Department of Legislative Services

Maryland General Assembly
2019 Session

FISCAL AND POLICY NOTE
Third Reader - Revised

Senate Bill 699 (Senator Kelley, *et al.*)

Finance Health and Government Operations

Maryland Medical Assistance Program - Home- and Community-Based Waiver Services - Prohibition on Denial

This bill prohibits the Maryland Department of Health (MDH) from denying an individual access to a Medicaid home and community-based services waiver due to lack of funding for the waiver if (1) the individual is living at home or in the community at the time of application; (2) the individual received home and community-based services through Community First Choice (CFC) for at least 30 consecutive days; (3) the individual will be or has been terminated from Medicaid due to becoming eligible for or enrolled in Medicare; (4) the individual meets all of the eligibility criteria for participation in the waiver within six months after the completion of the application; and (5) the home and community-based services provided for the individual would qualify for federal matching funds. **The bill takes effect July 1, 2019.**

Fiscal Summary

State Effect: Medicaid expenditures increase by an indeterminate but likely significant amount (50% general funds, 50% federal funds) beginning in FY 2020, as discussed below. Federal funds revenues increase correspondingly. **This bill increases the cost of an entitlement program beginning in FY 2020.**

Local Effect: None.

Small Business Effect: Meaningful.

Analysis

Current Law: Medicaid home and community-based waivers allow individuals to receive long-term care services in the community rather than an institutional setting. MDH may not deny an individual access to a Medicaid home and community-based services waiver due to lack of funding for waiver services if:

- the individual is living in a nursing facility at the time of application for waiver services;
- at least 30 consecutive days of the individual's nursing facility stay are eligible to be paid for by Medicaid;
- the individual meets all of the eligibility criteria for participation in the home and community-based services waiver; and
- the home and community-based services provided to the individual would qualify for federal matching funds.

Background: The CFC option provides community services and supports to enable older adults and people with disabilities to live in their own homes. To be eligible, an individual must reside in the community and meet the level of care required to qualify for services in an institution. CFC services include personal assistance, supports planning, nurse monitoring, personal emergency response systems, assistive technology, environmental assessments, accessibility adaptations, consumer training, transition services, and home delivered meals. CFC participants are also eligible to receive other Medicaid services, which may include physician and hospital care, pharmacy, home health, laboratory services, mental health services, disposable medical supplies, and durable medical equipment.

The federal Patient Protection and Affordable Care Act created a Medicaid expansion coverage group known as the "A-track," which has income limits but no asset test for financial eligibility. Individuals in the A-track are eligible for long-term care services under CFC. However, coverage ends when a person becomes Medicare-eligible (*i.e.*, either enrolls due to disability or turns age 65).

Since 2014, CFC has served 1,063 A-track individuals, 668 of whom subsequently lost their A-track coverage due to becoming Medicare-eligible. Of these 668 individuals, 163 (24%) reenrolled in CFC by qualifying for Medicaid under another coverage group. The remaining 505 individuals did not qualify for Medicaid due to having greater than $2,000 in assets.

The bill is intended to allow individuals currently receiving CFC services to maintain enrollment in the program when they become eligible for or enrolled in Medicare.

State Fiscal Effect: Medicaid advises that the bill increases expenditures by $7.8 million (50% general funds, 50% federal funds) in fiscal 2020, which accounts for the bill's July 1, 2019 effective date. In fiscal 2024, expenditures increase by a total of $14.0 million. This estimate reflects the cost to provide services under a Medicaid home and community-based services option to 253 individuals who likely currently qualify under the bill (50% of the 505 former CFC participants who did not qualify for Medicaid), as well as 51 additional individuals annually in future years. Medicaid assumes that, based on trend, 134 A-track individuals will lose CFC coverage annually, 33 will regain it under another Medicaid eligibility category, and half of the remaining 101 individuals qualify for a waiver slot under the bill. Thus, a total of 253 individuals are provided with a waiver slot in fiscal 2020, increasing to 457 individuals by fiscal 2024. The average annual cost for waiver services is $30,733. This estimate does not reflect any increase in waiver costs such as potential rate increases.

However, the Department of Legislative Services notes that, to the extent the bill allows CFC participants to maintain their eligibility, overall expenditures are likely offset. For example, to the extent the bill reduces the number of individuals who lose CFC coverage from entering a nursing home, Medicaid expenditures of approximately $79,000 per person per year are avoided. Therefore, while Medicaid expenditures increase (likely significantly) under the bill, an exact amount cannot be reliably estimated.

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

Additional Information

Prior Introductions: None.

Cross File: HB 832 (Delegate Pena-Melnyk, *et al.*) - Health and Government Operations.

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

Fiscal Note History: First Reader - March 8, 2019
mag/ljm Third Reader - March 29, 2019
Revised - Amendment(s) - March 29, 2019
Revised - Correction - March 29, 2019

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