SB 819

Department of Legislative Services

Maryland General Assembly
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FISCAL AND POLICY NOTE
Revised

Senate Bill 819 (Senator Hollinger, *et al.*)

Finance Health and Government Operations

Department of Health and Mental Hygiene - Federal Waivers - Waiver for Older Adults and Medicaid Managed Care Pilot Program

This bill requires the Department of Health and Mental Hygiene (DHMH) to apply to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to establish the Community Choice Program, a managed care system that provides long-term care services to eligible Medicaid enrollees. Medicaid program recipients are required to enroll in a community care organization (CCO), which promotes the delivery of services in the most appropriate, cost-effective setting, including nursing facilities and community-based services. Prior to submitting the waiver to CMS, DHMH must submit the proposed waiver to the Legislative Policy Committee for its review and comment.

The bill takes effect June 1, 2004 and the Community Choice Program terminates May 31, 2008.

Fiscal Summary

State Effect: Medicaid general fund expenditures decrease by $588,200 and federal fund expenditures increase by $911,800 in FY 2007 upon implementation of the Community Choice Program waiver. The FY 2008 estimate reflects 2% savings.

(in dollars)	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Revenues	$0	$0	$0	$0	$0
GF Expenditure	0	0	(588,200)	(3,590,500)	0
FF Expenditure	0	0	911,800	(3,590,500)	0
Net Effect	$0	$0	($323,600)	$7,181,000	$0

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: The program must include: (1) adults who are dually-eligible for Medicare and Medicaid; (2) adult Medicaid recipients who meet the nursing home level-of-care standard; and (3) Medicaid recipients over 65 years of age. If an enrollee requires nursing home level of care, the enrollee may choose to receive services in a nursing home or in the community if community placement is cost effective. The program may not operate in more than two areas of the State. DHMH must make capitation payments to each CCO at a level that is actuarially adjusted for the benefits provided.

In developing the waiver, DHMH must determine whether it is in the best interest of waiver enrollees to provide a standard prescription drug formulary and drug utilization review for medically necessary drugs for waiver and nonwaiver recipients in nursing homes, and consider maintaining the same nursing home prescription drug benefit for all nursing home residents until federal implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

DHMH must use the savings realized under the Community Choice Program to increase reimbursement rates to community providers and develop a statewide single point-of-entry system to accept applications, make eligibility determinations, enroll individuals, and provide coordinated services.

The bill specifies certain enrollee protections, such as the ability to choose between at least two CCOs, the right to hospice care, and the requirement that pharmacy benefits be provided to an enrollee, regardless of placement. The bill requires DHMH to certify a CCO for participation in the program. Each CCO must meet certain criteria such as having a quality assurance program, ensuring an adequate provider network, meeting solvency and capital requirements, and meeting other requirements and standards as specified by DHMH. The bill specifies reimbursement rates CCOs must pay to nursing homes, adult day care facilities, hospitals, and hospital emergency facilities. Each enrollee receiving services in a nursing home, assisted living facility, adult day care, psychiatric rehabilitation program, or residential rehabilitation program has the option to continue care in the respective facility.

If an enrollee requires specialty mental health services, the individual must receive these services from an approved mental health provider under a separate arrangement from the Community Choice Program, and DHMH must directly pay the provider at the Medicaid-established rate for such services.

The bill also requires DHMH to seek permission from CMS to change the level-of-care definition for individuals to be medically-eligible to receive services in the Waiver for Older Adults. An individual is medically-eligible 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 nursing facilities, including individuals who have severe cognitive impairments.

Beginning December 1, 2004, DHMH must report annually to the General Assembly on the status of the Community Choice Program. DHMH must initially submit emergency regulations to begin implementation of the Community Choice Program. DHMH must study ways to provide incentives for CCOs and must report to specified committees by September 30, 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.

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.

State Fiscal Effect: Medicaid general fund expenditures could decrease by $588,181 and federal fund expenditures could increase by $911,818 in fiscal 2007, resulting in a net Medicaid expenditure increase of $323,637. This estimate assumes total expenditures to implement the Community Choice Program are $4,426,701 ($2,963,350 federal funds, $1,463,351 general funds) and total savings derived from the managed care structure of the program are $4,103,064 ($2,051,532 federal funds, $2,051,532 general funds). A July 1, 2006 enrollment date is assumed for the Community Choice Program because CMS approval of the waiver could take up to 18 months from the date of application.

Medicaid would incur one-time administrative costs in fiscal 2007 to implement the program, including: (1) $3 million (75% federal funds, 25% general funds) for programming and systems changes to the Medicaid Management Information Systems mainframe; and (2) $1 million (50% federal funds, 50% general funds) to contract with an external quality review organization. Personnel and other operating costs would increase by $426,701 (50% federal funds, 50% general funds), beginning in fiscal 2007. This includes the cost of hiring 13 new positions to conduct enrollment, quality review, and computer programming. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

These expenditures are offset by savings achieved from the Community Choice Program. It is assumed that the managed care structure of the program would reduce Medicaid expenditures by about 1%. Based on the savings achieved during the transition from Medicaid fee-for-service to the HealthChoice managed care program, it is assumed a long-term care managed care program would save 1% the first year, 2% the second year, and 3% in subsequent years. Approximately 17,694 individuals would enroll in the program in fiscal 2007 (25% of 70,774 eligible Medicaid enrollees), reducing fee-for-service Medicaid expenditures of $410,306,376 by about 1%, or $4,103,064.

Future year expenditures: (1) reflect full salaries with 4.6% annual increases and 3% employee turnover; (2) reflect 1% annual increases in ongoing operating expenses; (3) assume 2% savings in fiscal 2008; and (4) reflect the program's May 31, 2008 termination date.

Medicaid expenditures would not be affected by the modified level-of-care standard in the Wavier for Older Adults. The waiver is authorized to allow 7,500 individuals to participate; however, it is currently funded to provide services to only 3,135. Since participation in the waiver is limited by the budget, expanding the eligibility criteria would not have any fiscal impact.

Additional Information

Prior Introductions: None.

Cross File: HB 1360 (Delegate Goldwater) – Health and Government Operations.

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

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Analysis by: Susan D. John

Direct Inquiries to:
(410) 946-5510
(301) 970-5510