HB 1360

Department of Legislative Services

Maryland General Assembly
2004 Session

FISCAL AND POLICY NOTE

House Bill 1360 (Delegate Goldwater)
Health and Government Operations

Olmstead Compliance Act of 2004

This bill requires the Department of Health and Mental Hygiene (DHMH) to develop a program designed to reduce the number of Medicaid recipients in nursing facilities and assist dually-eligible individuals in obtaining long-term care services in the community.

Fiscal Summary

State Effect: DHMH Medicaid expenditures increase by $13.9 million (50% general, 50% federal) in FY 2005. Maryland Department of Aging (MDoA) expenditures increase by $494,600 (50% general, 50% federal) in FY 2005. Future year estimates reflect annualization, Medicaid savings from transferring individuals from nursing facilities to the community, and inflation.

($ in millions)	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Revenues	$0	$0	$0	$0	$0
GF Expenditure	7.2	9.9	8.3	8.8	9.3
FF Expenditure	7.2	9.9	8.3	8.8	9.3
Net Effect	($14.4)	($19.7)	($16.5)	($17.6)	($18.7)

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

Local Effect: None.

Small Business Effect: Meaningful. Small business community service providers could receive additional clients and increase income.

Analysis

Bill Summary:

Community-based Services: DHMH must develop a program by July 1, 2004 to reduce the number of nursing facility beds occupied by Medicaid long-term care recipients and assist dually-eligible nursing facility residents who choose to obtain long-term care in the community. The program must include: (1) provisions of support services that are necessary for a dually-eligible individual to achieve maximum participation in the community; and (2) procedures or programs designed to offset the loss of income realized by a nursing home due to the reduction in residents. These programs may include: (1) tax credits; (2) grants toward conversion of a licensed nursing home bed to an assisted living bed, respite care bed, or medical day care; or (3) from a portion of the savings generated from moving dually-eligible residents to the community, an adjustment in Medicaid reimbursement for the sickest residents in the facility.

For every Medicaid long-term care recipient discharged from a nursing facility bed to a community-based waiver slot, DHMH must determine the average savings per recipient and must use the savings to: (1) fund implementation of the expanded medical eligibility requirements for nursing facilities; (2) assist medically and functionally impaired individuals in the community receive home- and community-based waiver services; and (3) make adjustments in Medicaid reimbursements.

Level of Care Standard: The bill lessens the "level of care" standard required for Medicaid long-term care eligibility. An individual is Medicaid-eligible for nursing facility services if the individual requires: (1) skilled nursing facility care or other related services; (2) rehabilitation services; or (3) health-related services above the level of room and board that are available only through institutional facilities, including, but not limited to, individuals who: (i) are currently unable to perform at least two activities of daily living (ADL) without hands-on assistance or standby assistance, and have been or will be unable to perform at least two ADLs for a period of at least 90 days due to a loss of functional capacity; or (ii) need substantial supervision for protection against threats to health and safety due to seer cognitive impairment.

Medicaid Waiver: By September 1, 2004, DHMH must apply to the federal Centers for Medicare and Medicaid Services (CMS) for an amendment to the existing home- and community-based services waiver under Section 1915(c) of the federal Social Security Act to receive federal matching funds for waiver services received by eligible individuals participating in the waiver and to receive federal matching funds for waiver services to assist dually-eligible nursing facility residents in obtaining long-term care services in the community. Waiver participation is capped at 7,500 individuals who are medically and

functionally impaired and 7,500 individuals who are dually-eligible nursing facility residents.

The waiver must permit: (1) an individual to direct, manage, and pay for home- and community-based services, including recruiting, screening, hiring, training, scheduling, supervising, and terminating a personal care attendant; (2) hiring an individuals' family member, including a spouse or friend, as a personal care attendant; (3) DHMH to set the wages for a personal care attendant; (4) the local Department of Social Services of local area agencies on aging to assist an individual in obtaining personal care attendants; and (5) DHMH to contract with an intermediary service organization to provide payroll, tax, and other payroll support services on behalf of an individual.

The waiver's financial eligibility criteria must include: medically needy individuals whose countable income exceeds 300% of the applicable payment rate for Supplemental Security Income (SSI) but is less than the average Medicaid reimbursement rate for long-term care after all deductions including the protection from spousal impoverishment.

The waiver must permit cash payments to personal care attendants by a waiver enrollee. Waiver services must be jointly administered by DHMH and MDoA.

DHMH and MDoA must: (1) designate the local area agencies on aging to serve as the single point of entry for individuals applying for wavier services; (2) develop a statewide single point-of-entry system to accept applications, make eligibility determinations, enroll individuals, and provide coordinated waiver services; (3) implement an automated provider licensure and inspection system; and (4) authorize providers to directly bill DHMH for services provided under the waiver.

Environmental Modifications: The bill changes the definition of "environmental modifications" to mean the physical adaptations made to an individual's home or place of residence to ensure the individual's health, welfare, and safety, or to ensure the individual's ability to function with greater independence and access. Modifications may include ramps, grab bars or handrails, staff glides, widening of doorways, modification of bathrooms or kitchens, or other specified adaptations. The total yearly cost of environmental modifications must be equal to or less than the total current monthly environmental modification benefit available under the program, multiplied by 12.

MDoA must report to the General Assembly by December 31, 2004, and each year thereafter, on the status of the implementation and continuation of the single point-of-entry system.

DHMH must first obtain legislative approval before applying for any waiver. DHMH and MDoA must develop a plan to assist local area agencies on aging in recruiting staff,

assisting with enrollment services, and monitoring providers, and for updating the provider system. The department must report its findings and recommendations to the Governor, the Senate Finance Committee, and the House Health and Government Operations Committee by December 1, 2004.

The bill takes effect June 1, 2004.

Current Law: Medicaid provides coverage for most long-term care services for an individual who meets certain financial and medical eligibility requirements.

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 six 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 Medically Fragile Children; (5) Waiver for Individuals with Autism Spectrum Disorder; and (6) Waiver for Adults with Traumatic Brain Injury (see **Exhibit 1** for enrollment information).

Exhibit 1
Medicaid Home- and Community-based Services Waiver Programs

Program	Year Implemented	Number of Waiver Participants as of December 2003	Administering Agency
Waiver for Older Adults	2001	3,135	MDoA and DHMH
Living at Home	2001	400	DHMH
Waiver for Individuals with Developmental Disabilities	1984	7,670	DHMH
Waiver for Medically Fragile Children	1985	200	DHMH
Waiver for Children with Autism Spectrum Disorder	2001	900	Maryland State Department of Education and DHMH
Waiver for Adults with Traumatic Brain Injury	2003	0	DHMH

Level of Care Standard: Medicaid defines "nursing facility services" as services that are: (1) skilled nursing care and related services, rehabilitation services, or health-related services above the level of room and board; (2) needed on a daily basis; (3) required to be provided on an inpatient basis; (4) provided by a facility that is certified for Medicaid participation; and (5) ordered by and provided under the direction of a physician. All five elements must be satisfied in order to establish medical eligibility for Medicaid reimbursement for nursing facility services.

If a waiver program offers community services, an individual certified as in need of a nursing facility level of care may elect to receive services through the wavier rather than through institutional placement.

Federal Medicaid Law Provisions: Medicaid reimbursement of a legally-responsible relative, such as a spouse or parent of a minor child, is prohibited. States may use financial eligibility standards of up to 300% of SSI to qualify for Medicaid coverage of nursing facility services.

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 2001, there were about 250 nursing facilities in Maryland, with an operating capacity of about 30,000 beds, that provided services for over 9.5 million patient days. Medicaid paid for approximately 63% of patient days, resident or family income paid for 24%, Medicare paid for about 11%, and the remaining patient days were paid by other sources. As of January 3, 2003, Maryland nursing facilities had an average 13% bed vacancy rate. There are about 37,000 people in Maryland nursing facilities. Of these, approximately 8,500 have expressed interest in returning to a community-based setting. From December 2002 to December 2003, approximately 130 individuals transferred from nursing facilities to home- and community-based services waiver programs.

Effective January 2004, the SSI payment for an eligible individual is $564 per month and $846 per month for an eligible couple.

State Fiscal Effect: DHMH expenditures could increase by $13,948,688 (50% general funds, 50% federal funds) in fiscal 2005 from increased enrollment in nursing facilities and adult medical day care due to the revised level of care standard required to meet Medicaid eligibility for long-term care. DHMH must also develop a single point-of-entry system to accept applications, make eligibility determinations, fully automate licensure for community health service providers, and contract with a vendor to provide payroll, tax, and other support services on behalf of personal attendants who provide care for waiver enrollees in the community. This estimate assumes Medicaid changes the level of care standard July 1, 2004. The information and assumptions used in calculating the estimate are stated below:

- 360 new individuals move into nursing facilities;
- 701 new individuals enroll in medical day care;
- the average annual Medicaid cost per nursing facility resident is $37,500;
- the average annual Medicaid cost per medical day care enrollee is $10,741;
- enrollment would occur throughout the year so that the average length of time in nursing facilities or medical day care is six months;
- the new Single Point-of-Entry System, automated licensure, and payroll third-party administrator cost $3,223,673; and
- associated DHMH administrative costs are $210,294.

Future year estimates reflect 6.5% medical inflation in the Medicaid program.

Savings: Medicaid expenditures could decrease by as much as $4,126,410 (50% federal funds, 50% general funds), beginning in fiscal 2006, which assumes a July 1, 2005 implementation date of the new waiver. The information and assumptions used in calculating the estimate are stated below:

- 8,500 nursing facility residents express interest in moving into the community;
- of those, 612 Medicaid enrollees over 50 move into the community, reducing Medicaid expenditures $7,560 per year per enrollee;
- 153 Medicaid enrollees with physical disabilities move into the community, reducing Medicaid expenditures $23,700 per year per enrollee; and
- transitions into the community would occur throughout the year so that the average length of time after transitioning into the community is six months.

It is assumed these savings would be used to offset costs from increased nursing facility and adult medical day care enrollment generated by the revised level of care standard,

beginning in fiscal 2006. Future year estimates reflect full enrollment and assume the annual savings per enrollee remains the same.

The bill provides that spouses or others may function as personal care attendants for individuals in the community, and specifies what types of environmental modifications may be done to facilitate an individual's medical care at home or in the community. To the extent there are increases in the numbers of personal care attendants employed or environmental modifications approved, Medicaid expenditures could increase, beginning in fiscal 2006. There are insufficient data to reliably estimate any increase.

MDoA: MDoA expenditures could increase by $494,573 in fiscal 2006 to provide case management and related administrative costs for 765 individuals who are enrolled in waiver services beginning July 1, 2005. Annual case management costs average $1,293 per person and this estimate assumes each individual is enrolled in a waiver service for an average of six months. MDoA's reporting requirements could be handled with existing budgeted resources.

Additional Information

Prior Introductions: None.

Cross File: SB 819 (Senator Hollinger, *et al.*) – Finance.

Information Source(s): Federal Centers for Medicare and Medicaid Services, Department of Human Resources, Department of Health and Mental Hygiene (Medicaid, Office of Health Care Quality, Developmental Disabilities Administration, Family Health Administration), Maryland Department of Aging, Department of Legislative Services

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