SB 624

Department of Legislative Services

Maryland General Assembly
2003 Session

FISCAL AND POLICY NOTE
Revised

Senate Bill 624 (Senators Hollinger and Green)

Finance Health and Government Operations

Medical Assistance Programs - Long-Term Care Services

This bill: (1) requires the Department of Health and Mental Hygiene (DHMH) to determine the appropriate level of care standard for individuals eligible for nursing home care; (2) provides for a senior assisted living subsidy for certain group homes; and (3) requires DHMH to apply for a home- and community-based long-term care services waiver under the federal Social Security Act.

The bill takes effect July 1, 2003.

Fiscal Summary

State Effect: Medicaid expenditures increase by $4.7 million ($1.6 million general funds, $3.1 million federal funds) in FY 2005. Future year estimates reflect inflation and projected savings under the managed care waiver for long-term care services. No effect on revenues. Expansion of the assisted living subsidy could increase general fund expenditures by a significant amount.

($ in millions)	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
Revenues	$0	$0	$0	$0	$0
GF Expenditure	0	1.6	(.7)	(1.6)	(2.8)
FF Expenditure	0	3.1	(.7)	(1.6)	(2.8)
Net Effect	$0	($4.7)	$1.4	$3.2	$5.6

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: Meaningful. Small business providers could either lose income due to discounted services under a managed care long-term-care waiver, or could gain income from an increased number of Medicaid enrollees utilizing community-based services more than nursing homes.

Analysis

Bill Summary:

Level of Care Standard: This bill requires DHMH to develop criteria to determine when an individual requires the level of care provided in a nursing facility and an objective instrument to collect and assess information about an individual's condition in order to establish if the criteria are met.

The criteria developed must include the need for assistance based on behavioral, functional, or cognitive defects and the need for skilled nursing or rehabilitative services. DHMH must implement the criteria by July 1, 2004 or, if implementation of the criteria would result in additional costs to DHMH, subject to the appropriation of sufficient funds from the State budget.

Waiver: By December 15, 2003, DHMH must apply for a home- and community-based long-term care services waiver under the federal Social Security Act. If this waiver is approved by September 1, 2004, DHMH must develop a program by July 1, 2005 to integrate delivery of long-term care services through a mandatory managed care system for community-based individuals 60 years of age or older who are eligible for both Medicare and Medicaid. Individuals eligible for services under the waiver and a program for all-inclusive care for the elderly approved by the federal Centers for Medicare and Medicaid Services (CMS) may elect to receive services under either program. DHMH may offer home- and community-based long-term care services under this waiver on a statewide basis or DHMH may limit the geographical area to include at least the entire areas of Baltimore City and Baltimore County.

Each individual enrolled in the Waiver for Older Adults or another a waiver program at the time the waiver required by this bill is implemented, has the right to remain in the waiver or any other State waiver program. DHMH and the Maryland Department of Aging (MDoA) must develop a detailed plan that specifies: (1) how DHMH and MDoA will implement improvements to the waiver; (2) when each improvement to the waiver will be implemented; (3) any regulatory or statutory changes that are needed in order to implement the improvements; and (4) the cost to implement each improvement.

Assisted Living Subsidy: The bill creates a senior assisted living subsidy, which is provided to eligible seniors living in any assisted living facility where the facility has entered into an agreement with MDoA or its designee to participate in the Senior Assisted Living Subsidy Program. If additional funds are appropriated to MDoA for an expanded Senior Assisted Living Subsidy Program, the bill provides that any assisted living facility, regardless of the number of beds in the facility, may participate in the subsidy.

Current Law: Medicaid provides coverage for most long-term care services for an individual who meets certain financial and medical eligibility requirements. Most Medicaid recipients must enroll in HealthChoice, a managed care program that provides most medical services for a capitated monthly fee. Excluded from HealthChoice are Medicaid enrollees who are in nursing homes or other institutions, or who are dually-eligible for both Medicaid and Medicare. Medicaid pays for these enrollees' services on a fee-for-service basis.

The federal Social Security Act gives states the option of requesting waivers of certain federal requirements in order to develop community-based alternatives to placing Medicaid-eligible individuals in hospitals, nursing facilities, or institutions. Medicaid home- and community-based waivers allow individuals to receive long-term care services in the community rather than an institutional setting. Maryland is approved to operate five waivers: (1) Waiver for Older Adults; (2) Waiver for Individuals with Disabilities (Living at Home Waiver); (3) Waiver for Mentally Retarded/Developmentally Disabled Individuals; (4) Model Waiver for Disabled Children; and (5) Waiver for Individuals with Autism Spectrum Disorder.

MDoA provides a monthly subsidy to group homes that house between 4 and 16 residents. The subsidy, which may be up to $650 per month per resident, attempts to meet the gap between a resident's income and the cost of care provided to the resident.

Background: In June 1999, the Supreme Court ruled in *L.C. & E.W. vs. Olmstead* that states may not discriminate against persons with disabilities (including persons with developmental disabilities, persons with physical disabilities, persons with mental illness, and the elderly) by providing services in institutions when the individual could be served in the community. States are required to provide community-based services for persons with disabilities if: (1) treatment professionals determine that it is appropriate; (2) the affected individuals do not object to such placement; and (3) the state has the available resources to provide community-based services. States that maintain waiting lists for community-based services must make a good faith effort to move people on the list to community programs at a reasonable pace.

In addition to ensuring compliance with the *Olmstead* decision, states are looking for ways to contain costs of providing long-term care to their residents. Increasingly, states are expressing an interest in providing long-term care services in a managed care environment or using a limited pool of providers. In addition to providing traditional long-term care state plan services (e.g., home health, personal care, institutional services), many states are proposing to include nontraditional home- and community-based services (e.g., homemaker services, adult day health services, respite care) in their managed care programs. In essence, states use the 1915(b) waiver authority to limit freedom of choice, and use the 1915(c) waiver authority to provide the home- and community-based services and expand Medicaid eligibility.

The Texas STAR+PLUS program, approved in January 1998, was the first concurrent 1915(b)/(c) waiver program to be implemented. This mandatory program, which serves disabled and elderly beneficiaries in Harris County (Houston), integrates acute and long-term care services through a managed care delivery system consisting of three managed care organizations (MCOs) and a primary care case management system. The majority of STAR+PLUS enrollees are dually eligible for Medicaid and Medicare. Although STAR+PLUS is a Medicaid program and does not restrict Medicare freedom of choice, an enhanced drug benefit is provided as an incentive to dual eligibles who elect to enroll in the same MCO for their Medicaid and Medicare services. Care coordination is an essential component of the STAR+PLUS model.

Nationally, cost-savings under Medicaid managed care are difficult to achieve for dually eligible individuals, as providers do not have the ability to directly influence service utilization. This goal has been difficult to achieve in state programs because most of the acute care services used by dually eligible individuals are paid for by the Medicare program, and Medicaid providers do not have the ability to directly influence the utilization of Medicare services. Several case studies conducted by the Kaiser Family Foundation in 2001 did not reveal whether the Medicaid managed care programs for dually eligible individuals led to Medicaid cost savings.

State Fiscal Effect: Medicaid expenditures could increase by $4,679,362 ($1,589,681 general funds, $3,089,681 federal funds) in fiscal 2005, which reflects a July 1, 2005 waiver implementation date. This estimate reflects the cost of a one-time $3 million Medicaid Management Information Systems (MMIS) programming cost, $1 million for external quality review organization (EQRO), and 13 positions to conduct the waiver redesign, and manage eligibility, enrollment, and claims. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Salaries and Fringe Benefits	$660,323
MMIS Programming	3,000,000
EQRO Contract	1,000,000
Other Operating Expenses	19,039
Total FY 2005 State Expenditures	**$4,679,362**

Future year expenditures reflect: (1) full salaries with 4.5% annual increases and 3% employee turnover; and (2) 1% annual increases in ongoing operating expenses.

DHMH advises the implementation of a managed care waiver for long-term care services would result in Medicaid expenditure reductions, beginning in fiscal 2006, the first year of waiver implementation. Under the current fee-for-service Medicaid program, 23,000 individuals would cost $77 million in fiscal 2006. This estimate assumes all 23,000

individuals enroll in the managed care waiver. First year savings are projected at 4% of overall costs, or $3.1 million. Future year savings reflect inflation.

Expansion of the Senior Assisted Living Subsidy Program could increase MDoA general fund expenditures by a significant amount. In fiscal 2003, MDoA provided $3.4 million for subsidies to 336 participating group homes with 4 to 16 residents. Subject to the appropriation of additional funds in MDoA's budget, MDoA may expand the subsidy program to any assisted living facility, regardless of size. Smaller group homes that house between one and three residents are most likely to seek participation in the program. There are currently 837 group homes that could qualify and seek subsidies for residents. There are insufficient data at this time to reliably estimate the number of group homes that would participate and the resulting increase in general fund expenditures to fund the subsidies.

Additional Information

Prior Introductions: None.

Cross File: None.

Information Source(s): *Medicaid Managed Care for Dual Eligibles, A Case Study of Programs in Georgia, Minnesota, and Pennsylvania*, July 2001, Kaiser Family Foundation; U.S. Centers for Medicare and Medicaid Services; National Conference of State Legislatures; Department of Health and Mental Hygiene (Medicaid, Office of Health Care Quality); Department of Aging; Department of Legislative Services

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