National Academy of Elder Law Attorneys (NAELA) – Maryland/DC Chapter
HCBOW Legislation - Background and Justification
House Bill 1176 & Senate Bill 1057

- **HISTORY: Home and Community Based Options Waiver**

Medicaid Long-Term Services and Supports ("LTSS") is the program that provides long-term care assistance to individuals with physical and cognitive disabilities in nursing homes. States also have the option to establish a "Medicaid Waiver" program that provides long-term care services at home or in the community. In Maryland, the Medicaid Waiver that serves older Marylanders and Marylanders with disabilities at home and in the community is known as the "Home & Community Based Options Waiver" ("HCBOW").

The HCBOW was originally established to give individuals the choice to "age-in-place" at home, while minimizing Medicaid costs to Maryland and the federal government by providing long-term care services in a more cost-effective environment. However, the HCBOW is a "capped" waiver, meaning that the program can only serve an approved maximum number of individuals per year. Due to the popularity of the program, a waitlist was established for the HCBOW.

Maryland's HCBOW waitlist currently contains 25,000 individuals with a waiting period of approximately 8 years. Due to the long waiting period, individuals on the waitlist must often choose to forego long-term care services, or unnecessarily enter a nursing home to qualify for Medicaid LTSS and then exit the nursing home to enroll in the HCBOW.

The Maryland/DC Naela Chapter over the past 15+ years have advocated for changes to expand capacity, eliminate the waitlist, improve and clarify the application process for eligible individuals.

- **CURRENT HISTORY:**

Legislation passed in the 2022 Session Senate Bill 28 (House Bill 80) – Home and Community Based Services Waiver (HCBOW)- Participation and Applications.

- The legislation directed the Department to apply to the federal Centers for Medicare and Medicaid Services for an amendment to increase the waiver cap size to least 7,500 individuals.
- Additionally, each month the Department is directed to send a waiver application to at least 600 individuals on the waiting list/registry.
- The waiver application must state clearly and conspicuously that the applicant:
  - must submit the application within six weeks of receipt and
  - must meet all eligibility criteria for waiver participation within six months of application submission.

Information recently provided by the Maryland Department of Health shows a marked increase in the number of individuals on the registry. Not only have the registry numbers increased, but we also understand that the letters being sent are not clearly and conspicuously stating the timeline and due date criteria.

Registry Numbers by Age	***5/1/2022***	***5/1/2023***
Up to 17	*122*	*184*
18-64	*5,025*	*6,439*
65 and Over	*14,531*	*18,471*
Total on Registry	***19,678***	***25,094***

- **2024 Legislation Components:**

House Bill 1176 & Senate Bill 1057 will do the following 3 things:

1. Establish standard policy for the Department of Health to allow a married couple to pool their assets to allow a spouse to meet waiver eligibility standards.
2. Adjust the Income Cap to allow for more individuals to qualify financially if they are otherwise eligible for home and community-based services.
3. Require the Department of Health to develop regulations specific to the population who are transitioning from Community First Choice to the HCBOW.

Detailed explanations for each provision of the proposed bill follow:

1. HCBOW Spousal Impoverishment Policy for waiver eligibility:

The State lacks standard policy that allows for a married couple to pool their assets to allow a spouse in need of HCBS services to meet income eligibility standards. The lack of a policy makes it unclear as well as unlikely that a married couple where one spouse needs HCBOW services can achieve income eligibility. The State of Maryland has stated that they don't have the authority to resolve this matter.

However, the federal Center for Medicare and Medicaid Services (CMS) has provided the following guidance to States through their Letter to State Medicaid Directors SMD# 21-004 "RE: State Flexibilities to Determine Financial Eligibility for Individuals in Need of Home and Community-Based Services"[1]. Specifically, the letter states the following:

- Section 1924 of the Act, commonly referred to as the "spousal impoverishment statute," requires that financial eligibility determinations for "institutionalized" spouses be determined consistent with the spousal impoverishment statute's methodology.
- Section 1924(h)(1) of the Act defines an "institutionalized spouse" as a married individual who is in a medical institution or, at state option, is eligible for the 217 group, and is married to an individual who is not in a medical institution or nursing facility.
- However, section 2404 of the Affordable Care Act (ACA), as amended by the Consolidated Appropriations Act, 2021, P.L. 116-260,13 requires that section 1924(h)(1)'s definition of an "institutionalized spouse" include, through September 30, 2023, married individuals who are in need of HCBS authorized under section 1915(c), (i), or (k) of the Act, or a comparable package of HCBS available under section 1115 authority.
- The spousal impoverishment statute generally ensures that the "community spouse" of an institutionalized beneficiary is permitted to keep a share of the couple's combined income and resources to meet the individual's own community needs, up to certain maximum standards established under section 1924(c) of the Act. In determining the amount of the couple's combined resources to set aside for a community spouse (referred to as the "community spouse resource allowance," or CSRA), the spousal impoverishment statute requires that all resources owned by either spouse, jointly or solely, be pooled. The CSRA is then subtracted from this amount and the remainder is deemed to be available to the institutionalized spouse and counted in determining whether the value of his or her resources is at or below the resource standard for eligibility.

2. Income Cap Adjustment:

As noted above CMS provides leeway to states to make determinations most advantageous to their population, without being more stringent than what CMS requires. For example, the letter referenced above[2] states:

- "This letter provides guidance to states on a "rule of construction" of the Medicaid Act under section 3(b) of the Sustaining Excellence in Medicaid Act of 2019, Pub. L. No. 116-39, which has been included in several subsequent federal laws (hereafter the "construction rule").
- The construction rule provides that states have the option to target and tailor income and resource disregards at individuals who are eligible for, or seeking coverage of, home and community based services (HCBS) authorized under section 1915(c), (i), (k) and 1115 authorities.
- This new option permits states to adopt higher effective income and resource eligibility standards for people who need HCBS, either for all such individuals or for a particular cohort of such individuals.
- This option presents states with a critical tool to use in their efforts to "rebalance" their Medicaid coverage of long-term services and supports (LTSS) from institutional to community-based care."

It is time to revisit financial eligibility caps in Maryland allow patients to receive care that best fits their needs whether that is care in a skilled nursing facility or more cost effectively in their home or community-based setting.

[1] https://www.medicaid.gov/sites/default/files/2021-12/smd21004_0.pdf
[2] https://www.medicaid.gov/sites/default/files/2021-12/smd21004_0.pdf

The State's healthcare services structure is still institutionally heavy and with more commitment and redeployment of health care resources (both services and service providers) community-based care can become more of the norm and less conditioned on eligibility and resource barriers.

3. Regulations for Community First Choice Transition to HCBOW:

Legislation passed in the 2019 Session, Senate Bill 699 - Maryland Medical Assistance Program - Home- and Community-Based Waiver Services - Prohibition on Denial. This bill prohibits the Maryland Department of Health (MDH) from denying an individual access to a Medicaid home and community-based services waiver due to lack of funding for the waiver if:

(1) the individual is living at home or in the community at the time of application;

(2) the individual received home and community-based services through Community First Choice (CFC) for at least 30 consecutive days;

(3) the individual will be or has been terminated from Medicaid due to becoming eligible for or enrolled in Medicare;

(4) the individual meets all of the eligibility criteria for participation in the waiver within six months after the completion of the application; and

(5) the home and community-based services provided for the individual would qualify for federal matching funds.

Marylanders who have community Medicaid including Medicaid Expansion and get long-term care services through the Community First Choice (CFC) program for as little help as someone to assist in bathing and dressing at home, would lose all access to services if both: (1) they get Medicare and (2) they have too much income or assets. This law allows eligible individuals to continue to receive CFC services.

While the law took effect July 1, 2019, there has been no standard policy established by the Department to handle the transition of these individuals from CFC to the HCBOW. The proposed legislation requires the Department to develop regulations specifically to handle this circumstance.