HB 1176

Department of Legislative Services

Maryland General Assembly
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FISCAL AND POLICY NOTE
First Reader

House Bill 1176 (Delegate Cullison)
Health and Government Operations

Home- and Community-Based Services Waiver - Eligibility

This bill expands the financial eligibility criteria for the Medicaid Community Options Waiver to include (1) categorically needy individuals with an income disregard up to 300% of the Supplemental Security Income (SSI) monthly benefit amount and (2) a community spouse resource allowance calculated by assets owned as of the first day of the month of continuous institutionalization for 30 or more days, or as of the first day of the month in which the applicant receives an application for waiver services. The Maryland Department of Health (MDH) must adopt regulations that establish a timeline within which MDH must approve or deny a waiver application. By October 31, 2024, MDH must apply to the federal Centers for Medicare and Medicaid Services (CMS) for an amendment to expand eligibility for the waiver consistent with the bill.

Fiscal Summary

State Effect: Medicaid expenditures increase by a *significant* amount (50% general funds, 50% federal funds) beginning as early as FY 2025 to expand waiver eligibility. Federal fund revenues increase accordingly. *For context only*, MDH advises that total costs could increase by as much as $300 million, or more, on an annualized basis, as outlined below; however, the Department of Legislative Services (DLS) advises that this estimate was not provided in time to be *fully* analyzed and that obtaining waiver approval would take several months. **This bill increases the cost of an entitlement program beginning as early as FY 2025.**

Local Effect: Revenues and expenditures increase for local health departments (LHDs) to conduct additional assessments of medical eligibility, as discussed below.

Small Business Effect: Potential meaningful.

Analysis

Current Law:

Medicaid Home- and Community-Based Services

The Medicaid Home- and Community-Based Services program, authorized under § 1915(c) of the federal Social Security Act, permits a state to furnish an array of home- and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. An individual must be determined medically eligible to receive services if the individual requires skilled nursing care or other related services, rehabilitation services, or health-related services above the level of room and board that are available only through nursing facilities.

Medicaid Community Options Waiver

The Community Options Waiver must include (1) a cap on waiver participation of at least 7,500 individuals; (2) a plan for waiver participation of at least 7,500 individuals; (3) specified financial eligibility criteria; (4) waiver services that include specified services; (5) the opportunity to provide eligible individuals with waiver services 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) enhancement of compliance with *Olmstead v. L.C.* (1999) by offering cost-effective, community-based services in the most appropriate setting.

Financial eligibility criteria for the waiver must include (1) the current federal and State Medicaid long-term care rules for using services provided by a nursing facility; (2) medically needy individuals using services provided by a nursing facility under the current federal and State Medicaid eligibility criteria; and (3) categorically needy individuals with income up to 300% of the applicable payment rate for SSI.

The Community Options Waiver was approved by CMS for a five-year period (January 1, 2023, through December 31, 2027). The number of authorized slots is 6,348 annually for fiscal 2023 through 2026. The authorized number of slots will increase to 7,500 for fiscal 2027 through 2029.

State Fiscal Effect: Medicaid expenditures (50% general funds, 50% federal funds) increase by a *significant* amount beginning as early as fiscal 2025 to implement the bill, which assumes waiver approval and receipt of corresponding federal revenues. MDH advises that costs could be as high as $301 million in fiscal 2025, increasing to $379 million by fiscal 2029. However, information about the estimated effect was not provided in time

for DLS to *fully* analyze the fiscal impact of this legislation. Moreover, the estimate for fiscal 2025 does not appear to take into account the amount of time it would take to obtain waiver approval. Nevertheless, the key drivers of additional costs as estimated by MDH – principally the cost to fill additional waiver slots and the wider impact of an income disregard on the Medicaid program – are outlined below. DLS notes that, while additional waiver slots are more readily filled under this legislation, at least a portion of costs attributed to the expansion may be incurred under the waiver as currently approved.

Additional Waiver Slots

There are currently 6,348 authorized slots for the waiver, 4,921 of which are funded. An additional 1,427 slots authorized under the waiver are unfunded. Expanding eligibility to include categorically needy individuals with an income disregard up to 300% of the SSI monthly benefit amount will increase demand for waiver slots and require funding of additional slots, as well as other associated costs.

Initial and Annual Assessments of Medical Eligibility: Each waiver applicant must receive an assessment of medical eligibility performed by an LHD, which is reimbursed by Medicaid at a rate of $482.92 per assessment. Once enrolled, each waiver participant must receive this assessment annually. Thus, for every 500 individuals who apply for the waiver, costs for assessments increase by $241,460, and by an additional $482.92 annually for each individual enrolled in the waiver.

Annual Cost Per Waiver Slot: MDH advises that the estimated total annual cost to fill each waiver slot is $40,000. DLS notes that the estimated annual net cost to Medicaid per waiver slot is $22,500 based on the midpoint estimate from The Hilltop Institute's 2020 *Joint Chairmen's Report* response. Thus, for every 100 individuals who enroll in the waiver, costs increase by $2.25 million annually. To the extent that all 1,427 unfunded waiver slots are filled, costs increase by $32.1 million annually.

Should waiver costs be as high as $40,000 per year, for every 100 individuals who enroll in the waiver, costs increase by $4.0 million. To the extent that all 1,427 unfunded waiver slots are filled, costs increase by $57.1 million annually.

Personnel to Serve Additional Waiver Enrollees: To the extent that a significant number of new individuals applies for the waiver under the bill, MDH advises that seven full-time staff are necessary to accept applications, process technical and financial eligibility, preauthorize services for waiver participants once they are enrolled, and provide ongoing services related to waiver participation to the new waiver participants. MDH advises that additional staffing costs are $549,551 in fiscal 2025, reflecting the bill's October 1, 2024, effective date, increasing to $729,279 in fiscal 2029.

Extending Income Disregard to Long-term Care

Medicaid financial eligibility requirements currently permit enrollment by an individual with an income up to 300% of SSI. Under the bill, eligibility is expanded to include categorically needy individuals with an income disregard up to 300% of the SSI monthly benefit amount. For an applicant, this means that income of up to 300% of the SSI monthly benefit is disregarded (excluded or deducted) from the applicant's total income before determining eligibility for the waiver. Thus, the applicant is able to qualify for Medicaid with a higher income level.

MDH advises that it cannot establish different financial standards for individuals receiving waiver services in the community and individuals residing in long-term care facilities. Therefore, the bill's proposed income disregard would need to be adopted as part of the financial eligibility requirements for *both* populations.

Reduction in Contribution of Care for Enrollees in Nursing Facilities: Adopting an income disregard of up to 300% of the SSI monthly benefit amount for the long-term care population (individuals residing in a nursing facility) results in a reduction in the number of Medicaid participants required to contribute to the cost of their care and greatly increases the number of individuals eligible for full Medicaid coverage for their long-term care costs.

In fiscal 2023, Medicaid covered the total cost of nursing home care for 4,096 participants. An additional 15,985 participants received subsidized long-term care (and paid a portion of the cost of their care). Contributions to care for these 15,985 participants totaled $197 million in fiscal 2023. MDH advises that implementing an income disregard for the long-term care population may reduce the number of participants required to contribute to their cost of care by as much 80%, which could increase Medicaid costs by up to $158 million annually.

Additional Private Pay Individuals Eligible for Medicaid: Approximately 10% of individuals residing in a nursing facility pay the full private rate. Under the income disregard, many private pay individuals will apply for Medicaid. For each new applicant, Medicaid costs increase for additional long-term care coverage review by the utilization control agent at a cost of $78.83 per review. For each enrollee who becomes fully covered by Medicaid for their long-term care costs, Medicaid costs increase by $112,212 per year. To the extent that 100 additional individuals residing in nursing homes apply for and enroll in full Medicaid coverage, costs increase by $11.2 million annually.

Other Requirements of the Bill

Under the bill, the waiver must include a community spouse resource allowance calculated by assets owned as of the first day of the month of continuous institutionalization for 30 or

more days, or as of the first day of the month in which the applicant receives an application for waiver services from MDH. DLS was not provided with information on the impact of this provision.

The bill also requires MDH to adopt regulations that establish a timeline within which MDH must approve or deny a waiver application. MDH advises that, at this time, the staffing costs associated with establishing a timeline remain indeterminate for the purpose of determining the fiscal impact of this provision.

By October 31, 2024, MDH must apply to CMS for an amendment to expand eligibility for the waiver consistent with the bill. This analysis assumes that MDH can apply for a waiver with existing budgeted resources. However, MDH notes that the request for the income disregard may not be approved (in which case, implementation would require 100% general funds).

MDH further notes that implementation of the bill likely increases spending on institutional settings as compared to community-based settings in a ratio that conflicts with rebalancing efforts to increase the amount of funding allocated to care in community rather than institutional settings.

Local Fiscal Effect: LHD revenues increase beginning in fiscal 2025 from reimbursement to conduct medical eligibility assessments for waiver applicants and enrollees. LHD expenditures also increase to conduct the assessments.

Small Business Effect: Small business health care providers serve additional waiver participants under the bill.

Additional Information

Recent Prior Introductions: Similar legislation has not been introduced in the last three years.

Designated Cross File: SB 1057 (Senator Kramer) - Finance.

Information Source(s): Maryland Department of Health; Department of Legislative Services

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km/ljm

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