



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

OCT 02 2007

The Honorable Ulysses Currie
Chairman
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Norman H. Conway
Chairman
House Appropriations Committee
131 Lowe House Office Bldg.
Annapolis, MD 21401-1991

The Honorable Thomas M. Middleton
Chairman
Senate Finance Committee
3 East Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Peter A. Hammen
Chairman
House Health and Government
Operations Committee
161 Lowe House Office Bldg.
Annapolis, MD 21401-1991

RE: HB 594 (Ch. 244 of the Acts of 2007) – Department of Health and Mental Hygiene – Long-Term Care Services for Cognitive and Functional Impairments – Study and Analysis

Dear Chairmen Currie, Middleton, Conway and Hammen:

The Department of Health and Mental Hygiene, in consultation with interested stakeholders, is required by HB 594 (Ch. 244 of the Acts of 2007) to conduct a study and comprehensive analysis of the options that may be available to the State to increase access to long-term care services, including home- and community-based services such as adult medical day care, for individuals at high risk of institutionalization because of cognitive impairments, mental illness, traumatic brain injury or other conditions, who meet the financial eligibility for Medical Assistance in effect as of June 1, 2007. The Department is submitting the enclosed interim report due October 1, 2007. A final report will be submitted by December 1, 2007.

If further information is required, please contact Tricia Roddy, Director of Planning, at (410) 767-5806.

Sincerely,



John M. Colmers
Secretary

Enclosure

cc: John Folkemer
Susan Tucker
Mark Leeds
Tricia Roddy
Anne Hubbard

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House Bill 594

October 1, 2007 Interim Report

Introduction

House Bill 594 (Chapter 244, Laws of Maryland 2007, hereafter HB 594) requires the Department of Health and Mental Hygiene (DHMH or the Department) to study and analyze “the options to increase access to long-term services, including home- and community-based services such as adult medical day care, for individuals at high risk of institutionalization because of cognitive impairments, mental illness, traumatic brain injury, or other conditions.” HB 594 directed the Department to design and conduct a study and analysis “in consultation with interested stakeholders.” It further specified that the study and analysis shall include these components:

1. “a review of the practices of other states regarding the provision of long-term care services;
2. a determination of the feasibility of developing criteria for an alternative level of care;
3. a determination of the feasibility of increasing access to long-term care services through the Federal Deficit Reduction Act, the State Plan Amendments, the Older Adults Waiver, and other options available to the State; and
4. a cost-benefit analysis of the options examined, including the projected long-term savings to the State realized by the delay or reduction in need for the provision of care in hospitals or other institutional savings.”

HB 594 requires the Department to submit an interim report on the study and analysis by October 1, 2007 with a final report due to the Legislature on December 1, 2007. This report is submitted in compliance with that first requirement.

Stakeholder Meetings

The Department held public meetings with interested stakeholders on August 17 and 24, 2007. The purpose of the meetings was to discuss the legislation and to outline Departmental ideas for the study. Attendees were asked to comment on the ideas and to make other suggestions for the study. The study design incorporates suggestions, requests, and insights from the stakeholders who participated in this process. Appendix A provides a list of the stakeholders attending these two meetings.

Status Report on Components of Study and Analysis

Review of Other States –

Research is underway to analyze how selected states have pursued a variety of long-term care system reforms that have been focused on expanding access to community-based long-term care. Based on input from stakeholders, and the Department's knowledge of leading states, the following states were selected for analysis: Vermont, Washington, Oregon, New Jersey, New York, Florida, Michigan and the District of Columbia.

These states were selected because they met at least one of the following criteria:

- The state has reduced institutional long-term care utilization while increasing community-based services;
- The state modified its nursing facility level of care process at some point in its history with the intention of expanding access to community-based long-term care services under a home and community-based services Medicaid waiver;
- The state has developed and implemented innovative federal Medicaid waivers that promote community-based services and limited nursing facility utilization; and/or
- The state utilized innovative assessment and utilization management tools to help manage long-term care services.

A set of standard questions was developed to conduct interviews with officials from these states. A list of the questions may be found in Appendix B. These questions and other forms of research and literature reviews guided the key informant interviews with the state agency staff in these states. Interviews have been conducted with all the listed states about their programs, methods and outcomes. Certain follow-up interviews may be needed, but most of the primary data collection has occurred. Case studies from these states and key findings will be included in the final report due December 1, 2007.

The Department will study whether states modified their existing level of care assessment process in order to promote lower nursing facility utilization and higher utilization of home- and community based services. In addition, the Department will focus on the data available in the informant states to demonstrate the outcomes of the states' reforms, in terms of the effect on access and the long-term financial implications of changes in the nursing facility level of care threshold. Finally, the Department is investigating how the informant states plan to sustain their efforts as the baby boomer demographic trend increases the need for long-term care services.

The final report will address these major areas for each state studied and will attempt to analyze the implications of undertaking these types of reforms in Maryland.

With respect to the remaining three mandatory components of the study and cost analysis, the Department, with the assistance of stakeholders, has identified the following options for increasing access to Medicaid-reimbursed long term care services for its further study and cost-analysis:

- Option 1** – Changing the Current Level of Care Assessment Process by:
- a. Reducing the score necessary to meet nursing facility level of care as calculated on the Department’s assessment instrument, known as DHMH Medical Eligibility Review Form 3871B. The 3871B score is the sum of the numeric values represented by responses to a standard assessment of care needs, and both cognitive and functional limitations, of applicants seeking to establish medical eligibility to receive Medicaid reimbursement for nursing facility level of care.
 - b. Establishing two alternative methods for determining that an individual meets the nursing facility level of care. One would involve implementing a methodology which allows the nursing facility level of care criteria to be established when an individual needs assistance with two activities of daily living (ADLs). The second would allow the nursing facility level of care to be established when an individual scores under ten on the Folstein Mini-Mental test, consistent with dependency in the following instrumental activities of daily living (IADLs): orientation to person, medication management, telephone utilization, or self-expression;
- Option 2** – Add funding for Medicaid waiver slots under the Older Adult and Living at Home Waivers in order to move people now on the waiver registries into waiver services.
- Option 3** – Submit to the Centers for Medicare and Medicaid Services (CMS) a proposal for a program of home- and community-based services under the Federal Deficit Reduction Act provision at Section 1915(i) of the Social Security Act, which permits the provision of home- and community-based services under a Medicaid State Plan as a Medicaid optional service, with a lower threshold standard than the existing waiver programs. Further background on this option will be included later in the report.

Data Sources and Assumptions

The general approach to analyze the fiscal implications of these options will include estimating the potential number of additional Medicaid recipients who will be eligible for services under each option, along with cost estimates for those services. The Department will also estimate potential cost savings associated with each option, as required by HB 594. Since historical Maryland Medicaid data to make such estimates are limited, discussion regarding potential savings will be drawn primarily from the experience in

other states, and will be provided as contextual background for preliminary assumptions of general savings.

Option 1-Changing Level of Care Criteria for Nursing Facility Level of Care

Data to assess the implications of Option 1 will rely on limited historical data drawn from the current process used to make level of care determinations in the Maryland Medicaid program. Currently, nursing facility level of care is determined based primarily on an assessment form, the 3871B, as submitted by a provider, scored electronically, and if necessary reviewed in detail on behalf of the Department by clinical staff at a third-party utilization review contractor. A score for each person is established based on responses to the assessment tool, and a nursing facility level of care is established where the score meets a minimum threshold value. Individuals may also receive a nursing facility eligibility determination based on additional information about their clinical or care needs. In these situations, a physician reviewer from the Department's third-party utilization review contractor may determine that the person meets the nursing facility level of care standard even if he or she did not receive a threshold score on the 3871B assessment instrument.

The data available to examine this process include roughly 2 1/2 years of results from the former third-party contractor responsible for the level of care process between July of 2004 and January 2007, as well as 6 months of data from the current third-party utilization control contractor. Preliminary analysis of the data files indicates that the scores will be useful, but the data will require some further refinement prior to this analysis, because it was not originally generated with this purpose in mind.

Medicaid eligibility denials from this period will be examined to estimate how many additional individuals would have been eligible for Medicaid reimbursement for nursing facility level of care if the minimum score used to establish approval had been lowered. This is one method to determine, among the previous applicants, how many additional people might have qualified, had the Department utilized a lower qualifying score. Data from this time period will also be used to examine how many additional applicants would have qualified if the State had used a two ADL standard or a mini-mental score of less than ten points. Separate denial rates will be examined by type of long term care service (e.g., nursing facility, medical day care, home- and community-based services waiver [Older Adult and Living at Home]) as the data allow. Cost estimates will be calculated using average costs for services by type of determination.

It is important to note that historical data on the nursing facility level of care determination process is, at best, limited to individuals for whom some assessment has been made and completed. As such, those data are likely to provide only a minimal estimate of any increase in level of care determination approvals associated with a change in level of care scoring. In other words, a retrospective analysis of persons who actually sought a determination of their medical eligibility for Medicaid reimbursed services, does not account for additional applicants who might pursue long-term care services (in both

institutional and home- and community-based services setting), if the nursing facility level of care standard was lower (e.g. the woodwork effect).

Where available, U.S. Census and other public use data, as well as other specialized data such as a 2006 sample survey of support need for activities of daily living (ADLs) among community-based Medicaid recipients, will be used to provide estimates of the full potential Medicaid population that may be eligible for long-term care supports and services. It should be noted at the outset, however, that publicly available data do not generally reflect the same type of determination as that reflected in the 3871B scoring process. Thus, less precisely defined measures of need for support services, such as the number of ADLs for which a person requires assistance, may have to be used as a basis for estimating a broader population of Medicaid recipients that might be eligible for nursing facility level of care approval under less restrictive requirements.

Option 2- Increasing the Number of Waiver Slots

Option 2 involves increasing the number of funded waiver slots in the existing home- and community- based waiver programs. The waiver registry/ interest list for each waiver will provide historic information with which to examine this option. Under the current process, once waiver slots are available, those individuals whose names have been on the registry the longest are invited to apply for the waiver. It is only then that a full eligibility determination both medical and financial is made to determine whether the person qualifies. In other words, the size of the registry significantly overstates the number of slots that would need to be funded, because not all individuals on the registry would become eligible for the program. However, it is also true that, should the Department experience a large infusion of funds in these waivers, additional people would place their names on the registry, thereby growing the list with new applicants.

In order to estimate the fiscal effects of Option 2, the current waiver registry for each waiver program will be examined, to establish the maximum number of slots that would be needed in order to eliminate the existing registry. Other historic data regarding funding of new waiver slots will also be considered. At the same time, the average cost of services provided under each waiver will be calculated. The impact of different assumptions regarding how many additional waiver slots might be made available will then be calculated by multiplying the average costs by the number of slots.

Option 3- Adopting a Service Expansion under the Deficit Reduction Act

Option 3, which allows the provision of optional State Plan services under Section 1915(i) of the Social Security Act, will require the state to implement a lower threshold level of care than the nursing facility level of care.

Section 6086 of the Deficit Reduction Act of 2005 (DRA) authorized what is commonly called the “1915(i) option” for the provision of home- and community-based services under the Medicaid program. This group of services may be offered as an alternative to,

or in conjunction with, the Medicaid home- and community-based services waiver authority at Section 1915(c) of the Social Security Act.

The purpose of Section 1915(i) is to provide states greater flexibility in how they structure home- and community-based services, by fundamentally de-linking the existing level of care relationship between Medicaid home- and community-based services and nursing facility level of care criteria. In other words, a person may be eligible for home- and community-based services under Section 1915(i) even if the person is not sufficiently limited, cognitively and functionally, to meet the state's nursing facility level of care.

The DRA requires that the cognitive and functional criteria for home- and community-based services offered under Section 1915(i) must be lower than the state's nursing facility level of care criteria. The policy objective behind 1915(i) is to give states a new tool in the Medicaid State Plan to offer home- and community-based services to eligible individuals to maintain cognitive and functional status, to delay or avoid loss of functioning, and therefore potentially to avoid or delay institutional long term care services. In other words, Section 1915(i) enables states to establish programs that do not simply substitute home- and community-based care for persons already requiring nursing facility-level care, but instead seek to prevent or at least to defer institutional-level care as long as possible. The DRA permits a state to limit the number of people receiving Section 1915(i) services, even though these services will be offered under the Medicaid State Plan.

The policy goal is not only to de-link the cognitive and functional eligibility criteria for Section 1915(i) from nursing facility level of care, but also to enable states to provide home- and community-based services to a broader range of individuals who have some functional limitations, but are not yet so severely impaired that they already qualify for institutional care. It is important to stress, however, that this Section 1915(i) does not create a new eligibility category for Medicaid. Instead, Section 1915(i) allows a state to add a new optional State Plan service for individuals already financially eligible for Medicaid. In this respect, Section 1915(i) is less powerful than a Section 1915(c) Medicaid home- and community-based services waiver, which is a new eligibility category that offers a less restrictive financial eligibility test for qualifying individuals (i.e., enables the state to serve certain individuals who do not meet the financial eligibility standard in the community, but would become eligible for Medicaid if they were in the institution).

Section 1915(i) services, if adopted as an optional State Plan service, may only be provided to individuals with income up to 150 percent of the Federal Poverty Level (FPL). This ceiling is lower than the financial eligibility test that applies to nursing facility eligibility, and home- and community-based services Section 1915(c) waiver eligibility under both the Older Adults and Living at Home waivers. However, 150 percent of the FPL is much higher than the current Medicaid financial eligibility thresholds for most community-eligible adults on the Maryland Medicaid program.

The challenging part of the eligibility requirement under Section 1915(i) is that a person cannot qualify financially unless they meet the current community financial eligibility standard. Thus, if Maryland were to propose and CMS would approve a program under 1915(i), Maryland would still need to continue to provide services through its 1915(c) home- and community-based waivers in order to continue to serve this population.

Finally, Section 1915(i) does not permit states to overtly target populations to be served in the same way that Section 1915(c) waivers permit targeting services to specific populations. Thus, any Medicaid-eligible individual who meets the defined functional criteria for Section 1915(i) would be eligible for the services defined in the optional State Plan amendment service package; only eligibility criteria for these individual services may be tailored for specific need-defined groups. As a result, in studying and analyzing this option for HB 594, the Department will include all potentially-eligible individuals, such as persons with developmental disabilities, in the analysis.

Option 3 of the study will require that we develop both eligibility criteria and a specific set of services to be included in a potential new Section 1915(i) State Plan option. For the purposes of this report the medical eligibility determination for DRA will be defined to include any persons who need the following:

- Hands on assistance with 2 ADLs (eating, toileting, transferring, mobility, bathing, dressing, continence);
- Standby assistance to ensure safety of self-performance of 2 ADLs;
- Substantial supervision to protect self due to “severe cognitive impairment” (<10 on the mini-mental test) consistent with dependency in the following instrumental activities of daily living (IADLs): orientation to person, medication management, telephone utilization, or self-expression; or
- Substantial supervision to protect self due to “severe behavioral impairment” as measured by wandering, hallucinations, aggressive/abusive behavior, disruptive/ socially inappropriate behavior, or self-injurious behavior.

Services in the cost-benefit analysis of Section 1915(i) may include the following:

- Medical day care;
- Social day care ;
- Case monitoring function;
- Personal care (Level 2 and 3) – both agency- and self-directed;
- Inpatient respite (up to 14 days per year).

Because most of the factors that would be utilized to determine level of care for Option 3 are currently part of the 3871B process, initial estimates of the population may be drawn from these data. Estimates will also need to be made regarding additional recipients who might be eligible given the new level of care requirements, although data sources that reflect these criteria are quite limited, and assumptions will need to be made by the Department. Analyses regarding the level of care determination process and estimates of the total eligible population under Option 1 are likely to inform this analysis to some extent. It is also useful to remember that the provisions under Section 1915(i), outlined above, allow the Department to establish a limit to available slots under this option. Nevertheless, once available and appropriate data sources are identified and assessed, projections will be made regarding likely eligibility under the program, “take up” rates for utilization, and estimated costs per participant.

As noted above, historical Maryland Medicaid data which would be used to make estimates of potential savings associated with less restrictive level of care requirements are very limited. Discussion regarding potential savings will be drawn primarily from the experience in other states and provided as contextual background for preliminary assumptions of general savings.

Conclusion

This interim report describes the Department’s approach to fulfill the study and analytic components of the legislation, and provides an update on the status of the study. The findings and conclusions for the completed work will be contained in the final report, which is due December 1, 2007.

Appendix A

List of Stakeholders Invited to Public Meetings

Name	Organization
Karen Armacost	PACE (Hopkins Elder Plus)
Marianne Athen	Maryland Association of Adult Day Services
Kris Baldack	Active Day Adult Day Care
Kimberly Burton	Mental Health Association of Maryland
Carl Burke	Maryland 4A
Lori Doyle	Community Behavioral Health Association of Maryland
Michele Douglas	Alzheimer's Association
Jason Frank	Elder Health Law Section of Maryland Bar Association
Mike Johansen	Rifkin, Livingston, Levitan and Sullivan
Morris Klein	Elder Health Law Section of Maryland Bar Association
Anita Langford	PACE (Hopkins Elder Plus)
Diane McComb	Maryland Department of Disabilities
Dr. Matt McNabney	PACE (Hopkins Elder Plus)
Chuck Milligan	University of Maryland Baltimore County
Chris Morris	Maryland Association of Adult Day Services
Kelley Ray	Health Facilities Association of Maryland
Ilene Rosenthal	Maryland Department on Aging
Wayne Smith	University of Maryland Baltimore County
Leland Spencer	Local Health Officers
Diane Triplett	Brain Injury Association
Gail Yerke	Kent County

Appendix B

Questions to Stimulate Conversation with States for HB 594 Report

1. How does your level of care determination process work? What are the level of care criteria for nursing facility eligibility?
2. Specifically, have you lowered the nursing facility level of care criteria? If so, why, and what did you lower it to, and what was the effect of doing so?
3. What changes have occurred in your state's balance between nursing facility and community-based services over time? Provide year-to-year data if possible (e.g., numbers/days of nursing facility and numbers receiving community-based services).
4. What are the principal drivers that help shift individuals from institutional care to home and community-based services?
5. How do you assist individuals who want to leave nursing homes to home and community-based services (i.e. transition services)?
6. Has your state studied the future demand for long-term care in anticipation of the baby boom effect? If so, can you share the study?
7. Are your institutional/community services trends sustainable in light of the coming baby boom effect? What will make it so?
8. Do you have cost and utilization data that demonstrates that serving more people in home/community settings saves money over the long haul? What is your methodology for calculating savings?
9. Assuming you have cost data analyses, when was the breakeven point?
10. How do you use utilization review to control access to nursing facility services and to ensure against "plan of care creep" in community services?
11. How has your long-term care budget grown over the years?