SHORT IN EXPANDING HOME CARE SERVICES TO THE ELDERLY

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I. INTRODUCTION

Mary Jane Scanlon, a seventy-year old California woman who had been disabled much her of life, needed a live-in caregiver to continue living at home.[2] Unaware of the proper channels to find a qualified home caregiver, Mary Jane hired Diane Warrick through an ad posted on Craigslist.[3] Unfortunately, Mary Jane was oblivious to Diane's disturbingly extensive criminal and mental history.[4] In 1997, Diane tried to take a drug counselor hostage at Napa State Hospital in California,[5] shooting at sheriff's deputies during the incident.[6] Warrick was convicted of four counts of attempted murder of a peace officer, but was found not guilty by reason of insanity and committed to Patton State Hospital.[7] By 2002, a judge found that Warrick had "regained her sanity," and authorities released her to an outpatient program in Contra Costa County.[8] Nine years later, a Contra Costa County jury found Diane Warrick guilty of second-degree murder in the stabbing of Mary Jane

[2] CAL. S. OFFICE OF OVERSIGHT & OUTCOMES, CAREGIVER ROULETTE: CALIFORNIA FAILS TO SCREEN THOSE WHO CARE FOR THE ELDERLY AT HOME, S. 2011-2012, 1st Sess., at 7 (Apr. 21, 2011), *available at* http://sooo.senate.ca.govsites/sooo.senate.ca.gov/files/2385.caregiver%20roulette.pdf.

[3] *Id.* at 8; FUGITIVE WATCH (Mar. 14, 2011), http://www.fugitive.com/2011/03/14/diane-warrick-a-caretaker-convicted-of-killing-mary-jane-scanlon-at-1870-elinora-drive-pleasant-hill-june-2010.

[4] CAL. S. OFFICE OF OVERSIGHT & OUTCOMES, *supra* note 2, at 8.

[5] *Id.* Napa State Hospital is a low to medium security hospital operated by the California Department of State Hospitals for adults recovering from serious mental illnesses. *Department of State Hospitals - Napa*, ST. CAL., http://www.dsh.ca.gov/napa (last visited Mar. 15, 2015).

[6] CAL. S. OFFICE OF OVERSIGHT & OUTCOMES, *supra* note 2, at 8.

[7] *Id.* Patton State Hospital is a major forensic mental hospital operated by the California Department of State Hospitals for patients who have been committed by the judicial system for mental treatment. *Department of State Hospitals - Patton*, ST. CAL., http://www.dsh.ca.gov/Patton/default.asp (last visited Mar. 15, 2015).

[8] FUGITIVE WATCH, *supra* note 3.

Scanlon in her home.[9] At trial, Warrick testified that she had hallucinated when she stabbed Mary Jane, believing her abusive father was attacking her at the time.[10]

The tragic death of Mary Jane Scanlon reveals a disturbing problem in obtaining contemporary long-term care: with a swelling senior citizen population,[11] skyrocketing costs of institutional care,[12] and a strong consumer preference for home and community-based services (HCBS),[13] Americans lack access to reliable home care services at a reasonable cost. So long as Medicaid continues to provide these services exclusively through optional state waiver and demonstration programs,[14] this problem will persist.[15]

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[9] CAL. S. OFFICE OF OVERSIGHT & OUTCOMES, *supra* note 2, at 8.

[10] FUGITIVE WATCH, *supra* note 3.

[11] *See* ADM. ON AGING, U.S. DEP'T OF HEALTH & HUMAN SERVS., *A Profile of Older Americans: 2012*, ADMIN. FOR COMMUNITY LIVING (2012), http://www.aoa.gov/AoAroot/Aging_Statistics/Profile/index.aspx. As the "Baby Boomer" generation begins to reach the age of 65, the population of 65 and over has increased 18%, from 35 million in 2000, to 41.4 million in 2011 and is expected to increase to 79.7 million by 2040. *Id.*

[12] GENWORTH FIN. INC., *Executive Summary Genworth 2013 Cost of Care Survey* (Mar. 18, 2013), https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/131168_031813_Executive%20Summary.pdf. In 2013, the median annual rate for a private nursing home room was $83,950, a 19.57% increase from the 2008 median annual rate of $67,525. *Id.*

[13] AGENCY FOR HEALTHCARE & RESEARCH QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., LONG-TERM CARE FOR OLDER ADULTS: A REVIEW OF HOME AND COMMUNITY-BASED SERVICES VERSUS INSTITUTIONAL CARE 2 (2012), *available at* http://effectivehealthcare.ahrq.gov/ehc/products/369/1276/CER81_Long-Term-Care_ExecutiveSummary_20121023.pdf. "Consumers have expressed a preference for more LTC in the community . . . ." *Id.* Home and community care includes:

> [h]omemaker/home health aide services; chore services; personal care services, nursing care services provided by, or under the supervision of, a registered nurse; respite care; training for family members in managing the individual; adult day care; In the case of an individual with chronic mental illness, day treatment or other partial hospitalization, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility); and such other home and community-based services (other than room and board) as the Secretary may approve.

42 U.S.C. § 1396t (1999).

[14] Waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program. This authorizes states to develop Medicaid programs individually that differ from the standard federal program. There are four primary types of waivers and demonstration projects: Section 1115 Research & Demonstration Projects, Section 1915(b) Managed Care Waivers, Section 1915(c) Home and Community-Based Services Waivers, and Concurrent Section 1915(b) and 1915(c) Waivers. *Waivers*, MEDICAID.GOV, http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html (last visited Mar. 15, 2015).

[15] AM. ASS'N OF HOMES & SERV. FOR THE AGING, IN THE PLACE THEY CALL HOME: EXPANDING CONSUMER CHOICE THROUGH HOME AND COMMUNITY-BASED SERVICES 9 (2009),

Medicaid is the primary payer for long-term services and supports (LTSS).[16] While Medicaid allows for states to choose whether or not they want to offer home care services,[17] it mandates that each state provide nursing facility services to their elderly population.[18] This has led to a well-known institutional bias that steers those with long-term care needs into nursing homes regardless of whether or not the

available at http://www.hospitalathome.org/files/HCBS_Cabinet_Report_Final-PDF_version.pdf.

[16] The type of healthcare coverage an individual has is commonly called a "payer." A "primary payer" pays what it owes on your medical bills first. Then, depending on whether more than one insurer covers you, the primary payer may send the rest of the bill to be covered by secondary or third payers. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICARE & OTHER HEALTH BENEFITS: YOUR GUIDE TO WHO PAYS FIRST 5 (2014), *available at* http://www.medicare.gov/Pubs/pdf/02179.pdf. *See also Coordination of Health Insurance Benefits With Traditional Medicare*, NAT'L ACAD. ELDER L. ATTORNEYS, INC., http://www.naela.org/Public/About_NAELA/Public_or_Consumer/Coordination_of_Health_Insurance.aspx (last visited Mar. 15, 2015). Long-Term Services and Supports (LTSS) are defined as the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications. CYNTHIA H. WOODCOCK, LONG-TERM SERVICES AND SUPPORTS: CHALLENGES AND OPPORTUNITIES FOR STATES IN DIFFICULT BUDGET TIMES (2011), *available at* http://www.nga.org/files/live/sites/NGA/files/pdf/1112LTSSBRIEF.PDF; *see also Medicaid is the Primary Payer for Long-Term Services and Supports (LTSS), FY 2011*, HENRY J. KAISER FAM. FOUND. (Oct. 17, 2013), http://kff.org/medicaid/slide/medicaid-is-the-primary-payer-for-long-term-services-and-supports-ltss-fy-2011.

[17] Charlene Harrington, Allen J. LeBlanc, Juanita Wood, Norma F. Satten & M. Christine Tonner, *Met and Unmet Need for Medicaid Home-and Community-Based Services in the States*, 21 J. APPLIED GERONTOLOGY 484, 484–85 (2002).

> [H]ome and community-based services for elderly: (1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this subchapter shall include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

42 U.S.C. § 1396n(d) (2013).

[18] Medicaid defines nursing facility services as services provided in a nursing home licensed and certified by the state survey agency as a Medicaid Nursing Facility (NF). *Nursing Facilities*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html (last visited Mar. 15, 2015); *see also* 42 U.S.C. § 1396n(a) (2013).

individual would prefer to receive care at home.[19] With institutional care receiving most of the Medicaid funding and states varying greatly in the types of home care services they choose to offer,[20] home care options for the elderly nationwide can be described as inconsistent at best.[21]

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA).[22] In an effort to rebalance states' spending on LTSS towards home care, PPACA created four new options under Medicaid with which states could provide home care services to their citizens.[23] While, PPACA's creation of these four optional Medicaid HCBS programs allows states more flexibility and the capability to provide enhanced home care services to its citizens, it falls short of completely addressing the existing institutional bias in Medicaid by failing to create a mandatory Medicaid state service plan for home care services. Part II describes home care workers, provides a legislative history of home care services, and outlines how Medicaid provides nursing facility care. Part III analyzes the shortcomings of PPACA's plan to improve access and delivery of home care services. Part IV proposes recommendations to better provide the elderly with reliable and affordable home care services.

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[19] *Navigating Medicare and Medicaid: Medicaid-online version*, HENRY J. KAISER FAM. FOUND., http://kff.org/other/navigating-medicare-and-medicaid-medicaid-online-version (last visited Mar. 15, 2015).

[20] MOLLY O'MALLEY WATTS, ADVANCING ACCESS TO MEDICAID HOME AND COMMUNITY-BASED SERVICES: KEY ISSUES BASED ON A WORKING GROUP DISCUSSION WITH MEDICAID EXPERTS (2009), *available at http*://kaiserfamilyfoundation.files.wordpress.com/2013/01/7970.pdf. In 2007, spending on Medicaid long-term care services reached $112 billion, with spending on home and community-based programs representing only 43% of that total. *Id*. *See also* TERENCE NG, CHARLENE HARRINGTON, MARYBETH MUSUMECI & ERICA REAVES, HENRY J. KAISER FAMILY FOUND., MEDICAID HOME AND COMMUNITY-BASED SERVICES PROGRAMS: 2009 DATA UPDATE (2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7720-06.pdf.

[21] *See* NG ET AL., *supra* note 20.

[22] *See* The Patient Protection and Affordable Care Act, Pub. L. No. 11-148, 124 Stat. 119 (2010) (codified as amended in scattered 42 U.S.C. §§ 21, 25, 26, 29 and 42).

[23] *Navigating Medicare and Medicaid: Medicaid-online version*, *supra* note 19. The Community First Choice State Plan 1915(k), 1915(i) Home and Community State Plan Option, and the State Balancing Incentive Payments Program, and Money Follows Person Program. *Id*.

II. BACKGROUND

A. What are Home Care Workers?

Home care workers provide hands-on care, supervision, and emotional support for the elderly in the United States.[24] Home care workers administer essential support and services that enable older adults, who otherwise could not live on their own, to reside safely in their homes and participate in their communities.[25] Home care workers' tasks primarily consist of assisting clients with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).[26] The U.S. Department of Health & Human Services defines ADLs as primarily personal care tasks, such as bathing, dressing, feeding, and toileting.[27] IADLs include household chores such as shopping, preparing meals, housework, and even handling money.[28]

Home care workers generally receive less formalized training than other members of the direct-care workforce.[29] This can be attributed mainly to three general characteristics.[30] First, unlike medical services provided by nursing homes

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[24] Christopher M. Kelly, Jennifer Craft Morgan & Kendra Jeanel Jason, *Home Care Workers: Interstate Difference in Training Requirements and Their Implications for Quality*, 32 J. APPLIED GERONTOLOGY 804, 806 (2012). Home care workers are also known by several other titles such as personal assistants, direct support professional and in-home care providers The Bureau of Labor Statistics classifies them as "personal care aides." *39-9021 Personal Care Aides, Standard Occupational Classification*, BUREAU LAB. STAT., http://www.bls.gov/soc/2010/soc399021.htm (last modified Mar. 11, 2010).

[25] PARAPROFESSIONAL HEALTHCARE INST., PERSONAL CARE AIDE TRAINING REQUIREMENTS: SUMMARY OF STATE FINDINGS 2 (2013), *available at* http://phinational.org/sites/phinational.org/files/research-report/pca-training-reqs-state-findings.pdf.

[26] *39-9021 Personal Care Aides*, *supra* note 24.

[27] OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING & EVALUATION, U.S. DEP'T HEALTH & HUM. SERVICES, *Glossary of Terms*, ASPE.HHS.GOV, http://aspe.hhs.gov/daltcp/diction.cfm#B (last visited at Mar. 15, 2015).

[28] *Id.*

[29] It is important to point out the distinction between home care workers and home health aides, as the two professions are often confused with one another. Home health aides, while also assisting with IADLS and ADLS directly in the home of the elderly, are also capable of administering routine medical care to patients. Kelly et al., *supra* note 24, at 806. Home care workers, on the other hand, are restricted to providing only nonmedical services. *Id.* "Direct care worker" is an umbrella term that includes certified nursing assistants, home health aides, personal care assistants, direct support professionals, home care workers and other similar occupational titles. *About Direct Care Workers*, DIRECT CARE ALLIANCE, INC., https://www.directcarealliance.org/document/docWindow.cfm?fuseaction=document.viewDocument&documentid=64&documentFormatId=68 (last visited Mar. 15, 2015). Direct care workers help care for older adults and individuals with disabilities by providing assistance with activities of daily living (such as eating, bathing, going to the bathroom, dressing, etc.) and certain health care and rehabilitation services. *Id.* They do this work in a variety of settings, including private homes, community-based residential settings such as group homes and assisted living facilities, and institutional settings such as nursing facilities and hospitals. *Id.*

[30] Kelly et al., *supra* note 24, at 810.

and home health agencies, Medicare does not reimburse home care services.[31] Therefore, home care providers are not subject to federal Medicare requirements to participate in the program.[32] Second, although Medicaid can pay for home care,[33] it does not provide federal oversight in areas, such as training and licensure.[34] Instead, Medicaid leaves the decision of whether or not to require formalized training of home care workers up to the states, and only a few states exercise this authority.[35] Third, home care workers are "more likely than other members of the direct-care workforce to work for employers and/or in settings that are not licensed by the state."[36] Combined, these factors contribute greatly to the fact that home care workers today receive less oversight than other direct-care workers in areas such as orientation, in-service training, and on-site supervision, exacerbating the growing concern that many home care workers lack the initial training and the ongoing skills assessment and evaluation necessary to provide quality home care.[37]

Over the past ten years, the United States has seen a massive growth in the home care workforce to match the growing senior population and their growing preference to receive nursing care at home. The Bureau of Labor Statistics (BLS) expects the direct care workforce to add an additional 1.6 million new positions from 2010 to 2020.[38] This expected growth in workforce will make direct-care workers the largest occupational group in the United States by the year 2020, outpacing professions such as retail salespersons, grade school teachers, and even law enforcement.[39]

Home care workers are a subcategory of and a major contributor to the rapidly growing direct-care workforce.[40] From 2010 to 2020, the BLS expects home care workers to be the fastest growing occupation in the United States, with a growth rate of 70.5%.[41] The BLS predicts that home care workers will add the fourth most jobs in that time, adding approximately 607,000 new jobs.[42] Additionally, the direct-care

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[31] *Id.*

[32] *Id.*

[33] *Id.* For example, home care services are often provided through 1915(c) home and community-based services and the Personal Care Services Option Plan. *Id*. at 807.

[34] *Id*. at 810.

[35] *Id*. at 811.

[36] *Id.*

[37] *Id.*

[38] PARAPROFESSIONAL HEALTHCARE INST., OCCUPATIONAL PROJECTIONS FOR DIRECT-CARE WORKERS 2010-2020 1 (2013), *available at* http://www.phinational.org/sites/phinational.org/files/phi_factsheet1update_singles_2.pdf; *see also Employment by major industry sector*, *Employment Projections*, BUREAU LAB., http://www.bls.gov/emp/ep_table_201.htm (last modified Dec. 19, 2013).

[39] PARAPROFESSIONAL HEALTHCARE INST., *supra* note 38, at 2.

[40] Kelly et al., *supra* note 24, at 807. This classification of workers includes psychiatric aides, nursing aides, orderlies, and attendants, and home health aides. PARAPROFESSIONAL HEALTHCARE INST., *supra* note 38, at 2.

[41] PARAPROFESSIONAL HEALTHCARE INST., *supra* note 38, at 2; *see also Employment by major industry sector*, *supra* note 38.

[42] PARAPROFESSIONAL HEALTHCARE INST., *supra* note 38, at 2.

workforce continues to shift from facilities to home and community-based settings.[43] As the demand for home care workers clearly continues to grow, the pressure continues to mount for policymakers to ensure that the elderly are able to obtain high quality workers at a reasonable cost.[44]

B. Legal History of Home and Community-Based Services

Medicaid primarily acts as joint federal and state health financing program for low-income individuals.[45] It also remains the most significant government program offering home care assistance in the United States.[46] The two predominant means through which Medicaid participants receive home care services are through the Medicaid Title XIX Personal Care Services Optional State Plan Benefit (PCS) and the Medicaid 1915(c) Home and Community-Based Services ("HCBS") waiver program.[47] States may cover home care services through the waiver program, the personal care option, or both.[48] Since the Supreme Court's decision in *Olmstead v. L.C.*, both Congress and the states have been looking for ways to increase home and community-based services to comply with the decision.[49] This resulted in the creation and enhancement of several new options for states to offer home and community-based services to Medicaid beneficiaries with the passage of PPACA.[50]

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[43] *Id.* at 4. By 2020, about 68% of direct-care workers will work in home and community settings, a 7% shift away from facility settings from 2010. *Id.*

[44] *Id.* at 5.

[45] Medicaid was established in 1965 as a part of Title XIX of the Social Security Act. Under Medicaid, each state establishes its own eligibility standards, determines type, amount, duration, and scope of services; sets repayment rates for services; and administers its own program. *Medicaid Program Description and Legislative History, Annual Statistical Supplement, 2011*, U.S. SOC. SECURITY ADMIN. OFF. RETIREMENT & DISABILITY POL., *http://www.ssa.gov/policy/docs/statcomps/supplement/2011/medicaid.html* (last visited Jan. 26, 2014). While the federal government sets broad national guidelines through statutes, regulations, and policies, Medicaid policies often vary widely between states. Therefore, a person who is eligible for Medicaid in one state may not be eligible in another, or the scope of services offered may differ greatly. *Id.*

[46] Allen J. LeBlanc, M. Christine Tonner & Charlene Harrington, *State Medicaid Programs Offering Personal Care Services*, 22 HEALTH CARE FIN. REV. 155, 156 (2001).

[47] *Id.*

[48] *Id.* at 160.

[49] HENRY J. KAISER FAMILY FOUND., OLMSTEAD V. L.C.: THE INTERACTION OF THE AMERICANS WITH DISABILITIES ACT AND MEDICAID 3–4 (2004), *available at* http://www.wvdhhr.org/oig/olmstead/what%20is%20the%20olmstead%20decision/olmstead%20interaction%20with%20ada%20and%20medicaid.pdf.

[50] MARYBETH MUSUMECI, ERICA REAVES & JULIA PARADISE, KEY ISSUES IN STATE IMPLEMENTATION OF THE NEW AND EXPANDED HOME AND COMMUNITY-BASED SERVICES OPTIONS AVAILABLE UNDER THE AFFORDABLE CARE ACT 1 (2013), *available at* http://kff.org/medicaid/issue-brief/key-issues-in-state-implementation-of-the-new-and-expanded-home-and-community-based-services-options-available-under-the-affordable-care-act.

1. Medicaid Section 1915(c) HCBS Waiver Program

When Congress passed Section 2176 of the Omnibus Budget Reconciliation Act of 1981, it established the Medicaid 1915(c) HCBS waiver program through Section 1915(c) of the Social Security Act.[51] Section 1915(c) authorized the Health Care Financing Administration to waive certain Medicaid statutory requirements to enable states to cover home and community-based services so that individuals can avoid institutional nursing home care.[52] Congress initially limited the program to only cover home and community-based services for individuals who would otherwise have required the level of care provided in a skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.[53] Congress has since expanded eligibility over time to include ventilator dependent individuals who require a hospital level of care and individuals who would otherwise require Medicaid-funded long-term hospital care.[54] States may also provide a variety of nonmedical services to their citizens, such as case management, homemaker services, personal care, and adult day care services.[55]

Under Section 1915(c), states have the flexibility to define the specific services covered in each waiver program, as well as the flexibility to define the geographic area each waiver program covers.[56] States may use this flexibility to tailor specific types of services to specific subgroups within the long-term care population.[57] Further, states are required to specify a limit on the number of individuals who may receive benefits for each Section 1915(c) waiver.[58] This is known as an enrollment

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[51] Nancy A. Miller, Sarah Ramsland, Elizabeth Goldstein & Charlene Harrington, *Use of Medicaid 1915(c) Home-and Community-Based Care Waivers to Reconfigure State Long-Term Care Systems*, 58 MED. CARE RES. & REV. 100, 103 (2001).

> The Secretary may by waiver provide that a State plan approved under this title may include as "medical assistance" under such plan payment for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan. For purposes of this subsection, the term "room and board" shall not include an amount established under a method determined by the State to reflect the portion of costs of rent and food attributable to an unrelated personal caregiver who is residing in the same household with an individual who, but for the assistance of such caregiver, would require admission to a hospital, nursing facility, or intermediate care facility for the mentally retarded.

42 U.S.C. § 1396n(c)(1) (2006).

[52] Miller et al., *supra* note 51.

[53] *Id.*

[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] LeBlanc et al., *supra* note 46, at 157.

cap. The enrollment cap, combined with the flexibility to choose services and target populations allows states to control the growth and costs of the program.[59] By limiting programs to one or more eligibility groups, states can relax financial eligibility and functional requirements existing through the traditional Medicaid program.[60] For example, a state may set the financial eligibility criteria to determine an institutional level of care higher than what Medicaid traditionally requires, enabling more citizens to be financially eligible for 1915(c) waiver than traditional Medicaid.[61] This flexibility contrasts other Medicaid option plans, where states must provide coverage to all citizens that meet the program criteria.[62]

2. Personal Care Services Optional State Plan Benefit

Congress formally incorporated The Personal Care Services Optional State Plan Benefit (PCS) into federal Medicaid law under Section 13601(a)(5) of the Omnibus Budget Reconciliation Act of 1993.[63] This added Section 1905(a)(24) to the Social Security Act, which included payment for personal care services under the definition of medical assistance.[64] Under the PCS plan, states use standard Medicaid criteria for

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[59] Miller et al., *supra* note 51.

[60] *Id.*

[61] *Id.*

[62] *Id.*

[63] Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, § 1905(a), 107 Stat.1, 301-302 (1993).

> Section 1905(a) (42 U.S.C. § 1396d(a)) is amended—(1) in paragraph (7), by striking 'including personal care services' and all that follows through 'nursing facility';(2) by striking 'and' at the end of paragraph (21); (3) in paragraph (24), by striking the comma at the end and inserting a semicolon; (4) by redesignating paragraphs (22), (23), and (24) as paragraphs (25), (22), and (23), respectively, by striking the semicolon at the end of paragraph (25), as so redesignated, and inserting a period, and by transferring and inserting paragraph (25) after paragraph (23), as so redesignated; and H. R. 2264—302 (5) by inserting after paragraph (23), as so redesignated, the following new paragraph: '(24) personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home or other location.

Id.

[64] U.S. DEP'T OF HEALTH & HUMAN SERV., UNDERSTANDING MEDICAID HOME AND COMMUNITY SERVICES: A PRIMER 185 (2000), *available at* http://www.aspe.hhs.gov/daltcp/reports/primer.pdf. 42 U.S.C. § 1396d(a)(24) states:

> [p]ersonal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise

categorically and/or medically needy persons to determine financial eligibility.[65] Under Medicaid rules, states can use special institutional financial eligibility standards of up to 300% of the Supplemental Security Income.[66] Because this criterion is more stringent than institutional financial eligibility, PCS plans tends to have tighter financial eligibility standards than the HCBS waiver programs.[67] Unlike nursing home eligibility rules and many HCBS waiver programs, PCS plans may not allow spouses of beneficiaries to retain additional income or assets.[68] Need criteria under the PCS plan is left totally to the discretion of the state. However, states that choose to enroll in PCS plans must provide services to all Medicaid beneficiaries that meet categorical and functional eligibility requirements.[69] States have the flexibility to define the specific services they will provide under the PCS benefit, but the same services must be available statewide for all eligible beneficiaries.[70] This generally results in states adopting more stringent financial and need criteria, requiring prior authorization for services, and setting formal limits on the amount of personal care allowed in order to limit enrollment and control costs.[71]

3. The *Olmstead* Decision

On June 22, 1999, the United States Supreme Court issued a decision in *Olmstead v. L.C ex rel. Zimring.*,[72] holding that unjustified institutionalization of people with disabilities violates the Americans with Disabilities Act of 1990 ("ADA").[73] This proved to be a landmark decision in that the Court not only

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authorized for the individual in accordance with a service plan approved by the State, (B) provided by an individual who is qualified to provide such.

42 U.S.C § 1396d(a)(24) (2006).

[65] LeBlanc et al., *supra* note 46, at 157.

[66] *Id.* Supplement Security Income program pays benefits to disabled adults and children who have limited resources and income. To be eligible for SSI payment, recipient's assets and countable income must fall below set statutory thresholds. These thresholds are set by each state individually. *See* CONG. BUDGET OFFICE, SUPPLEMENTAL SECURITY INCOME: AN OVERVIEW 1 (2012), *available at*http://www.cbo.gov/sites/default/files/43759-SupplementalSecurity.pdf.

[67] LeBlanc et al., *supra* note 46, at 157.

[68] LAURA L. SUMMER & EMILY S. IHARA, THE MEDICAID PERSONAL CARE SERVICES BENEFIT: PRACTICES IN STATES THAT OFFER THE OPTIONAL STATE PLAN BENEFIT 4 (2005), *available at* http://assets.aarp.org/rgcenter/health/2005_11_medicaid.pdf.

[69] LeBlanc et al., *supra* note 46, at 157–58.

[70] SUMMER & IHARA, *supra* note 68.

[71] LeBlanc et al., *supra* note 46, at 158.

[72] *See* Olmstead v. L.C., 527 U.S. 581 (1999).

[73] *Id.* at 597; *see also* The Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990). Congress enacted the ADA to establish a clear and comprehensive prohibition of discrimination on the basis of disability. HENRY J. KAISER FAMILY FOUND., *supra* note 49, at 1. To fall under the protection of the ADA, individuals must: 1. Have a physical or mental impairment that substantially limits one or more major life activities; 2. Have record of the impairment; or 3. Be regarded as having an impairment. *Id.* The federal

interpreted the ADA for the first time, but it also directly influenced the way Medicaid provided long-term services and supports to people with disabilities.[74]

Olmstead involved two women, Lois Curtis and Elaine Wilson, both of whom suffered from mental illnesses and were voluntarily admitted to psychiatric units for treatment.[75] By 1993, Ms. Curtis's treatment team determined her psychiatric condition had stabilized and that her needs could be met in a home and community-based program supported by the state of Georgia.[76] Despite this evaluation, Ms. Curtis remained institutionalized.[77] As a result, Ms. Curtis filed suit in federal court alleging that the state's failure to place her in a community-based program, violated Title II of the ADA.[78] Ms. Wilson, who similarly remained institutionalized after her treatment team recommended placement in a community setting, joined the lawsuit in 1995.[79]

The question before the Court was whether regulations implementing Title II of the ADA, which required states to operate public programs in a non-discriminatory fashion and to provide services in the most integrated setting appropriate to an individual's needs, also required states to place persons with mental disabilities in community settings rather than institutions.[80] In answering "yes" to this question, the Supreme Court held that unjustified institutional isolation of people with disabilities is a form of discrimination.[81] Furthermore, the court held that states are required to provide home and community-based services for persons otherwise entitled to institutional services when: 1. The state's treatment professionals reasonably determine that community placement is appropriate; 2. The person does not oppose community placement; 3. The placement can be "reasonably accommodated" by the state.[82] The Court also qualified their decision by noting that the state's responsibility is not boundless and that the needs of persons who require institutional care must be weighed against those who reside in the community.[83] Additionally, the

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government uses its power under the Fourteenth Amendment and Commerce Power to enforce the law's standards and protect against discrimination that people with disabilities face. *Id.*

[74] *See generally* HENRY J. KAISER FAMILY FOUND., *supra* note 49.

[75] *See* Olmstead, 527 U.S. at 593.

[76] *Id.*

[77] Olmstead v. L.C., 527 U.S. 581, 593 (1999).

[78] *Id.* at 593–94. "Subject to the provisions of this title, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." The Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (1990).

[79] Olmstead, 527 U.S. at 594.

[80] *Id.* at 587.

[81] *Id.* at 597.

[82] *Id.* at 587. This takes into account resources available to the state and the needs of others who receive state-supported disability services. *Id.*

[83] Olmstead v. L.C., 527 U.S. 581, 603 (1999).

Court stated the ADA's reasonable-modification standard does not require states to make fundamental alternations of its services or programs.[84]

Though *Olmstead* does not explicitly address Medicaid, it indirectly established that Medicaid programs must comply with the ADA.[85] In short, the *Olmstead* decision established that requiring individuals to receive services in segregated institutions is illegal discrimination under the ADA, but the Court did not order an immediate end to institutional isolation.[86] The Court's decision did not alter the law governing Medicaid, nor require an end to the institutional bias. Therefore, a rapid expansion of community-based long term services never materialized.[87] Instead, statewide offering of long-term services and supports have only seen a gradual shift in spending towards home and community-based services.[88]

4. The Patient Protection and Affordable Care Act Enhancement of Home and Community Based-Services

In an effort to increase long-term services and supports provided by the states, Congress created and enhanced new waiver, option, and demonstration programs under Title II of PPACA.[89] Several of these plans allow for new and alternative means for states to offer home and community-based services to their citizens.[90]

a. The Community First Choice State Plan Option Section 1915(k)

The Community First Choice State Plan Option is based off the proposed Community Choice Act, which was introduced to Congress in 2007 but did not pass.[91] The Community First Choice State Plan Option provides assistance with

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[84] *Id.* The Court stated that in assessing what is reasonable, states can balance the aggregate needs of people with mental disabilities, and are not required to consider the cost of institutional care versus the cost of providing services in the community on an individual basis. *Id.* at 605–06. Also, if a state has a waiting list for home and community-based care that moves at a reasonable pace and not motivated by the state's effort to keep institutions fully populated, the reasonable-modifications standard would be met. *Id.*

[85] HENRY J. KAISER FAMILY FOUND., *supra* note 49, at 3.

[86] *Id.*

[87] *Id.*

[88] *Id.*

[89] *See* The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of U.S.C. §§ 21, 25, 26, 29 and 42); *see also* HENRY J. KAISER FAMILY FOUND., MEDICAID LONG-TERM SERVICES AND SUPPORTS: AN OVERVIEW OF FUNDING AUTHORITIES (2013), *available at* http://kff.org/medicaid/fact-sheet/medicaid-long-term-services-and-supports-an-overview-of-funding-authorities.

[90] *Community-Based Long-Term Services & Supports*, MEDICAID.GOV,

http://www.medicaid.gov/AffordableCareAct/Provisions/Community-Based-Long-Term-Services-and-Supports.html (last visited Mar. 4, 2015).

[91] *See* Community Choice Act of 2007, S. 799, 110th Cong. (2007). The Community Choice Act sought to eliminate institutional bias in the delivery of long support and services through the implementation of two major changes. THE CTR. FOR DISABILITY RIGHTS, 1915(K) COMMUNITY FIRST CHOICE OPTION: FREQUENTLY ASKED QUESTIONS . . . ANSWERED! 1 (2011), *available at* http://cdrnys.org/files/CFC-FAQ-122211.pdf. First, the Act sought to establish framework for community-based system to deliver services and supports for people with

ADLs, IADLs and health-related function through home and community-based attendant services and supports. Though the program is optional for states to adopt, it is the first program to provide services based on functional need.[92] Once a state has adopted the program, it functions as a mandated service.[93] This means that once a state adopts the Community First Choice State Plan, it must provide services to any citizen who meets the eligibility requirements, eliminating the waiting lists which frequently exist in other state waiver plans.[94] The Community First Choice State Plan is a permanent program,[95] and if the state chooses to adopt the plan, the federal government will provide 6% of federal Medicaid matching funds to implement it.[96] In order for citizens to be eligible for the program, they must require an institutional level of care and have an income below 150% of the federal poverty level or up to the state limit for nursing facility services if it is higher.[97] The Community First Choice State Plan is considered a huge step towards eliminating Medicaid's institutional bias.[98] Though the program is not mandatory for the states to adopt, it is the first federal program to provide home and community-based services based on functional need.[99] Once a state adopts the program, it essentially functions as a mandatory service.[100] Unfortunately, as of May 2015, only four states have adopted the program.[101]

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disabilities based on functional needs, as opposed to diagnosis or age. *Id.* The Community Choice Act also mandated state implementation of the program and provided states with additional federal funding to do so. *Id.*

[92] *Id.*

[93] *Id.*

[94] Public Health, 42 C.F.R. § 441.500 (2012); *see also* THE CTR. FOR DISABILITY RIGHTS, *supra* note 91.

[95] Meaning there is no set time limit on the program's existence.

[96] THE CTR. FOR DISABILITY RIGHTS, *supra* note 91. "Since its enactment in 1965, the Medicaid program has used the Federal Medical Assistance Percentage (FMAP) to determine the federal government's share of the cost of covered services in state Medicaid programs. On average, the federal share has been 57 percent." HENRY J. KAISER FAMILY FOUND., MEDICAID FINANCING: AN OVERVIEW OF THE FEDERAL MEDICAID MATCHING RATE (FMAP) 1 (2012), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8352.pdf.

[97] HENRY J. KAISER FAMILY FOUND., *supra* note 89.

[98] THE CTR. FOR DISABILITY RIGHTS, *supra* note 91.

[99] *Id.*

[100] *Id.* It functions as a mandated service. Meaning once selected by the state, anyone who is eligible for the service gets it. Waiting lists are prohibited. *Id.*

[101] *Section 1915(k) Home and Community-Based Services State Plan Option*, HENRY J. KAISER FAM. FOUND., http://kff.org/medicaid/state-indicator/section-1915k-community-first-choice-state-plan-option/ (last visited June 14, 2015). *See also Community First Choice 1915(k)*, MEDICAID.GOV, http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/community-first-choice-1915-k.html (last visited June 14, 2015). These states are Maryland, California, Montana, and Oregon.

b. Community State Plan Option Section 1915(i)

Originally authorized under the Deficit Reduction Act ("DRA"), PPACA enhances DRA's authority through several changes to Section 1915(i).[102] Under Section 1915(i), states have the ability to provide state plan home and community-based services to individuals with incomes up to 150% of the federal poverty level and eligible for Medicaid.[103] These individuals must also meet needs-based eligibility criteria that are less stringent than what is required for institutional care.[104] PPACA expands upon Section 1915(i)'s financial eligibility by allowing states to offer state plan home and community-based services to individuals with income up to 300% of the Supplemental Security Income federal benefit rate and who would otherwise be eligible for home and community-based services under other existing waiver or demonstration programs.[105]

In addition to expanded financial eligibility, PPACA adds a new provision to Section 1915(i), permitting states to offer full Medicaid benefits, including home and community-based services, to individuals not otherwise eligible for Medicaid.[106] States that adopt this new coverage group may choose to cover either or both: 1. individuals with income up to 150% of the federal poverty level, with no resource test, who meet Section 1915(i) needs-based eligibility criteria and will receive Section 1915(i) state plan HCBS; and/or 2. individuals who would be eligible for Medicaid under Section 1915(c), (d), or (e) waiver or Section 1115 demonstration project, with incomes below 300% of the Social Security Income federal benefit rate.[107] States that chose to create this new eligibility group must offer the Section 1915(i) State Plan to individuals who would otherwise be eligible for Medicaid as well.[108]

PPACA also enables states to have more flexibility in targeting specific population groups under Section 1915(i), similar to what is allowed under Section 1915(c).[109] States may have multiple Section 1915(i) plans targeting specific

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[102] MOLLY WATTS, MARYBETH MUSUMECI & ERICA REAVES, HENRY J. KAISER FAM. FOUND., HOW IS THE AFFORDABLE CARE ACT LEADING TO CHANGES IN MEDICAID LONG-TERM SERVICES AND SUPPORTS (LTSS) TODAY? STATE ADOPTION OF SIX LTSS OPTIONS 1 (2013), *available at* https://kaiserfamilyfoundation.files.wordpress.com/2013/04/8079-02.pdf.

[103] *Id.* at 12. $1,436 per month in 2013. *Id.*

> Under § 1915(i), states continue to have the ability to provide state plan HCBS to individuals with incomes up to 150 percent of the federal poverty level (FPL) ($1,436 per month in 2013) who are otherwise eligible for Medicaid without regard to whether such individuals need an institutional level of care.

Id.

[104] *Id.*

[105] The federal benefit rate for 2013 is $2,134 per month. *Id.* at 12–13. *See* Section 1915(c), (d), or (e) waiver; or, for example, the Section 1115 demonstration program. *Id.*

[106] *Id.* at 13.

[107] *Id.* "These individuals do not actually have to be receiving waiver or demonstration services, so long as they meet the eligibility criteria for the waiver." *Id.*

[108] *Id.* at 12–13.

[109] *Id.* at 13.

populations based on specific criteria with services that vary in amount, duration, and scope.[110] States that adopt Section 1915(i) plans that target specific populations must renew them with CMS every five years.[111] However, PPACA prohibits states from limiting the number of individuals it serves or establishing waiting lists under a Section 1915(i) plan.[112] Further, PPACA requires that all Section 1915(i) plans are offered statewide, prohibiting states from limiting Section 1915(i) plans to specific geographic areas.[113] As of May 2015, only seventeen states have enrolled in the Community State Plan Option Section 1915(i).[114]

c. State Balancing Incentive Payments Program

PPACA also established the State Balancing Incentive Payments Program ("Balancing Incentive Program") to reduce the disparity in which states adopt home and community-based services.[115] The Balancing Incentive Program provides incentivizes states that devote less than 50% of their FY 2009 Medicaid long-term services and supports spending on home and community-based services to implement structural reforms to increase their home and community-based services.[116] States that spent between 25% to 50% of their Medicaid long-term services and supports funding on community-based services are eligible to receive a 2% increase in FMAP funding if they adopt a target of 50% home and community-based spending by September 2015.[117] States that spent less than 25% on home and community-based services will receive an increase of five percentage points if they target to increase their home and community-based spending to 25% by September 2015.[118] Additionally, states must implement three structural changes to their long-term services and supports delivery system: 1. A "no wrong door" or single entry

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[110] *Id.* (suggesting criteria states could use such as diagnosis, disability, Medicaid eligibility group, or age).

[111] *Id.*

[112] *Id.*

[113] *Id.*

[114] *Section 1915(i) Home and Community-Based Services State Plan Option*, HENRY J. KAISER FAM. FOUND., http://kff.org/medicaid/state-indicator/section-1915i-home-and-community-based-services-state-plan-option/ (last visited June 14, 2015). These states are California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Idaho, Indiana, Iowa, Louisiana, Maryland, Michigan, Mississippi, Montana, Nevada, Oregon, and Wisconsin. *Id.* 101.

[115] 42 U.S.C. § 1396d (2011).

[116] *Balancing Incentive Program*, HENRY J. KAISER FAM. FOUND. (Dec. 2014), http://kff.org/medicaid/state-indicator/balancing-incentive-program/. These services include the mandatory home health state plan benefit, the optional personal care state plan benefit, home and community-based waiver services, self-directed personal assistance services, and Program of All-Inclusive Care for the Elderly services. *Id.*

[117] *Id.*

[118] *Id.*

point system for all long-term services and supports;[119] 2. Conflict-free case management services;[120] 3. A core standardized assessment instrument to determine eligibility for non-institutional long-term services and supports.[121] Funding for the States Balancing Incentives Programs is available to states until September 2015, and states may combine this funding with other home and community-based programs.[122] As of May 2015, eighteen states are participating in the States Balancing Incentives Program.[123]

d. Money Follows the Person Demonstration Grant

Enacted in 2006, as a part of the Deficit Reduction Act, the Money Follows the Person Demonstration Grant offers states enhanced matching funds for twelve months for each Medicaid beneficiary who transitions from institutional long term care to a home or community-based setting.[124] The goal of the program is to increase the use of home and community-based services and reduce institutional bias by eliminating barriers in state law, Medicaid plans, and budgets, allowing individuals to receive long term care in the setting of their choice.[125] Medicaid beneficiaries who had been receiving institutional care for more than ninety consecutive days are eligible to participate.[126] PPACA extends the Money Follows the Person Demonstration Grant until 2016, allocating an additional $2.25 billion to the program.[127] Forty-six states have adopted the grant and over 25,000 individual have

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[119] *Id.* According to CMS implementation guidance, a "no wrong door" or single entry point system should be a statewide system that properly informs and enrolls individuals into the appropriate home and community-based services. *Id.*

[120] *Id.* CMS defines conflict free case management services as "those that develop a service plan, arrange for services and supports, support the beneficiary in self-directing the provision of services and supports, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes." *Id.*

[121] *Id.* States should design a core standardized assessment instrument to determine eligibility for home and community-based services uniformly statewide and determine an eligible individuals needs for specific services in accordance with an individual's service plan. *Id.*

[122] *Id.*

[123] .MOLLY O'MALLEY WATTS, ERICA L. REAVES, AND MARYBETH MUSUMECI, HENRY J. KAISER FAMILY FOUND., MEDICAID BALANCING INCENTIVE PROGRAM: A SURVEY OF PARTICIPATING STATES, *available at* http://kff.org/report-section/medicaid-balancing-incentive-program-a-survey-of-participating-states-report/. The participating states are Nevada, Texas, Iowa, Missouri, Arkansas, Illinois, Mississippi, Ohio, Kentucky, Georgia, Pennsylvania, New York, Maryland, New Jersey, Connecticut, Massachusetts, New Hampshire, and Maine. It is worth noting this only comprises one-half of the states eligible to participate in the program. Seventeen states are eligible but not participating and three states had previously been approved but are no longer participating in the program. *Id.*

[124] WATTS ET AL., *supra* note 102, at 7.

[125] *Id.*

[126] *Id.*

[127] *Id.*

transitioned to home and community-based settings since the program began.[128] However, the biggest challenge to transition individuals continues to be securing safe, affordable, and accessible housing for participants, as well as a shortage of qualified home and community-based service providers.[129]

C. Medicaid Mandatory Nursing Facilities

Medicaid requires states to provide nursing facility services to any individual over the age of twenty-one or older that need such services.[130] Unlike home care service programs, states must make nursing facility services available to all citizens, without waiting lists.[131] Though need for nursing facility services is defined by states,[132] state level of care requirements must provide access to individuals who meet the coverage criteria defined in Federal law and regulation.[133] Nursing facilities participating in Medicaid must provide for nursing or related services and specialized rehabilitative services to attain the highest practicable physical, mental, and psychosocial well-being for all of their residents.[134] Federal regulations do not include an exhaustive list of services that each nursing facility must provide.[135] Instead, federal regulations set out mandatory nursing facility services that states must provide, these include: nursing and related services, specialized rehabilitative services, medically-related social services, pharmaceutical services, dietary services individualized to the needs of each resident, professionally directed program of activities to meet the interests and needs for well-being of each resident, emergency dental services, room and bed maintenance, and routine personal hygiene items and services.[136] Each state then sets out in its Medicaid plan the general services each

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[128] *Id.*

[129] *Id.*

[130] *Nursing Facilities*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Institutional-Care/Nursing-Facilities-NF.html (last visited Nov. 10, 2013).

> Need for nursing facility services is defined by states, all of whom have established NF level of care criteria. State level of care requirements must provide access to individuals who meet the coverage criteria defined in Federal law and regulation. Individuals with serious mental illness or intellectual disability must also be evaluated by the state's PASRR program to determine if NF admission is needed and appropriate.

Id.

[131] *Id.*

[132] *Id.*

[133] *Id.*

[134] *Id.*

[135] *Id.*

[136] *Id.*

nursing facility must provide.[137] This allows states to expand or limit services as it sees fit in order to attain the highest-level of care for individuals.[138]

III. PPACA FALLS SHORT IN IMPROVING ACCESS TO HOME CARE SERVICES

A. PPACA Fails to Provide Mandatory Universal Home Care Services

Title II of PPACA seeks to improve access to home care services by creating and enhancing optional Medicaid waivers, state plan, and demonstration programs to the states.[139] Though these programs offer expanded options for states to provide home care services to Medicaid beneficiaries, citizens are still not guaranteed the same access to home care services as they are to institutional nursing care.[140]

1. Additional HCBS Options Further Fragments Services

A major contributor to the long existing institutional bias in the delivery of long-term services and support is that the federal government does not mandate the states to provide home and community-based services for individuals who would prefer to receive those services in that setting.[141] This, in combination with the large amount of discretion given to states in the adoption and implementation of the Personal Care Services Optional State Plan and the 1915(c) Home and Community-Based Services Waiver, has led to a fragmented and inferior delivery system of home and community-based services.[142] While generally the spending on home and community-based services has increased in the United States,[143] states vary widely in their program offering and expenditures. Statewide spending ranged from $5,323 of expenditures per capita in Illinois to $35,378 in Tennessee.[144] This disparity in expenditures is a reflection of the disparity of services and programs available to individuals in need of long-term services and supports, depending on the state they

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[137] *Id.*

[138] *Id.*

[139] 42 C.F.R. § 441.302 (2012).

[140] AM. ASS'N OF HOMES & SERV. FOR THE AGING, *supra* note 15, at 8.

[141] *See* HENRY J. KAISER FAM. FOUND., *supra* note 89.

[142] LeBlanc et al., *supra* note 46, at 156.

> Historically, Medicaid has funded services that are delivered in nursing and other nursing home and other institutional settings. As a result, Federal statutes and regulations concerning LTC under Medicaid are oriented toward institutional placement and a medical model care. Most significantly, Medicaid regulations make regulations making nursing facilities a mandatory entitlement program, while HCBS alternatives are discretion of each State.

Id.

[143] *See* WATTS ET AL., *supra* note 102, at 5. "[T]he national percentage of Medicaid spending on home and community-based services rose from 20% of total Medicaid spending in 1995 to 45% in 2010." *Id.*

[144] NG ET AL., *supra* note 20, at 7.

reside.[145] While all states have adopted some sort of home and community-based program to deliver long-term care, most do not implement enough programs to allow for all those desiring to receive long-term care at home to get it.[146]

In addition to fragmented services offered across state lines, home and community-based services are fragmented within the states as well.[147] The variety of different home and community-based service plans offered creates gaps in coverage for certain population groups, as well as administrative difficulties for states to properly cover individuals in need.[148] For example, Section 1915(c) waivers require that states only target one specific population group with each program they implement.[149] In an effort to provide more comprehensive coverage, states will implement multiple programs in order to target multiple populations groups.[150] Not only does this create administrative difficulties for states, but it also creates gaps in coverage where individuals do not fit within the requirements of a specific program.[151] While some states have tried to solve this issue through the creation of a single entry point system, many states have chosen not to address the problem at all. This has left many individuals throughout the United States without the home and community-based services they need.[152]

PPACA's implementation of four new optional programs further compounds the pre-existing disparity in the delivery of home and community-based services nationwide.[153] While the addition of these four programs does give the states the ability to expand their delivery of home and community-based services, it does not change the fact that some states will choose to adopt more programs while others will not.[154] This still leaves individuals residing in states less inclined to provide

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[145] *Id.* at 11.

[146] *See id.* at 505. "([T]he large majority of state officials (42) reported an unmet need for HCBS services . . . .").

[147] *See* WATTS ET AL., *supra* note 102, at 3.

[148] CHARLENE HARRINGTON, TERENCE NG, STEPHEN H. KAYE, & ROBERT NEWCOMER, HOME AND COMMUNITY-BASED SERVICES: PUBLIC POLICIES TO IMPROVE ACCESS, COSTS, AND QUALITY 8 (2009), *available at* http://www.pascenter.org/documents/PASCenter_HCBS_policy_brief.php.

[149] *See supra* text accompanying notes 57–63.

[150] Harrington et al., *supra* note 17 at 486.

[151] *See generally id.* (discussing the barriers of expanding coverage for those that would benefit from more care).

[152] *Id.* at 497 (noting that individuals with mental illness, autism, behavioral problems, Alzheimer's disease, developmental disabilities, the aged, the disabled, children, were all groups by states that were identified as being underserved).

[153] WATTS ET AL., *supra* note 102, at 7.

[154] *See id.* at 1, 3. As of March 2013, forty-six states have adopted Money Follows the Person, fifteen have adopted Balancing Incentive Program, fourteen have adopted Home and

home and community-based services with inadequate options and target groups not covered under 1915(c) programs without any options in states that choose not to expand.[155] The creation of these new programs does not guarantee that all individuals nationwide will receive improved access to home and community-based services.[156] Instead, individuals desiring to receive long-term services and supports in a home or community-based setting are still at the mercy of their state legislatures to implement these new options.[157]

Intrastate fragmentation of services will also grow from the expansion of optional programs. New optional programs means that the services are further fragmented based on the requirements of each additional program adopted. This fragmentation enhances administrative costs for states, as each program usually comes with their own administrative structures, financial eligibility criteria, need criteria, screening and assessment procedures, provider recruitment and management, reimbursement structures, and quality oversight.[158] Not only does increased fragmentation add costs to the states, the additional optional programs create more confusion to consumers who are unsure what programs are available and what they qualify for.[159] The Balancing Incentive Program attempts to centralize the delivery of home and community-based services by requiring states to develop a single entry point system for long-term services and supports, implementing conflict-free case management and establishing a core standardized assessment instrument for determining eligibility.[160] However the effectiveness of this program appears to be limited, as only fifteen states have adopted it.[161] The program is set to end in September 2015.[162]

2. Optional Programs Leave Personal Care Service at Risk

PPACA does not create any federally mandated Medicaid programs through which States must offer home care services to its citizens.[163] While states now have more options in offering coverage for home care services beyond Section 1915(c) and the PCS Optional State Plan Benefit Plan, the fact that these programs are optional puts citizens at risk of losing home care services in light of Medicaid and

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Community-Based Services State Plan Option, and nine have adopted the Community First Choice State Plan Option. *Id.*

[155] For example, Nebraska only adopted one new home and community-based program: The Money Follows The Person Demonstration. *Id.*

[156] Harrington et al., *supra* note 17, at 503.

[157] *See id.*

[158] Harrington et al., *supra* note 17, at 486.

[159] *Id.*

[160] *See supra* text accompanying notes 115–34.

[161] WATTS ET AL., *supra* note 102, at 3.

[162] *Id.* at 2.

[163] *Id.* at 6.

state budgetary constraints.[164] In 2013, thirty states plus Washington D.C. faced budget shortfalls.[165] Furthermore, Medicaid spending will reach $276 billion with home care comprising 20.2% of those payments.[166] While certain factors indicate that states will continue to increase personal care service offerings,[167] recent fluctuations in home and community-based Medicaid spending and cuts in PCS Optional State Plan enrollments show that personal care services are far from immune from state budget cuts.[168]

B. PPACA Fails to Eliminate State Strategies to Limit Enrollment

1. 1915(c) Waiver Program Enrollment Limitations

States have utilized various strategies to limit enrollment in 1915(c) waiver programs in the interest of containing costs.[169] States must do this in order to meet the cost neutrality requirements imposed by federal law.[170] While the cost neutrality requirement allows for 1915(c) waiver states to save significantly in comparison to nursing facilities,[171] limiting enrollment in home care services can unnecessarily force the elderly into institutions.[172] Though demand for personal care for the elderly continues to increase, PPACA failed to address enrollment limitations imposed by states by not explicitly prohibiting the limitations or removing the cost neutrality requirements of the program.[173]

In 2011, all states reported using cost controls in Medicaid HCBS programs.[174] These included restrictive financial and functional eligibility standards, enrollment limits and waiting lists.[175] Twenty-six percent of waiver programs used more restrictive financial eligibility standards for HCBS waivers compared to those used for Medicaid coverage of institutional care, ten waivers used more restrictive

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[164] *State Budget Shortfalls, SFY2013, State Health Facts*, HENRY J. KAISER FAM. FOUND. (June 27, 2012), http://kff.org/other/state-indicator/state-budget-shortfalls-sfy13/#note-2 (Nov. 5, 2013).

[165] *Id.*

[166] AM. ASS'N OF HOMES & SERV. FOR THE AGING, *supra* note 15, at 51.

[167] *Medicaid is the Primary Payer for Long-Term Services and Supports (LTSS), FY 2011*, *supra* note 16.

[168] THE HENRY J. KAISER FAMILY FOUND., *supra* note 89.

[169] These strategies include financial eligibility, functional eligibility, waiting lists, cost control measures. NG ET AL., *supra* note 20, at 2–3.

[170] "Average expenditures for each 1915(c) waiver do not exceed the state estimated Medicaid expenditures for a comparable level of care." 42 U.S.C. § 1396n (2013).

[171] States spent 63% less 1915(c) waivers than on institutional nursing facilities. Harrington et al., *supra* note 17.

[172] *Id.* at 497.

[173] NG ET AL., *supra* note 20, at 1.

[174] *Id.* at 2.

[175] *Id.*

functional eligibility criteria for waivers.[176] The average wait period to receive waiver services was more than two years, and the number of persons on waiver waiting lists increased by 19% over the previous year.[177] Without the federal government specifically prohibiting state enrollment limitations, it is obvious that states will continue to limit their 1915(c) personal care waiver programs in the interest of cost-saving and at the expense providing more comprehensive personal care services to the elderly.

2. Personal Care Services Optional State Plan Benefit Enrollment Limitations

States have also applied cost containment mechanisms when offering PCS Optional State Benefit Plans.[178] PCS Option State Plans prohibit states from maintaining waiting lists or geographically limiting services.[179] However, States can restrict enrollment by only providing PCS Option Plan benefits to those who meet the applicable income standard for categorically-needy groups, though they have the option to expand Medical financial eligibility beyond the federal minimum thresholds.[180] States also curtail PCS Option Plan expenditures by limiting the types of services provided.[181] Furthermore, federal regulation allows states to limit expenditures and provider reimbursements in the interest of cost containment.[182] Again, PPACA failed to eliminate any of these cost containment mechanisms in its effort to expand personal care services.[183]

In 2011, 59% of states used some form of cost control limits with their optional state plan personal care services programs.[184] Only 56% of states allowed for the elderly to "spend down"[185] to increase Medicaid eligibility.[186] Furthermore, 12% of states withheld IADLs assistance from their personal care services.[187] Where states

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[176] *Id.*

[177] *Id.* at 3.

[178] *Id.* at 12.

[179] *Id.*

[180] *Id.* States may expand Medicaid financial eligibility by providing a pathway for individuals to "spend down" to Medicaid financial eligibility levels. *Id.*

[181] *Id.* at 13. For example, states will limit services to ADLs only, transportation services excluded. *Id.* at 12.

[182] *Id.* at 13.

[183] *See id.*

[184] *Id.* at 13.

[185] NG ET AL., *supra* note 20, at 12. When people have too much income to qualify for Medicaid they will "spend down" their excess income on medical bills in order to qualify for Medicaid. *Spend Down Procedures, Medicaid*, NYSED.GOV (June 5, 2009), http://www.oms.nysed.gov/medicaid/resources/spend_down_procedures.html. For example, a person over 65 is denied Medicid because her monthly income is $50 more than the limit for Medicaid eligibility. NG ET AL., *supra* note 20, at 12.If she incurs medical bills of $50 per month, the rest of her medical bills will be covered by Medicaid. Thus, the "spend down" in this case is the $50 of medical bills she incurs. *Id.*

[186] *Id.* at 12.

[187] *Id.*

most heavily restrict spending is through provider reimbursements.[188] On average, states reimbursed agencies $17.73 per hour for personal care services administered by an agency and $11.90 per hour from a direct provider.[189] This starkly contrasts the average reimbursement of $89.73 paid to registered nurses for home health visitations.[190] PPACA's failure to address PCS Plans enrollment limitations has allowed states to continue restrict the elderly access to personal care services.

C. PPACA Fails to Implement Universal Licensure and Regulation

The Federal Government does not impose any formalized training requirements upon states that choose to offer home care services.[191] This is because, unlike nursing homes, Medicare does not reimburse for home care, and Medicaid does not require regulation of home care workers.[192] Instead, Medicaid leaves the decision entirely to the states as to whether or not to implement formalized training of home care workers.[193] Because home care workers administer non-medical care, only twenty-nine states require any sort of formalized training and licensure.[194] Within these twenty-nine states there exists a great variety of training requirements.[195] To contrast, nursing homes must employ workers under strict national guidelines in order to ensure participation in Medicaid and Medicare programs.[196] While PPACA attempted to increase the availability of home care services to the elderly, it completely failed to ensure that the elderly receive quality care by not requiring at least a minimum standard licensure.

IV. PROPOSED RECOMMENDATIONS

A. Create Single Mandatory Medicaid Program Offering Home and Community-Based Services

In order to truly eliminate the institutional bias in the provision of long-term services and supports, the federal government needs to create a single mandatory Medicaid program that offers home and community-based services. Similar to home health aides, Congress should amend Section 1915(a) of the Social Security Act[197] to

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[188] *Id.* at 13.

[189] *Id.*

[190] *Id.*

[191] Kelly et al., *supra* note 24, at 810.

[192] *Id.*

[193] *Id.*

[194] *Id.* at 813.

[195] *Id*. at 810.

[196] *Id*.

[197] The "woodwork effect" is the theory that if home and community-based services are expanded, individuals who previously received only informal care might take advantage of the expanded home and community-based program, and would continue to be unwilling to use institutional services even if made available. H. Stephen Kaye, Mitchell P. LaPlante & Charlene Harrington, *Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?*, 28 HEALTH AFF. 262, 263 (2009).

include home care services as mandatory service for individuals who are eligible for Medicaid. Creating a mandatory program ensures that states will provide home care to all elderly who are eligible for Medicaid and would eliminate the current fragmented delivery of home care. Furthermore, creating a single program alleviates administrative difficulties for states trying to implement multiple option programs and provides the elderly with a simple, single point of entry to home care services.

Medicaid should adopt a mandatory plan to deliver home and community-based services modeled off the recently expanded upon Section 1915(i) Home and Community-Based Services waiver plan. Out of all of the plans offering personal care services, Section 1915(i) requires the broadest coverage by the states and has the most lenient financial eligibility criteria.[198] Individuals who earn an income of up to 300% of the supplemental security income federal benefit rate are eligible for Section 1915(i).[199] The more lenient standard is important in order to close the financial gap between those who are not able to afford home care services on their own but earn more than what would make them financially eligible for programs with stricter financial eligibility.[200] At the same time, leaving some form of financial eligibility intact can serve as a cost control mechanism by limiting enrollment to only those who are financially eligible. Other cost control measures are eliminated under Section 1915(i), which allow for greater access statewide. Individuals do not need to meet an institutional level care to qualify, waiting lists are not permitted, and states are required to implement the plan statewide.[201] The only other existing cost control measure within Section 1915(i) is that states have the option to specific target population groups.[202] If made into a mandatory program, this limitation would obviously have to be removed in light of the fact that states would need to use this one program to administer all of their home and personal care services. The federal government should increase matching funds in order to offset the loss of this limitation. All of these characteristics are important to ensure that the most individuals have access to home and community-based services.

Many states have voiced concerns that adding another mandatory program to Medicaid will add an overwhelming amount of costs to an already overburdened entitlement program.[203] Not only would the implementation and administration of new entitlement programs add additional costs to Medicaid but policy makers and state officials fear the "woodwork effect" might skyrocket enrollment and in turn the

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[198] On July 16, 2013, Participants in a Kaiser Commission on Medicaid and the Uninsured roundtable meeting cited the Section 1915(i) Home and Community-Based Services State Plan Option "as a needed cost-effective alternative that enables states offer services to beneficiaries before their needs rise to an institutional level of care. Participants emphasized the importance of having appropriate services available to support beneficiaries wherever they are living, regardless of the care setting." MUSUMECI ET AL., *supra* note 50, at 4–5.

[199] WATTS ET AL., *supra* note 102, at 12–13. This was calculated to be $2,130 a month or $25,560 a year for an individual in 2013. *Id.* at 12.

[200] AM. ASS'N OF HOMES & SERV. FOR THE AGING, *supra* note 15, at 8.

[201] WATTS ET AL., *supra* note 102, at 6.

[202] *Id.* at 2.

[203] Total Medicaid spending topped $438 billion in 2013. *Total Medicaid Spending*, HENRY J. KAISER FAM. FOUND., http://www.kff.org/medicaid/state-indicator/total-medicaid-spending.

costs of administering home and community-based services.[204] However, a recent study examining this issue put these concerns to rest. The study found that states that offered extensive non-institutional services experienced comparable growth in overall long-terms services and supports expenditures as those states that offered strictly institutional based care.[205] Furthermore, consolidating home and community-based services into one program will save states the extra cost of administering multiple programs in order to adequately provide home and community-based services to the individuals who need them.[206] With each program requiring their own administrative structures, financial eligibility criteria, need criteria, screening and assessment procedures, provider recruitment and management, reimbursement structures, and quality oversight, a state being able to accomplish the same coverage with one program that previously needed required multiple programs[207] will undoubtedly provide major cost reductions for states.

B. Develop Universal Quality and Regulation Standard for Home Care Services

Developing universal quality and regulation standards for home care services would ensure that the elderly population receives a well-trained and professional home care worker. Currently, it is up to the states to establish licensure and regulatory standards for home care workers without any national guidelines.[208] Training requirements are generally low across the long-term care workforce and home care stands out as the least regulated workforce in long-term care.[209] While regulation of home care workers varies greatly among the states, a handful of states[210] have been identified as innovators in home care policies.[211] Congress should consider modeling a national licensure and regulatory standard based off those policies. In order to properly regulate home care workers, Congress should establish guidelines creating a separate licensure category for home care providers, establish minimum training requirements for home care workers, and establish a list of core competencies that each home care worker must demonstrate before being allowed to enter client homes.

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[204] This concern is that if HCBS are expanded, individuals who previously received only informal care might take advantage of new HCBS program even though they would not be willing to use institutional services. Kaye et al., *supra* note 197.

[205] Kaye et al., *supra* note 197, at 207. This study compared states with low home and community-based services expenditures with states with high home and community-based expenditures from 1995-2005. *Id.*

[206] MUSUEMCI ET AL., *supra* note 50.

[207] Every state except Hawaii has more than one 1915(c) Home and Community-Based Waiver Program. *Total Number of Medicaid Section 1915(c) Home and Community-Based Service Waivers, State Health Facts*, HENRY J. KAISER FAM. FOUND., http://kff.org/medicaid/state-indicator/total-number-of-medicaid-section-1915c-home-and-community-based-services-waivers/ (last visited Mar. 18, 2005).

[208] Kelly et al., *supra* note 24, at 804.

[209] *Id.* at 805.

[210] In a survey of all fifty states' home care licensure and regulation policies, Colorado, New Hampshire, and Tennessee were identified as innovators. *Id.* at 825.

[211] *Id.*

1. Establish Minimum Training Requirements

It is important that home care workers are properly trained to deliver quality care comparable to that administered in an institution. In order to achieve this goal, Congress must establish minimum-training requirements that home care workers must meet in order to be licensed to administer care in an individual's homes.[212]

Each state should implement a mandatory orientation for all home care workers.[213] Currently, the minimum number of training hours varies greatly among states.[214] Ohio requires that home care workers receive a minimum of 60 hours of training, while most states do not have any specific minimum hour requirements at all.[215] One possibility for establishing a federal minimum number of training hours is averaging the minimum number of training hours of the states that require training.[216] However, modeling a minimum number of training hours that allows more flexibility to the states may make it easier for states to save costs and tailor their training programs to best fit their needs. Instead of adopting an arbitrary minimum requirement for training hours, the federal government could model a requirement after Nebraska's home care statute, requiring home care workers to have "training sufficient to provide the requisite level for in-home personal services offered."[217] This would give the states sufficient flexibility to tailor their training program to as they see fit, while at the same time still requiring them to have some training program in place. CMS could publish regulations where needed to clarify ambiguities and ensure that states do not try to cheat the system.

In addition to classroom orientation for home care workers, requiring in-service training could also help increase the quality of the workforce. This also gives supervisors the opportunity to evaluate whether or not a prospective home care worker has the requisite inter-personal skills to aid elderly individuals on a daily basis.[218] Again, the in-service training requirements could be established through an hourly minimum requirement,[219] or could be left up to the discretion of the states.[220] Ideally, the content area covered in the in-training program would be unique from the orientation training.[221] Supervisors could focus on areas such as infection control, abuse and neglect prevention, client rights and responsibilities, and emergency on-

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[212] Only twenty-nine states require licensure for home care providers. Out of these twenty-nine states only fifteen require in-service training. *Id.* at 813.

[213] Only twenty-six states currently require any specific training of home care workers. *Id* at 816.

[214] *Id.* at 814–15.

[215] Eighteen of twenty-six states do not require a minimum number hours of training. *Id.*

[216] This figure totals 22.5 hours. *Id.*

[217] *Id.*; *see also* NEB. REV. STAT. § 71-6502 (2007).

[218] Kelly et al., *supra* note 24, at 821.

[219] This could be modeled after the average minimum in-training hours of 7.9 hours in the states that do require in-service training. *Id* at 817.

[220] Eight states with in-service training programs did not specify a minimum hourly requirement of in-service training. *Id.*

[221] *Id.* at 817–21.

site with home care trainees.[222] This allows for the worker to gain real life experience and for the supervisor to assess the skills of the worker.[223] Flexibility should be left for the states to add in topics where they see fit.[224]

Finally, Congress must require on-site supervision of home care workers to ensure that the worker is adequately caring for the client.[225] Regular visits to assess home care workers would also serve as an important way to ensure that the worker is not abusing or taking advantage of the client, a situation that unfortunately has been all too prevalent in home care.[226] States could require that agencies perform this on-site supervision checkup and then assign case managers to those individuals who decide to hire a home care independent of an agency.[227] Federal Medicare rules require an on-site reassessment within 30 days for medical services.[228] Modeling off this rule, several states have adopted a 90-day on-site reassessment for nonmedical services.[229] This should be adopted into a federal minimum on-site reassessment requirement as well. To save on administrative costs, on-site visits should be limited to a specific time period during the employment relationship.[230] While possibly costly, on-site supervision is an important tool to ensure home care workers are held accountable for their actions and the client's rights are protected, especially since those who usually require home care are unable to protect those rights themselves.

2. Establish Minimum Core Competencies That All Home Care Workers Must Obtain

Congress must establish a set of core competencies that every home care worker should obtain as a result of their training. Identifying these core competencies would

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[222] *Id.* at 817–20. Infection control, abuse and neglect prevention, client rights and responsibilities, and emergency are the most common in-service topics covered among states that offered in-service training. *Id.*

[223] *Id.* at 821.

[224] Examples of states allowing for this flexibility can be found in Virginia, who allows for the in-service training topics to be determined by the on-site supervisor and Nevada, which allows for home care workers to suggest training topics. VA. CODE ANN. § 381-200 (2010); *see generally* Nevada Medicaid Services Manual, § 3503.18 (2015).

[225] Only fifteen states required on–site supervision of home care workers after they had been hired. Kelly et al., *supra* note 24 at 821.

[226] For example, one woman with multiple sclerosis went through multiple home care workers who stole from her, ordered groceries from themselves with her money, ignored the woman's cries for assistance, and treated her disrespectfully. Judith Graham, *Who's Watching Mom?*, N.Y. TIMES (July 19, 2012, 2:48 PM), http://newoldage.blogs.nytimes.com/2012/07/19/whos-watching-mom.

[227] Fifteen states required on-site supervision to be performed by agency personnel while Wyoming assigned case managers to each home care client. Kelly et al., *supra* note 24, at 821.

[228] *Id.* at 825.

[229] *Id.*

[230] Thirteen states specify time period limitations, ranging from one month to six months. *Id.* at 821. Once a supervisor establishes that the home care worker is adequately performing their duties and the client is satisfied, continuing to monitor during that employment relationship would most likely be unnecessary. *Id.*

not only ensure that home care workers are equipped with the necessary skills to properly care for clients, but they also serve several other important purposes. Identifying core competencies allows for easier predictability of quality that currently does not exist in home care but does in other areas of long-term care.[231] Well-established core competencies also help clients, families, and home care agency employers assess possible employees and help them make more informed hiring decisions.[232] Core competencies also serve to develop career lattices for the workers and help them understand their role and take pride in attaining the necessary skills and knowledge to attain licensure.[233] Some states have already implemented specific core competencies in their training programs that should be included in a federal licensure requirement, while experts have also identified components that should be added to further the quality of home care services.[234]

First, a set of basic skills should be included in federal training requirements that most states already include in their current training programs. This includes training in agency policy, assistance with ADLS and IADLS, maintaining a healthy, clean, and safe living environment for the client, awareness of abuse and neglect reporting requirements, and communication.[235] In addition to these basic skills, the federal training requirements should include a set of advanced requirements that only a small portion of state training programs require.[236] This would include training in the use of common assistive and adaptive equipment,[237] emergency preparedness and accident prevention, and coordination with other community services. Attention should also be given to understanding the physical, emotional, and developmental needs of the elderly, behavioral management, and cultural awareness.[238] Finally, in order to continue to elevate the quality of home care workers, experts have suggested training components that should be implemented into federal training requirements. These skills include learning basic medication information,[239] awareness of self-neglect,[240] caring for patients with cognitive issues,[241] and legal and ethical issues

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[231] *Id* at 823. For example, long-term care includes nursing home facilities. *Id*.

[232] *Id.*

[233] *Id.*

[234] *Id.* at 827.

[235] *Id.* at 823.

[236] Only two states require these sets of skills. *Id.*

[237] *Id* at 824. This would include devices such as mechanical lifts, wheelchairs, etc. *Id.*

[238] *Id.*

[239] Controlling and administering client medication is often a responsibility a home care worker takes on. *Id.* Examples of basic medication information a home care worker should learn before taking on this responsibility would include usage, adverse reactions, and drug interactions. *Id.*

[240] Self-Neglect is defined as: 1. Persistent inattention to personal hygiene and/or environment 2. Repeated refusal of some/all indicated services which can reasonably be expected to improve quality of life. 3. Self-endangerment through the manifestation of unsafe behaviors (e.g., persistent refusal to care for a wound, creating fire-hazards in the home). Maria P. Pavlou & Mark S. Lachs, *Self-neglect in Older Adults: a Primer for Clinicians*, 23 J. GEN. INTERN. MED. 1841, 1842 (2008).

that often arise in caring for the elderly, such as advance directives and guardianship.[242] Studies have found that training programs that implement not only the basic skills but also the advanced and interpersonal skills proposed have improved direct care worker performance, created safer living environment for clients, and have even reduced worker turnover in other long term care settings.[243] Therefore, an important step to improving the delivery of home care services is for federal training requirements to be established.

3. Possibility of Third-Party Credentialing

If the licensure and regulation of home care workers proves too costly for the government to implement themselves, Medicaid should look to an independent credentialing agency to certify and regulate home and community-based services. In order for a health care organization to participate and receive payment from Medicare or Medicaid,[244] it must meet eligibility requirements for program participation set forth in federal regulations.[245] For certain health care organizations, CMS has passed regulations considering those organizations that achieve accreditation status through an independent credential agency to have achieved

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[241] Examples of cognitive problems would include diseases such as Alzheimer's, Dementia, Parkinson's, and the mental effects of a stroke. Kelly et al., *supra* note 24, at 824.

[242] *Id* at 824–25. Advance directives are legal documents that allow for a person to dictate his/her end-of-life care ahead of time when he/she is no longer able to make decisions due to illness of incapacity. MEDLINE PLUS, *Advance Directives*, http://www.nlm.nih.gov/medlineplus/advancedirectives.html (last visited Mar. 7, 2015). A guardian is a person, association or corporation appointed by a probate court to be legally responsible for another person and/or another person's property. Most commonly, individuals are appointed to serve as guardians. OHIO STATE BAR ASS'N, *Guardianships*, (Mar. 10, 2014), https://www.ohiobar.org/ForPublic/Resources/LawFactsPamphlets/Pages/LawFactsPamphlet-10.aspx.

[243] Kelly et al., *supra* note 24 at 825; *see also* Janette S. Dill, Jennifer Craft Morgan & Thomas R. Konrad, *Strengthening the Long-Term Care Workforce*, 29 J. APPLIED GERONTOLOGY 196, 209 (2010).

[244] Health care organizations include facilities such as hospitals, critical access hospitals, home health agencies, and psychiatric hospitals. *Facts About Federal Deemed Status and State Recognition*, JOINT COMM'N (Aug. 1, 2014), http://www.jointcommission.org/facts_about_federal_deemed_status_and_state_recognition/.

[245] *Id.* For example, the conditions of participation for a psychiatric hospital are that the psychiatric hospital must:

> (a) be primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons; (b) meet the conditions of participation specified in §§ 482.1 through 482.23 and §§ 482.25 through 482.57; (c) Maintain clinical records on all patients, including records sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries, as specified in § 482.61; and (d) Meet the staffing requirements specified in § 482.62.

42 C.F.R. § 482.60 (2007).

compliance with Medicare and Medicaid requirements.[246] Home health agencies, the more medically based cousin of the home care agency, have been authorized by CMS to achieve compliance with Medicare Home Health Agency Conditions of Participation through independent accreditation agencies since June 1993.[247] The Joint Commission already offers a home care agency accreditation, so it would just be up to CMS to adopt a regulation recognizing Joint Commission accreditation as compliance with any licensure requirements CMS should choose to enact.[248] In addition to the Joint Commission, there are several other third party agencies that offer credentialing services for home care agencies and workers, giving CMS multiple accreditation agencies to choose to confer accreditation authority.[249] Allowing for these agencies to issue credentials home care agencies and workers could ease the potential administrative burden brought on by a universal licensure and regulatory scheme for home care workers.

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[246] *Facts About Federal Deemed Status and State Recognition*, *supra* note 244. For example, in the District of Columbia, "a psychiatric facility that is not a hospital and is accredited by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation of Services for Families and Children, or by any other accrediting organization with comparable standards recognized by the State." *Id*.; *see also State Recognition Details*, JOINT COMM'N, http://www.jointcommission.org/state_recognition/state_recognition_details.aspx?ps=100 (last visited Mar. 19, 2015).

[247] *Id*. For Home Health Agencies in Ohio, see the following definition:

> An institution defined as a home health agency in section 3701.881 of the Revised Code, that conducts all telephone solicitation activities according to sections 310.3, 310.4, and 310.5 of the telemarketing sales rules adopted by the federal trade commission in 16 C.F.R. part 310, and engages in telephone solicitation only within the scope of the institution's certification, accreditation, contract with the department of aging, or status as a home health agency; and that meets one of the following requirements: (a) The institution is certified as a provider of home health services under Title XVIII of the Social Security Act, 49 Stat. 620, 42 U.S.C. 301, as amended; (b) The institution is accredited by either the joint commission on accreditation of health care organizations or the community health accreditation program; (c) The institution is providing passport services under the direction of the Ohio department of aging under section 173.40 of the Revised Code; (d) An affiliate of an institution that meets the requirements of division (B)(26)(a), (b), or (c) of this section when offering for sale substantially the same goods and services as those that are offered by the institution that meets the requirements of division (B)(26)(a), (b), or (c) of this section.

Id; see also OHIO REV. CODE. ANN. § 4719.01(26) (LexisNexis 2013).

[248] *See generally* THE JOINT COMM'N, JOINT COMMISSION ACCREDITATION FOR PERSONAL CARE ORGANIZATIONS: A QUALITY-FOCUSED COMPETTIVE ADVANTAGE LIKE NO OTHER, *available at* http://www.jointcommission.org/assets/1/18/PCValue.pdf.

[249] For example, the Direct Care Alliance offers credentialing for Direct Care Workers. *DCA Personal Care & Support Credential*, DIRECT CARE ALLIANCE, INC., http://directcarealliance.org/index.cfm?fuseaction=page.viewPage&pageID=595&nodeID=1 (last visited Mar. 7, 2015).

V. CONCLUSION

There is no doubt that the demand for home and community based-services will continue to surge in the coming years. The rising elderly population and institutional nursing home costs, coupled with the consumer preference for home and community-based services already evidences this change in demand.[250] Even the United States Supreme Court has recognized the importance of offering home and community-based services in their *Olmstead* decision. Despite this push for the increased access to home care for the elderly, policy makers on both the state and federal level have failed to rectify the long existing institutional bias and guarantee all elderly individuals' access to safe and affordable home care.

While PPACA makes great strides in the interest of providing home and community-based services, the creation of four new optional programs for states to adopt falls short in completely bridging the gap between institutional care and home and community-based services. By creating more optional programs, PPACA further fragments the offering of services by continuing to give states the choice of whether or not they want to expand their services and forcing states to provide those services through multiple, limited programs. Additionally, PPACA fails to adopt any mandatory minimum licensure standard and still leaves home and community-based services at risk to be eliminated by states due to budgetary constraints.

In order to truly eliminate the institutional bias, Medicaid must establish a single mandatory program to offer home and community-based services. This program should be modeled off Section 1915(i) because it requires states to offer the broadest coverage for citizens.[251] The creation of one mandatory program would eliminate the fragmentation of services offered as well as eliminate the administrative difficulties plaguing states that offer more than one plan. Medicaid should also establish minimum federal quality and regulation standards for home care services to ensure that the elderly are receiving quality workers in their home. Enacting this legislation would not only eliminate the institutional bias that exists in long-term care, it would also ensure that people like Diane Warrick would never get close to stepping foot in the homes of the elderly again.

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[250] *Supra* text accompanying notes 11–15.

[251] *Supra* text accompanying notes 198.