SB 711

Department of Legislative Services
Maryland General Assembly
2006 Session

FISCAL AND POLICY NOTE

Senate Bill 711 (Senator Hollinger, *et al.*)
Finance

Medical Assistance Programs - Long-Term Care Services

This bill modifies the medical eligibility standard in the Medicaid program for long-term care services.

The bill takes effect June 1, 2006.

Fiscal Summary

State Effect: Department of Health and Mental Hygiene (DHMH) Medicaid expenditures increase by $20.4 million (50% general, 50% federal) in FY 2007. Future year estimates reflect annualization and inflation. No effect on revenues.

($ in millions)	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Revenues	$0	$0	$0	$0	$0
GF Expenditure	10.2	21.7	23.1	24.6	26.2
FF Expenditure	10.2	21.7	23.1	24.6	26.2
Net Effect	($20.4)	($43.5)	($46.3)	($49.3)	($52.4)

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 increased income.

Analysis

Bill Summary: The bill modifies 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 severe cognitive impairment.

The individual's physician, to the extent feasible, must certify that the individual requires theses services.

The bill expands the Waiver for Older Adults program to include a program that allows an individual to hire a personal care attendant, including hiring an individual's family member or friend as a personal care attendant. DHMH may set the wages for a personal care attendant. DHMH may contract with an intermediary service organization to provide payroll, tax, and other payroll support services on behalf of an individual. The local department of social services of the local area agencies on aging may assist an individual in obtaining a personal care attendant.

DHMH must maintain a waiting list of eligible individuals who are interested in receiving waiver services. DHMH must develop guidelines for the initial screening of individuals interested in receiving waiver services before the individual is placed on the waiting list, including a spousal resource assessment. Before a Medicaid-eligible individual is placed in a nursing facility, DHMH must consider eligibility for the waiver. If the individual is eligible for the waiver, the individual must be placed on the waiting list and the individual's status must be monitored by DHMH. For every five Medicaid long-term care recipients discharged from a nursing facility bed to a community-based waiver slot, DHMH must use the savings to assist two medically- and functionally-impaired individuals either in the community or when discharged from a hospital, to receive home- and community-based waiver services.

The bill prohibits DHMH, without legislative approval, from amending any waivers or seeking approval of any pending, existing, or future waivers to the State Medicaid plan by any means that would: (1) consolidate federal grants or allotments; (2) cap federal contributions to Medicaid spending; or (3) alter the proportional share of federal or State Medicaid spending.

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.

DHMH is pending waiver approval for its Community Choice program.

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. Other individuals may be personal care attendants.

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.

State Fiscal Effect: DHMH expenditures could increase by $20,432,999 (50% general funds, 50% federal funds) in fiscal 2007 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. This estimate assumes Medicaid changes the level of care standard July 1, 2006. The information and assumptions used in calculating the estimate are stated below:

- 425 new individuals move into nursing facilities;
- 802 new individuals enroll in medical day care;
- 1,356 individuals with developmental disabilities enroll;
- for individuals who convert from day habilitation to medical day care, expenditures increase by $602,435;
- the average annual Medicaid cost per nursing facility resident is $37,464;
- the average annual Medicaid cost per medical day care enrollee is $11,430;
- the average annual Medicaid cost per day habilitation enrollee is $10,737;
- enrollment would occur throughout the year so that the average length of time in nursing facilities or medical day care is six months;
- associated DHMH administrative costs are $615,131.

The personal care attendant program provisions could be handled with existing Medicaid resources. Medicaid is already expected to permit the use of personal care attendants under the Community Choice program, although it does not permit spouses to provide care due to federal law restrictions. Future year estimates reflect 6.5% medical inflation in the Medicaid program.

DHMH advises that maintaining and monitoring a waiting list for individuals eligible for waiver services could be handled with existing budgeted resources. It is assumed that the bill's requirement that DHMH use any savings from every five Medicaid individuals discharged from a nursing facility be used to assist two medically- and functionally-impaired individuals receive home- and community-based care services falls under DHMH's current practice. DHMH's budgetary process does not track expenditures for each individual Medicaid recipient, and it would be difficult to capture the type of savings data required under the bill. However, DHMH proactively attempts to fill all home- and community-based waiver slots as budgetary restrictions allow.

Additional Information

Prior Introductions: The first reader version of SB 819 of 2004 had similar provisions related to the level-of-care standard for long-term care. These provisions were amended out of the bill, which later passed, creating the Community Choice program (Chapter 4 of 2004 special session).

Cross File: HB 1549 (Delegate V. Turner, *et al*.) – 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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