

## Article - Health - General

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§15–132.

- (a) (1) In this section the following terms have the meanings indicated.
- (2) “Assisted living program” has the meaning stated in § 19–1801 of this article.
- (3) “Assisted living services” means services provided by an assisted living program as defined in regulations adopted by the Department.
- (4) “Case management services” means services that assist waiver eligible individuals in gaining access to needed waiver services and other needed medical, social, housing, and other supportive services.
- (5) “Health related care and services” includes:
- (i) 24–hour supervision and observation by a licensed care provider;
  - (ii) Medication administration;
  - (iii) Inhalation therapy;
  - (iv) Bladder and catheter management;
  - (v) Assistance with suctioning; or
  - (vi) Assistance with treatment of skin disorders and dressings.
- (6) “Home health care services” means those services defined in § 19–401 of this article and in 42 C.F.R. 440.70.
- (7) “Medically and functionally impaired” means an individual who is assessed by the Department to require services provided by a nursing facility as defined in this section, and who, but for the receipt of these services, would require admission to a nursing facility within 30 days.
- (8) “Nursing facility” means a facility that provides skilled nursing care and related services, rehabilitation services, and health related care and services above the level of room and board needed on a regular basis in accordance with § 1919 of the federal Social Security Act.
- (9) “Waiver” means a home– and community–based services waiver under § 1915(c) of the federal Social Security Act, submitted by the Department to the Centers for Medicare and Medicaid Services.

(10) “Waiver services” means the services covered under an approved waiver that:

(i) Are needed and chosen by an eligible waiver participant as an alternative to admission to or continued stay in a nursing facility;

(ii) Are part of a plan of service approved by the program;

(iii) Assure the waiver participant’s health and safety in the community; and

(iv) Cost no more per capita to receive services in the community than in a nursing facility.

(b) (1) If permitted by the Centers for Medicare and Medicaid Services, an individual shall be determined medically eligible to receive services if the individual requires:

(i) Skilled nursing care or other related services;

(ii) Rehabilitation services; or

(iii) Health–related services above the level of room and board that are available only through nursing facilities, including individuals who because of severe cognitive impairments or other conditions:

1. A. Are currently unable to perform at least two activities of daily living without hands–on assistance or standby assistance from another individual; and

B. Have been or will be unable to perform at least two activities of daily living for a period of at least 90 days due to a loss of functional capacity; or

2. Need substantial supervision for protection against threats to health and safety due to severe cognitive impairment.

(2) The Department shall adopt regulations to carry out the provisions of this subsection.

(c) The Department’s waiver shall include the following:

(1) An initial cap on waiver participation at 7,500 individuals;

(2) A limit on annual waiver participation based on State General Fund support as provided in the budget bill;

(3) Financial eligibility criteria which include:

(i) The current federal and State medical assistance long–term care

rules for using services provided by a nursing facility, per §§ 1902, 1919, and 1924 of the federal Social Security Act, and applicable regulations adopted by the Department;

(ii) Medically needy individuals using services provided by a nursing facility under the current federal and State medical assistance eligibility criteria governed by regulations adopted by the Department and § 1919 of the federal Social Security Act; and

(iii) Categorically needy individuals with income up to 300% of the applicable payment rate for supplemental security income;

(4) Waiver services that include at least the following:

(i) Assisted living services;

(ii) Case management services;

(iii) Family training;

(iv) Dietitian and nutritionist services;

(v) Medical day care services; and

(vi) Senior center plus services;

(5) The opportunity to provide eligible individuals with waiver services under this section as soon as they are available without waiting for placement slots to open in the next fiscal year;

(6) An increase in participant satisfaction;

(7) The forestalling of functional decline;

(8) A reduction in Medicaid expenditures by reducing utilization of services; and

(9) The enhancement of compliance with the decision of the United States Supreme Court in the case of *Olmstead v. L.C.* (1999) by offering cost-effective community-based services in the most appropriate setting.

(d) This section may not be construed to affect, interfere with, or interrupt any services reimbursed through the Program under this title.

(e) If a person determined to be eligible to receive waiver services under this section desires to receive waiver services and an appropriate placement is available, the Department shall authorize the placement.

(f) The Department, in consultation with representatives of the affected industry and advocates for waiver candidates, and with the approval of the

Department of Aging, shall adopt regulations to implement this section.

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