Options to Increase Access to Long-Term Care: Maryland House Bill 594 Final Report

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Executive Summary

House Bill 594 (Chapter 244, Laws of Maryland 2007, hereafter HB 594) required the Department of Health and Mental Hygiene (DHMH or the Department) to study and analyze "the options that may be available to the State 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, who meet financial eligibility criteria in effect as of June 1, 2007."

Should Maryland elect to expand access to Medicaid home- and community-based services (HCBS), it has several possible approaches.

First, Maryland could lower its nursing facility (NF) level of care (LOC) criteria to ease entry into both NFs and community-based programs that are linked to these criteria:

- Reducing the NF LOC to a standard based on deficits in two or more activities of daily living (ADL), which is the standard in Washington State. This approach could serve approximately 3,300 more people at an estimated cost of $64.7 million (in 2006 total fund dollars);

- Reducing the NF LOC by lowering the qualifying score required to meet NF LOC under Maryland's current assessment instrument. This approach could serve approximately 730 more people at an estimated cost of $15.3 million (in 2006 total fund dollars); or

- Reducing the NF LOC by giving more weight to a cognitive test known as the Folstein Mini-Mental test. This approach could serve approximately 270 more people at a cost of about $4.1 million (in 2006 total fund dollars).

Second, Maryland could leave its NF LOC at its current standard, but expand access to HCBS by providing enough funds to move people from the registries for the Older Adult Waiver (OAW) and Living at Home (LAH) waiver into services. The estimated total funds needed to serve all qualified and interested individuals now on the registries is $86.9 million (in 2006 total fund dollars): $68.8 million for people now on the OAW registry, and $18.1 million for people now on the LAH registry.

Third, Maryland could adopt the new authority, included in the recently-enacted federal Deficit Reduction Act (DRA), to create a service package of HCBS without the need for a waiver. This option, known as Section 1915(i), would require a lower level of care (assessment) criteria for the new service array than the NF LOC used for nursing facilities and the OAW and LAH, so it would open up services to people who do not meet the current NF LOC. Even without accounting for the potential new beneficiaries described below who are external to our available data sources, more than 3,300 people may seek services under this option at a cost of $34.6 million (in 2006 dollars).

The estimates found above were drawn, in part, from two assessment-level data sets at the Department. The first data set contains information on the individuals who sought and were denied Medicaid long-term care services, based on their failure to satisfy the qualifications of the current NF LOC criteria. This data set contains sufficient information on each individual's functional status to estimate whether he/she would qualify for Medicaid long-term care services based on a lower NF LOC criteria. The second data set used in this study was a survey conducted of Medicaid beneficiaries now living in the community, to determine their functional status as measured by self-reported ADL deficits. The sample for this survey was limited, however, to only those individuals who would have been enrolled in the CommunityChoice program that never came into existence. In other words, the sample for the survey did not consist of the complete array of Medicaid beneficiaries.

As a result, the estimates presented above do not take into account two groups of potential new beneficiaries who are external to our data sources. First, a significant number of *current* Medicaid beneficiaries were not included in the ADL sample, nor have they been assessed for NF LOC using the existing assessment instrument and process. Many of these individuals might meet a new, lower NF LOC standard. For example, individuals with disabilities who are enrolled in the HealthChoice program, such as people in the Supplemental Security Income (SSI) eligibility category, were not included in the ADL survey. Most of these people have never been assessed for NF LOC, yet many of these individuals might meet a new, lower NF LOC standard, and they might pursue HCBS if the NF LOC standard is changed.

Second, a large number of people who have never sought Medicaid benefits might apply for Medicaid HCBS for the first time if Maryland changed the NF LOC criteria. This is a form of "external" effect, because these potential new beneficiaries are not presently within the system nor are they currently Medicaid beneficiaries. No data source exists to estimate the number of these individuals who might qualify for, and then pursue, Medicaid HCBS.

Therefore, the financial estimates provided above should be understood as low-end estimates of the likely cost of these potential policy changes, because they do not account for either of these two groups of potential new service beneficiaries.

In addition to cost estimates using Maryland data we looked at several comparison states for this study. Although Maryland compares favorably to the studied states in reducing per-capita Medicaid utilization of NFs, it compares poorly to the other states when compared to per-capita participation in HCBS waiver programs. This analysis, based on overall Census data which was aligned with Medicaid utilization figures, shows that two of the eight studied states far exceed all of the other states in most measures of rebalancing long-term care systems toward HCBS, and away from NFs: Oregon and Washington State.

Still, in all likelihood Washington State's investment in HCBS is not budget neutral for the state. This is notable because Washington State is the only state that has rigorously evaluated whether its investment in HCBS, over a long period of time, eventually pays for itself in reducing NF expenditures by delaying or avoiding eventual NF admissions. Washington State uses a methodology to evaluate whether its investment in HCBS is cost-effective, and its methodology

suggests savings in 2006 in the amount of $182 million (that is, higher expenditures in HCBS in the amount of $433 million are more than offset by savings in NF expenditures in the amount of $615 million). However, another methodology demonstrates that Washington State's investment in HCBS has not been budget neutral for the state, and that the state's higher investment in HCBS in 2006 of $433 million only produced NF savings in the amount of $322 million, or a net additional cost to the state in 2006 in the amount of $111 million.

This report discusses these options for expanding HCBS in greater detail.

Introduction

1. Purpose of HB 594

HB 594 directed the Department to study and analyze "the options 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." 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 Adult 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 required the Department to submit an interim report on the study and analysis by October 1, 2007, which was provided earlier. HB 594 required the Department to submit this final report due by December 1, 2007.

Ultimately, the purpose behind HB 594 was to provide the Legislature and other key decision-makers with estimates of the number of individuals who would benefit from an eased level of care criteria, and the related cost of expanding access to HCBS.

2. 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.

In addition, the Department distributed to all interested stakeholders a copy of the interim report dated October 1, 2007.

3. Organization of this Report

This report is organized in accordance with the provisions of HB 594. In the Results section that follows, there are three major sub-sections.

The first sub-section provides information gathered when reviewing seven other states and the District of Columbia, including six jurisdictions that altered their NF LOC, and two other states that the stakeholders expressed an interest in reviewing. The six jurisdictions that altered their NF LOC are the District of Columbia, Michigan, New Jersey, Oregon, Vermont, and Washington. The other selected states are Florida and New York.

The second sub-section provides an analysis of the estimated costs and effects of three options to increase access to Medicaid-funded long-term care services: altering the NF LOC (in several different ways); allowing everyone now listed on the registries for the OAW and LAH waivers to file an application for waiver services; and utilizing a new provision created by the Deficit Reduction Act (DRA) to expand HCBS without the requirement of a federal Medicaid waiver.

The third sub-section provides an analysis of the potential for long-term savings, should a state elect to lower its NF LOC. This sub-section focuses heavily on Washington State, which is the only state in the country that lowered its NF LOC and then studied the effects over time on its overall long-term care budget.

Results

1. Review of Other States

Based on input from stakeholders, and the Department's knowledge of leading states, eight states were selected for analysis: the District of Columbia, Florida, Michigan, New Jersey, New York, Oregon, Vermont, and Washington. 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 NF LOC with the intention of expanding access to HCBS;
- The state has developed and implemented innovative federal Medicaid waivers that promote community-based services and limited nursing facility utilization;
- Stakeholders were interested in learning more about the state's NF LOC criteria; 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 individuals who were interviewed is found as **Appendix B**. A list of the questions may be found in **Appendix C**. In addition, other secondary data sources were analyzed, including federal Census data, federally-reported Medicaid nursing facility expenditure and utilization data, and federally-reported Medicaid waiver expenditure and utilization data. Moreover, secondary research was analyzed from publicly-reported and available sources. The major results may be found in three appendices:

- **Appendix D** is a summary of the NF LOC criteria in the studied states.
- **Appendix E** is a summary of the studied states that focuses on the effects, if known, for the states that changed their NF LOC criteria or processes.
- **Appendix F** is a summary of the relative impact of the various approaches on the use, per 1,000 adults in each studied state, of Medicaid-funded NF and HCBS services.

There are several highlights from this research. First, as shown on Appendix E, of the seven states and the District of Columbia, which were studied, six jurisdictions have altered their NF LOC criteria or processes (the District of Columbia, Michigan, New Jersey, Oregon, Vermont, and Washington State). Of these, four made changes in the very recent past (the District of Columbia,

Michigan, New Jersey and Vermont), and no information exists to indicate what effects the changes will have in those states.

In the two states that changed their NF LOC criteria in the distant past (Oregon and Washington), it is clear from Appendix F that these changes have altered their long-term care service systems. Of the eight states that were studied, Oregon and Washington rank first and second in fewest adults in nursing facilities -- 3.9 per 1000 adults age 18 and older, and 4.9 per 1000 adults age 18 and older respectively -- and first and second in adults served in HCBS waiver programs -- 11.7 per 1000 adults age 18 and older and 6.5 per 1000 adults age 18 and older respectively.

Table 1 in Appendix F shows that Maryland compares quite favorably with the other states in reducing Medicaid NF utilization. Of the nine states included in this report (Maryland plus the other eight states), Maryland ranked third in fewest Medicaid-funded adults in nursing facilities, at 6.5/1000. However, Table 2 on Appendix F shows that Maryland came in next-to-last in supporting adults in HCBS waiver programs, at just .8/1000.

Finally, it must be noted that the states that profoundly restructured their long-term care systems undertook many changes beyond simply altering the NF LOC. Many of these changes were difficult for providers and advocates to support, but were crucial to changing those systems around. In Washington State, these changes are described in Appendix E. They included all of the following: aggressive diversion programs, with every nursing facility admission reviewed by dedicated nursing facility case managers; the creation of a true single point of entry for eligibility determinations and NF LOC decisions; improved training for HCBS providers; increases in HCBS provider payment rates; active and aggressive utilization controls of both institutional and community-based services (to avoid excessive community-based plans of care in favor of serving more people); active and aggressive estate recovery against the estates of deceased Medicaid beneficiaries, to recover and then reinvest funds back into long-term care; the development of new community residential settings (such as assisted living, boarding homes, and adult foster care); and improvements in quality management programs for oversight of services in community settings.

2. Analysis of Options

i. Introduction

After meetings with stakeholders, and in compliance with the requirements of HB 594, the Department selected three specific options for analysis:

Option 1: Change the current NF LOC criteria.

Option 2: Fund additional slots for both the Older Adults and Living at Home Waivers without changing the NF LOC.

Option 3: Adopt a provision of the federal Deficit Reduction Act to provide selected HCBS under Maryland's State Plan, without a waiver. Analysis of each option is presented below.

These analyses and comparisons utilize state fiscal year (SFY) 2006 data. All estimates of the number of people served, and the expenditures, hypothesize that the reforms were in place for SFY 2006. This allows for the various options to be compared. Because any reform would take place in the future, after cost increases, the analysis likely understates the actual cost of each option.

While each of the options is examined as an independent standalone option, the assumptions underlying each analysis are related in important ways, such as the methods used to estimate the "internal" group of potential new beneficiaries.[1]

ii. Option 1

Option 1 involves modeling the effect of changing the current NF LOC criteria. Three separate versions of changing the NF LOC were studied:

a. Reducing the threshold score needed on the Department's assessment instrument, known as "DHMH Medical Eligibility Review Form 3871B" (3871B).

b. Adding a new criterion that an individual who needs assistance with two or more activities of daily living (ADLs)[2] would meet the NF LOC.

c. Adding a new criterion that an individual who scores under ten on the Folstein Mini-Mental test would meet NF LOC. This criterion is consistent with a need for assistance in the following instrumental activities of daily living (IADLs): medication management, telephone utilization, or self-expression[3].

The analysis in Option 1 relied on data drawn from the current process used to make NF LOC determinations in the Maryland Medicaid program. Currently, NF LOC is determined based primarily on an assessment instrument, the 3871B, that is submitted by a provider, scored electronically, and then, if necessary, reviewed in detail by clinical staff at a third-party utilization review contractor. NF LOC is established for an individual where the score meets a minimum threshold value[4]. An individual also may receive a NF LOC based on additional information about

[1] Two other groups of potential new service beneficiaries are discussed in this report. The "internal" effect describes a situation where a person currently on Medicaid may become eligible for services. For example, a Medicaid beneficiary with a disability who does not meet the current NF LOC might meet a new, lower NF LOC, and therefore become eligible for new services. Two other groups of potential new service beneficiaries also exist, such as the group of individuals who are not currently on Medicaid but may be induced to apply for and become eligible for Medicaid by the availability of new services or new criteria to receive services.

[2] Specific ADLs include eating, toileting, transferring, mobility, bathing, and dressing. In order to be consistent with the ADL screen defined for Option 3 in this report, incontinence of bladder or bowel was counted as one of the six ADLs if it was recorded and toileting was not otherwise identified as requiring assistance. Incontinence was identified independently of toileting in less than 3 percent of cases using 3871B data.

[3] Specific IADLs include medication management, telephone utilization, or self-expression. A fourth IADL, orientation to person or the ability of an individual to state his/her name, was included for this in the preliminary report of this study but is not included for this analysis or in the analysis for Option 3 because it did not materially alter the mini-mental score in the absence of the other IADLs.

[4] The weighting criteria and minimum threshold value used in this determination are not publicly available in order to minimize gaming associated with attaining the minimum score value.

his/her clinical or care needs. In these situations, a physician reviewer from the third-party utilization review contractor may determine that the person meets the NF LOC standard, even if he or she did not receive the minimum threshold score on the 3871B assessment instrument. Approximately 33 percent of NH LOC determinations have less than the threshold score and are approved based on other clinical or care needs

The data available to examine this process include roughly 2 1/2 years of 3871B determinations from the former third-party utilization-review contractor between July 2004 and January 2007 (Delmarva), as well as 6 months of data from the current third-party utilization-review contractor (KePro). These data required some refinement prior to this analysis, because they were not originally generated with this purpose in mind. Data from SFY 2006 were more robust, with more complete information on NF LOC determinations, so these data were utilized for this study.

3871B denials were examined to estimate how many *additional* individuals would have met NF LOC under the three separate versions of altering the NF LOC criteria described above. Separate denial rates were examined by type of long-term care service (e.g., nursing facility, medical day care, HCBS waiver [Older Adult and Living at Home]) as the data allowed. Cost estimates were calculated using average annual costs for services by type of determination.

It is important to note that historical data on the NF LOC determination process is, at best, limited to individuals for whom some assessment already was made and completed. As such, estimates based on those data do not include the possibility of additional applicants who might pursue long-term care services, if the NF LOC criteria eased entry into services (the potential new service beneficiaries described elsewhere in this report).

Where available, specialized data, such as a 2006 sample survey of support-need for ADLs among community-based Medicaid beneficiaries, as well as U.S. Census and other public use data, were used to make estimates of the full potential Medicaid population that might become eligible for Medicaid-financed long-term care supports and services under the potential NF LOC criteria.

Table 1 shows the distribution of first NF LOC determinations by review type for the nearly 21,000 individuals who received these determinations in Maryland during FY 2006. These are displayed based on the provider-type that submitted the completed 3871B. Only 1,065, or 5.1 percent, of those cases were denied based on the current NF LOC criteria. The rest were approved. This is worth noting: nearly 95 percent of all applicants for a NF LOC were approved under the *current* standard. The current standard, therefore, is not serving as a barrier to 19 out of 20 applicants who apply. The pattern of denials differed by type of review, varying from a denial rate of 1.3 percent for nursing facility care to a denial rate of 16 percent for the Program for All-Inclusive Care for the Elderly (PACE) program. Medical day care was associated with the largest number of denials (577) and the second largest number of applications (4,221) for a NF LOC determination. The denial rate for medical day care was almost 14 percent[5].

[5] This analysis is based on first LOC determinations. However, there were more than 38,600 completed LOC determinations in FY 2006. Of the nearly 18,000 determinations that represented subsequent or re-certification assessments only 149 associated with Medicaid eligibility were denied (a denial rate of less than 1 percent for

Table 1: Level of Care Determinations by Review Type: First Cases Per Person in SFY2006

Review Type	Determination Type							
	Light	Moderate	Heavy	Heavy Special	Other	Denied	Total	% denied
1 Nursing Facility	2,056	5,748	3,355	1,474	9	172	**12,814**	1.3
2 Medical Adult Daycare	1,536	1,526	532	49	1	577	**4,221**	13.7
3 Nursing Facility OAW	583	1,494	803	71	0	272	**3,223**	8.4
4 Nursing Facility LAH	41	160	145	38	0	15	**399**	3.8
5 Nursing Facility PACE	85	55	11	1	0	29	**181**	16.0
Total	**4,301**	**8,983**	**4,846**	**1,633**	**10**	**1,065**	**20,838**	**5.1**

Table 2 shows the estimated number of additional approvals that would have occurred in FY 2006 under the three alternatives under Option 1. This analysis examines each alternative independently. Lowering the 3871B minimum threshold score by roughly 25% would have converted 167 of the denials into approvals. If a 2-ADL standard had been used, 741 of the 1,065 denials would have been approved (almost 70 percent), and the overall denial rate would have been just 1.6 percent (because only 1.6 percent of the 20,838 who applied would have been denied). The Mini-Mental score and associated IADLs would have produced the fewest number of additional approvals. While the pattern of additional approvals was much the same across review types based on either a lower 3871B score or a 2-ADL standard, additional approvals based on the Mini-Mental score were more commonly associated with medical day care.

Table 2: Additional Approvals Given Selected Changes to LOC Criteria (Option 1)

Review Type		Additional Approvals Given Individual Screens					
	Previously Denied	Lower Score 25%		2 ADLs at Supervisory Level		MM score < 10 & 1 of 3 IADLs	
	#	#	% now appd	#	% now appd	#	% now appd
1 Nursing Facility	172	33	19.2	127	73.8	4	2.3
2 Medical Adult Daycare	577	81	14.0	391	67.8	46	8.0
3 Nursing Facility OAW	272	50	18.4	199	73.2	6	2.2
4 Nursing Facility LAH	15	2	13.3	8	53.3	1	6.7
5 Nursing Facility PACE	29	1	3.4	16	55.2	0	0.0
Total	**1,065**	**167**	15.7	**741**	69.6	**57**	5.4
Number still denied		**898**		**324**		**1,008**	
Total cases submitted		**20,838**		**20,838**		**20,838**	
Overall denial rate		**4.3%**		**1.6%**		**4.8%**	

Although the potential changes to NF LOC criteria were analyzed as independent alternatives, they were also examined in combination with each other. Table 3 shows the number of additional approvals that would have been produced applying various combinations of the three independent

subsequent determinations). Forty-six out of 58 continuing stay reviews were denied, no re-certifications were denied, and the remaining denials were associated with changes in service setting.

alternative changes under Option 1. The combination of a lower 3871B score and a 2-ADL standard suggests that the lower score on the 3871B would not contribute any additional approvals beyond merely using a 2-ADL standard alone. Combining a lower 3871B minimum threshold score and a new test based on the Mini-Mental score suggests that those alternatives address distinctly different populations, since only 16 of a total 208 individuals who would otherwise be approved using that combination of screens would be approved using both screens. Only ten additional individuals would be approved using a combination of the 2-ADL standard and the Mini-Mental test as opposed to applying the ADL standard alone. Thus, the Min-Mental test would add relatively little to what would otherwise be achieved using the ADL standard.

Table 3: Additional Approvals Given Combinations of Changes to LOC Criteria (Option 1)

			Additional Approvals Given Combinations of Individual Screens						
	Review Type	Previously Denied	lower score & 2 ADLs		lower score & MM		2 ADLs & MM		lower score, 2 ADLs & MM	
		#	#	% now appd	#	% now appd	#	% now appd	#	% row
1	Nursing Facility	172	**127**	73.8	**35**	20.3	**127**	73.8	**127**	73.8
2	Medical Adult Daycare	577	**391**	67.8	**115**	19.9	**399**	69.2	**399**	69.2
3	Nursing Facility OAW	272	**199**	73.2	**55**	20.2	**201**	73.9	**201**	73.9
4	Nursing Facility LAH	15	**8**	53.3	**2**	13.3	**8**	53.3	**8**	53.3
5	Nursing Facility PACE	29	**16**	55.2	**1**	3.4	**16**	55.2	**16**	55.2
	Total	**1,065**	**741**	69.6	**208**	19.5	**751**	70.5	**751**	70.5
	Number still denied		**324**		**857**		**314**		**314**	
	Total cases submitted		**20,838**		**20,838**		**20,838**		**20,838**	
	Overall denial rate		**1.6%**		**4.1%**		**1.5%**		**1.5%**	

The additional approvals discussed in the preceding analysis were based on beneficiaries who applied for, and were denied, a NF LOC in FY 2006. Those cases represent the low-end impact of changing the NF LOC criteria, because lowering the NF LOC criteria might induce other current Medicaid beneficiaries to seek those services who otherwise would not apply under the current NF LOC standard. Data to estimate the impact of such an "internal" group of potential new service beneficiaries are not generally available for the Medicaid population as a whole.[6] However, data are available in Maryland to help address a portion of this question, based on a sample survey of self-reported need for support for ADLs among community-dwelling Medicaid beneficiaries conducted for the Department in May and June 2006[7].

The ADL survey sample was drawn from the community-dwelling Medicaid beneficiary population that would have been eligible for enrollment in the then-proposed federal 1115 waiver program known as CommunityChoice. The CommunityChoice population was broadly defined, and included many Medicaid beneficiaries who have never submitted a 3871B seeking a NF LOC determination. Those enrolled under Maryland's Developmental Disabilities Waiver and other selected small programs were excluded from the survey. The survey was not conducted with the HB 594 analysis specifically in mind. Nevertheless, this sample included people now on Medicaid who did not have an active NF LOC determination (such as so-called healthy or well dual eligibles), and who reported on their ADL needs. For estimation purposes a 2-ADL standard is

[6] See note 1.
[7] See CHPDM, "A Survey of Functional Status to Support CommunityChoice Rate Setting and Program Assessment," July 31, 2006 (http://www.chpdm.org/StudyFindingsTemp1.htm).

applied to the survey sample because it is closest to the most additive of the alternative screens included here.

Table 4 shows the results. The sample involved 2,000 individuals, and 1,579 individuals in the sample did not have a current NF LOC. Extrapolated to the Medicaid population as a whole, this translates to total community-dwelling population of 47,995, of which 39,198 were not otherwise already associated with a NF LOC[8]. Of the 1,579 in the sample who did not have a NF LOC, 8.6 percent reported a need for assistance with two or more ADLs. Adjusted for the age distribution of the comparable Medicaid population as a whole, this became 7.5 percent. As a result, extrapolating to the full Medicaid population as a whole, of the 39,198 Medicaid community-dwelling individuals who did not have a NF LOC and would have been enrolled in CommunityChoice, 2,955 individuals would qualify for a NF LOC under a 2-ADL standard based on their self-report. Data that reflect 3871B and/or Mini-Mental scores for the Medicaid population as a whole are not available, although rough estimates of the more limited impact of those screens can be calculated on a percentage basis from differences between those alternatives and the 2-ADL standard evident in the 3971B results.

Table 4: Number of ADLs Where Respondents Have Help or Don't Perform (Percent of Respondents)

			ADL Counts (Percent of Row)						
		Persons	**0**	**1**	**2**	**3**	**4**	**5**	**6**
1	Total Cmnty-Dwelling	2,000	68.7%	10.9%	6.2%	4.0%	3.6%	3.4%	3.3%
	Age Category								
2	21-49	397	76.8%	6.0%	4.5%	3.3%	3.5%	1.5%	4.3%
3	50-64	394	70.6%	12.7%	6.1%	3.0%	2.8%	3.0%	1.8%
4	65-74	427	79.6%	10.5%	3.0%	1.9%	3.0%	1.2%	0.7%
5	75-84	430	69.1%	12.3%	7.0%	4.9%	1.6%	3.5%	1.6%
6	=> 85	352	43.8%	13.1%	11.1%	7.1%	7.7%	8.5%	8.8%
	NF LOC Status								
7	NF LOC	421	18.5%	16.9%	15.2%	11.2%	11.9%	12.8%	13.5%
8	Other	1,579	82.1%	9.3%	3.8%	2.0%	1.4%	0.9%	0.5%

Community pop. w/no NF LOC: 39,198 **Percent & Number w/ 2-plus ADL: 8.6% 3,376**
Above adjusted for age: 7.5% 2,955

A few additional notes are in order before using the numbers reported here to estimate the cost implications of changes under Option 1. First, because the new individuals who would qualify for NF LOC under a lower criteria are assumed to be generally higher functioning than existing NF residents, cost estimates for additional cases associated with NF care are based only on beneficiaries with light or moderate days of care. Thus, the new residents would have a lower than average cost for Medicaid NF patients as a whole. Because it is less clear that individuals who would newly be approved for medical day care would use fewer resources than the average current user, the cost estimate for these approvals is based on the average annual medical day care cost per

[8] The sample and population numbers reflected here are slightly different from those included in the initial report of survey results because of changes in the Medicaid population between the report and a re-assessment of the population later in 2006, including NF LOC status.

person. A similar approach is used to calculate average annual costs for the OAW and LAH waiver programs.

Second, the OAW and LAH waiver programs are currently subject to a federal cap on the number of available slots under those programs. Presently, Medicaid beneficiaries who apply for either waiver from a nursing facility (where the individual has been for at least 30 days) and meet the waiver eligibility criteria are guaranteed a slot, regardless of the cap, assuming the person would retain financial and functional eligibility for Medicaid. The most recent data show that nearly all new LAH waiver slots involve transition from a NF, and that 35 percent of OAW approvals involve transfer from a NF. These factors are important, because people from the community (as opposed to NF) might newly qualify for a OAW or LAH waiver slot on the basis of meeting a new NF LOC, yet still not be placed into the waiver, due to the cap on waiver slots. Instead, these individuals might receive State Plan services, such as Medical Day Care and Medical Assistance Personal Care, which does not have a cap, but only if they financially and functionally qualify for non-waiver services.[9] For purpose of this analysis, new OAW approvals from the community are limited to the percentage of existing waiver approvals that meet standard State Plan financial criteria (40%, meaning two in five applicants for the OAW meet the standard Medicaid financial eligibility test)[10]. Costs for those approvals are assumed to be the same as those associated with medical day care. The PACE program is also limited by provider capacity and will be treated in the same way as new OAW approvals from the community. Medical day care costs are applied for those approvals.

Finally, both NF and waiver participants who are above the State Plan financial criteria also become eligible for all *other* State Plan Medicaid benefits. Therefore, an expansion of level of care criteria would open up not just long-term care services, but all Medicaid services. Additional "other" new Medicaid costs, such as Medicare co-payments and deductibles for those who are dually eligible for Medicare and Medicaid, need to be associated with the percentage of new approvals that are above the community financial standard and new to Medicaid. Fifty percent of new NF, 60 percent of new OAW, and 30 percent of new LAH waiver participants are assumed to be above the State Plan financial requirements and are also associated with additional Medicaid costs[11].

Table 5 presents the utilization and expenditure data based on the current NF LOC standard, and it was the foundation for the cost estimates for the new individuals who would qualify under the various alternatives under Option 1 to alter the NF LOC criteria.

[9] The financial limits for NF, OAW, and LAH services are higher, up to 220% of FPL, than the community standard for other State Plan services.

[10] The comparable percentages for NF and LAH waiver participants who meet State Plan financial criteria are 50% and 70%, respectively.

[11] An estimate of new NF approvals that are above Maryland State Plan financial requirements was drawn from FY 2006 data. Comparable estimates for OAW and LAH waiver participants were based on prior analysis by the Department.

Table 5: Annual Per Person Cost Estimates for Selected Review Types (FY 2006)

Review Type	Users (per service)	Expenditures	Average Annual $ (per User)
Nursing Facility Care*	15,782	$595,781,827	$37,751
Non-NF Costs for related NF Population**	15,782	$149,177,366	$9,452
Medical Day Care	6,204	$74,957,040	$12,082
Older Adult Waiver Costs	2,781	$55,997,492	$20,136
Non-Waiver Costs for OAW Population***	2,781	$31,633,087	$11,375
Living At Home Waiver Costs	461	$13,989,360	$30,346
Non-Waiver Costs for LAH Population****	461	$4,766,629	$10,340

* Limited to recipients with light or moderate NF days of care.
** Applied to 50% of new NF approvals
*** Applied to 60% of new OAW approvals
**** Applied to 30% of new LAH approvals

Table 6 is a summary of the full annualized cost estimates associated with the various alternatives included under Option 1. Rows 1 through 7 provide estimates of people who submitted a 3871B, were denied under the current standard, but would qualify under one or more new NF LOC standards. Table 6 also displays which service these individuals would qualify for (e.g., some people now in the community might qualify for OAW, but not receive a slot, and therefore would receive "Other" services). These rows suggest that altering the 3871B criteria would have a minimal impact on the group of people who were denied services under the current 3871B standard, in part because so few people were denied a NF LOC who submitted a 3871B. Rows 1 through 3 reflect each of the 3 alternative screens treated independently. Rows 4 through 7 reflect combinations of those screens. Rows 8 through 10 reflect the number of people who would have been enrolled in CommunityChoice, and includes the population that submitted a 3871B as well as those who have not submitted a 3871B. Based on the ADL survey results, these individuals can be identified as meeting the lower NF LOC criteria. Table 6 also presents their costs.[12]

To provide an example on how to read Table 6, had Maryland deployed a 2-ADL NF LOC in 2006, the minimum estimated additional number of beneficiaries would have been 663 (see Row 2), and the additional cost would have been $13.1 million. The number of additional people associated with the ADL survey sample population that would meet a 2-ADL standard is 3,301, with associated costs of $64.7 million (see Row 8). The 663 people identified in Row 2 are included in the 3,301 identified in Row 8. Again, these figures do not include two major groups of potential new service beneficiaries for which we have no data to make estimates, so they are the low-end of the financial impact. In addition, none of these estimates include administrative costs.

[12] This does *not* include the potential new service beneficiaries from the Medicaid program who were *not* potential CommunityChoice enrollees, and therefore were not part of the ADL survey. This group, such as non-elderly, non-dual eligible individuals who qualify for Medicaid on the basis of a disability, might include a large number who would meet a lower NF LOC standard that is tied to a deficit in two or more ADLs (for example).

Table 6: Annual Cost Estimates for Selected Changes to LOC Criteria -Option 1

	New LOC Screen	Additional Approvals Given Individual Screens											
		Nursing Faculity		Medical Day Care		OAW Waiver*		LAH Waiver		Other Waiver**		Total	
		#	$	#	$	#	$	#	$	#	$	#	$
1	Lower 3871B Score 25%	33	1,401,738	81	978,646	18	471,810	2	66,895	14	169,149	148	3,088,238
2	2 ADLs (Supervisory+)	127	5,394,567	391	4,724,082	70	1,877,804	8	267,581	68	818,438	663	13,082,471
3	MM < 10 & IADLs	4	169,908	46	555,774	2	56,617	1	33,448	2	18,848	55	834,595
4	Lower Score & 2 ADLs	127	5,394,567	391	4,724,082	70	1,877,804	8	267,581	68	818,438	663	13,082,471
5	Lower Score & MM	35	1,486,692	115	1,389,436	19	518,991	2	66,895	15	184,855	187	3,646,869
6	2 ADLs & MM	127	5,394,567	399	4,820,738	70	1,896,676	8	267,581	68	824,721	673	13,204,283
7	Score, ADLs, & MM	127	5,394,567	399	4,820,738	70	1,896,676	8	267,581	68	824,721	673	13,204,283
	ADL Survey-Based Population Estimates												
8	Lower Score***	166	7,071,628	409	4,937,172	78	2,101,627	9	297,978	71	853,338	733	15,261,743
9	2-ADL Standard	641	27,215,053	1,973	23,832,522	310	8,364,476	36	1,191,911	342	4,128,939	3,301	64,732,900
10	Mini-Mental < 10***	20	857,167	232	2,803,826	9	252,195	4	148,989	8	95,086	274	4,157,263

Total Additions from the Community (ADL Survey-Based using a 2 ADL Standard)**** **2,955**

Notes: Includes additional costs for 50% of NF, 60% of OAW, and 30% of LAH approvals for those above the community financial standard new to Medicaid.

* All LAH and 35% of OAW new approvals are assumed to come from NF and thus are guaranteed a waiver slot. Respective annualized waiver costs are used.

** MDC costs are used for waiver-related new approvals that would not be expected to fill an actual waiver slot.

*** Population estimates based on 2-ADL standard from ADL Survey reduced as a percentage of related new additions for this screen relative to the 2 ADL standard using 3871B data.

**** Additions to OAW and LAH Waivers assumed to come from an NF are in addition to the community-based numbers estimated from the ADL Survey.

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At least three additional factors may result in lower costs than estimated in Table 6. First, not all Medicaid recipients who would otherwise be eligible for services based on a NF LOC would request and receive those services. Second, even if a person meets NF LOC, he or she may prefer to receive medical day care in the community, rather than care in an institution. Whenever someone elects community-based medical day care in lieu of care in a NF, the more the costs come down. Third, there may be insufficient administrative and provider capacity to handle the new volume immediately. All of the effects would result in reduced costs.

Second, changes in eligibility for services are known to induce additional demand. As an example, prior to FY 2000, the Department received permission from CMS to increase the number of slots available under the State's Developmental Disabilities waiver in order to significantly reduce the waiting list for those services. The result was to further increase the number of applicants who were not already on the waiting list so that the number of individuals registered on the waiting list remained much the same, and continued to grow unabated.

Reducing the denial rate through lower NF LOC criteria may encourage some individuals who have not already considered applying for Medicaid support services (both among those already eligible for Medicaid and among those who may be eligible but have not applied for Medicaid benefits at all) to do so in much the same way as increasing the availability of waiver slots, particularly among those who may be eligible at a higher level of need who currently rely on informal community supports. While this may be an appropriate objective in any case, it is also known that family and other informal sources of care that currently offset Medicaid spending have been declining in recent years relative to formal care[13]. Declining family size[14], the increasing participation of women (who have traditionally provided a disproportionate share of informal family supports) in the workforce[15], and the higher percentage of older people expected to be living alone in the future[16] are just a few of the indicators that demand for formal (paid) care will continue to increase in the future.

iii. **Option 2**

Option 2 involves retaining the existing NF LOC criteria, but adding sufficient additional funds to open enough slots to serve everyone on the OAW and LAH registries who would qualify after completing an eligibility application and determination process.

The data sources used to complete the analysis for Option 2 included registry reports, tallies of letters to potential applicants, numbers of applications made, and the numbers of applicants who

[13] Liu, K., K. G. Manton, et al. (2000). Changes in Home care use by disabled elderly persons: 1982 – 1994. *Journals of Gerontology. 55B*(4), S245-S253.
[14] Congressional Budget Office. (2004). *Financing long-term care for the elderly*. Washington, DC: U.S. Congressional Budget Office.
[15] Burwell, B. O., B. Jackson. (1994). *The disabled elderly and their use of long-term care*. Washington, DC: U.S. Department of Health and Human Services.
[16] Hobbs, F. and N. Stoops. (2002). Demographic trends in the 20th century. Census 2000 Special Report CENSR-4. Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration.

received services in FY 2006 and 2007. Because FY 2007 expenditure and enrollment data were incomplete in time for this study, FY 2006 data were used.

Older Adult Waiver (OAW) – FY 2006

OAW "Take-Up" Rates. As indicated in Table 7, in FY 2006 an average of 6,314 individuals were listed on the OAW registry in any given month. During that year, 2,250 people on the registry were sent "opportunity to apply" letters, alerting the recipients that waiver slots were available, that their names had come up on the registry, and that they were invited to apply. These letters resulted in 826 individuals, or 36.7 percent of the total letters sent, making formal application for participation in the OAW. Of the 826 who applied, 435, or 52.7 percent, were found to be eligible (that is, met both the NF LOC criteria and Medicaid's financial eligibility test) and to have received OAW services. Thus, overall, 19.3 percent of the 2,250 individuals invited to apply for a slot in the OAW actually received OAW services.

Table 7: OAW Registry Process Measures - SFY 2006

Registry Process Stage	Individuals	Percent
Average Monthy Registry List*	6,314	
"Opportunity to Apply" Letters Mailed	2,250	100.0
Application Made	826	36.7
Became OAW Recipient	435	19.3

* Note: A monthly average is used here instead of the unduplicated total of registrants because it provides a better estimate of the ongoing service demand in the system at any given time throughout the FY.

While not directly a part of this analysis, it is worth noting that in FY 2006, 4,903 new names were placed on the OAW registry. Thus, the registry is very fluid, with new people coming on, while others are taken off the registry. The reasons why individuals are removed from the registry include: they officially applied for the waiver, they did not respond to the invitation to apply, or they were deceased, left the state, or no longer needed services. In FY 2007, the registry grew to an average monthly total of 7,990 individuals, and within that number, 5,895 new names were added to the registry.

As Table 7 shows, the actual take-up rate for those from the registry who received an "opportunity to apply" letter was 19.3 percent. For purposes of this analysis, however, we believe that this figure would be slightly higher, because the rapid acceleration of individuals from newly-entering the registry into actual services would reduce the number of people who fail to qualify for the OAW after the invitation on the basis of death, permanent institutionalization, or some other factor. We believe a better take-up figure for estimation purposes is 25 percent. For purposes of this analysis, the OAW registry total for October, 2007 (the latest available) was used as the baseline registry total from which the estimated 25 percent take-up rate would occur, and from which the costs to the Medicaid program would be estimated.

As of October 31, 2007, there were 10,204 individuals listed on the OAW registry. If everyone received an invitation to the OAW, and 25 percent eventually qualified for services, a total of 2,551 would receive waiver services. The additional cost to Medicaid, using FY 2006 expenditure data, would be $68.8 million -- $51.4 million in actual OAW costs, and $17.4 million in other Medicaid services that the new waiver beneficiaries also would be entitled to receive. The results are in Table 8.

Table 8: Estimated Cost of Inviting OAW Registry to Participate in OAW

Total Waiver Slots Needed:	**2,551**
Total Medicaid Waiver Costs (FY 2006 PMPY Waiver Cost - $20,136)	$51,366,936
Total Medicaid Non-Waiver Costs[17] (FY 2006 PMPY Non-Waiver Cost - $11,375)	$17,410,575
Total Medicaid Cost to Add 2,551 OAW Slots	$68,777,511

Realistically, the first year ramp-up costs would likely be much less. For example, assuming an equal distribution of new participants throughout the year, the total Medicaid costs to the OAW in the first year would be nearly $34.4 million. This does not include the administrative costs of expanding the waiver.

Living at Home (LAH) Waiver – FY 2006

The registry and application processes for the LAH operate somewhat differently from the OAW. Because the LAH waiver slots are capped at 560 and most of the vacancies in the waiver are taken by younger adults with disabilities transitioning from nursing facilities to the community, there are few "opportunity to apply" letters mailed to individuals on the LAH registry.

In FY 2006, the average monthly LAH registry list contained 1,328 individuals. New additions to the registry totaled 477 in FY 2006. During that period, 396 individuals applied for the LAH. While 108 of those applicants were found to be eligible, only 72 of those who applied in FY 2006 received services for the first time. One of the major challenges for individuals who are approved to receive LAH services is finding and securing affordable and accessible housing that enables them to live independently. Thus, it is likely that the difference between the number found eligible and the number actually receiving services for the first time is attributable in some measure to the difficulty beneficiaries have in securing housing. Still, 18.2 percent of those who applied to receive LAH services in FY 2006 actually received LAH waiver services.

Following the same rationale as set forth in the OAW discussion above, a slightly higher take-up rate was used in this study: 30 percent.

[17] Applicable only to the assumed 60 percent of new entrants who would not have already been enrolled in Medicaid as meeting the community eligibility standard, or, in this estimate, 60 percent of 2,551, or 1,531 individuals.

As of October 31, 2007, there were 1,807 individuals listed on the LAH waiver registry. The expected take-up rate of 30 percent results in the need for an additional 542 slots.

The additional cost to Medicaid, based on FY 2006 expenditure data, would be $18.1 million, comprising $16.4 million in LAW costs, and $1.7 million in non-waiver Medicaid costs, as set forth in Table 9.

Table 9: Estimated Cost of Inviting LAH Registry to Participate in LAH

Total Waiver Slots Needed:	**542**
Total Medicaid Waiver Costs	$16,447,360
(FY 2006 PMPY Waiver Cost - $30,346)	
Total Medicaid Non-Waiver Costs[18]	$ 1,685,381
(FY 2006 PMPY Non-Waiver Cost - $10,340)	
Total Medicaid Cost to Add 542 LAH Slots	$18,132,741

Realistically, the first year ramp-up costs would likely be much less. Thus, assuming an equal distribution of new participants throughout the year, the total Medicaid costs to the LAH waiver in the first year would be $9,066,371. This does not include the administrative costs associated with expanding the waiver.

iv. Option 3

Option 3 is based on the new provision, created in the DRA, to offer limited HCBS to otherwise eligible individuals without the need for a Medicaid waiver. Section 6086 of the DRA authorized what is commonly called the "1915(i) option" for the provision of HCBS under the Medicaid State Plan. This group of services may be offered as an alternative to, or in conjunction with, services provided under a Medicaid HCBS waiver authorized under the Social Security Act at Section 1915(c).

The purpose of Section 1915(i) is to provide states greater flexibility in how they structure HCBS, by de-linking the existing level of care relationship between HCBS Section 1915(c) waiver services and institutional level of care criteria.[19] In other words, a person may be eligible for HCBS under new Section 1915(i) even if the person does not meet the institutional level of care under the state's current institutional LOC criteria.

The DRA requires that a state create a lower level of care under Section 1915(i) than its institutional LOC. The policy objective behind 1915(i) is to give states a new tool to offer HCBS to eligible individuals, pre-institutional LOC, to maintain their cognitive and functional status in order to delay or avoid further loss of functioning. The goal is to avoid or delay

[18] Applicable only to the assumed 30 percent of new entrants who would not have already been enrolled in Medicaid as meeting the community eligibility standard, or, in this estimate, 30 percent of 542, or 163 individuals.
[19] The OAW and LAH waivers are examples of Section 1915(c) waivers.

institutional long-term care services. In other words, Section 1915(i) enables states to establish programs that do not simply substitute HCBS for persons who *already* require institutional LOC, but instead seek to prevent or at least to defer institutional-level care as long as possible.

As with a Section 1915(c) waiver, the DRA permits a state to limit the number of people receiving Section 1915(i) services. It is important to stress, however, that Section 1915(i) does not create a new eligibility category for Medicaid. It would not serve new *people*. Instead, Section 1915(i) allows a state to add a new optional State Plan *service* for individuals already financially eligible for Medicaid but who do not already receive HCBS under a 1915(c) waiver. In this respect, Section 1915(i) is less powerful than a Section 1915(c) waiver, which offers a less restrictive financial eligibility test for qualifying individuals (i.e., a 1915(c) waiver 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 currently-eligible 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 facilities and HCBS under both the Older Adults and Living at Home waivers.

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 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. 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. Only Option 3 would involve estimating expenditures related to serving additional people with developmental disabilities.

For the purposes of the analysis of Option 3, we retained the current NF LOC (and also did not alter the LOC criteria for other institutional settings, such as ICF/MR). Moreover, we estimated that the population eligible for the new 1915(i) services would include community-dwelling Medicaid beneficiaries who are currently financially eligible for Medicaid (i.e., they fit into an existing Medicaid eligibility category). For purposes of Option 3, the 1915(i) level of care criteria (assessment criteria), was defined to include any person who needed any of the following:

- Standby assistance to ensure safety of self-performance of 2 ADLs (eating, toileting, transferring, mobility, bathing, dressing, continence);[20]

[20] A fourth criterion involving hands-on assistance for 2 ADLs was included for this Option in the preliminary report of this study but is not included in this report because that criterion is by definition subsumed in a 2 ADL standard based on standby assistance. Analysis not reported here shows that a hands-on standard reduces new approvals based on 2 ADLs alone for first determinations by several hundred cases as compared to a standby standard. At the same time, more new approvals are independently identified by other alternative screens such that total new approvals associated with combinations of screens that involve 2 ADLs (as is defined for the DRA Option) decline by less than 200.

- 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): 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.

The following set of services were included as the new 1915(i) service package for this analysis:

- 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).

As in Option 1, this analysis will first estimate the number of additional cases that would be approved under the lower level of care associated with 1915(i), and then it attaches an estimated per-person cost to this caseload. Under Option 3, however, unlike Option 1, new recipients of the service must meet existing financial eligibility criteria (the community standard) and otherwise qualify for Medicaid. Because these individuals already qualify for Medicaid, the cost estimates do not need to incorporate additional State Plan (non-waiver) costs.

Table 10 is analogous to Table 2. It is based on reviewing the 1,065 denials of NF LOC, under the 3871Bs that were submitted in 2006. Yet, because some of these individuals would not financially qualify for Medicaid under an existing eligibility category, we estimate that only 807 of these 1,065 individuals potentially qualify for Medicaid, even if they met the lower 1915(i) functional test. Table 10 follows the same basic method used in Option 1. While the LOC screening criteria examined for Option 3 (and described above) are intended to be applied together, Table 10 shows the independent contribution of each of the three LOC component screens defined for this option. As in Option 1, the screen on behavioral markers would result in an approval for many of the people who sought and were denied a NF LOC from a Medical Day Care provider under the 3871B NF LOC standard.

Table 10: Additional Approvals Given Selected Changes to LOC Criteria (Option 3)

	Review Type	Previously Denied	Additional Approvals Given Individual Screens: 2 ADLs at Supervisory Level		MM score < 10 & 1 of 3 IADLs		1 of 5 Behavioral Markers	
		#	#	% now appd	#	% now appd	#	% now appd
1	Nursing Facility	172	127	73.8	4	2.3	28	16.3
2	Medical Adult Daycare	577	391	67.8	46	8.0	275	47.7
3	Nursing Facility OAW	272	199	73.2	6	2.2	26	9.6
4	Nursing Facility LAH	15	8	53.3	1	6.7	1	6.7
5	Nursing Facility PACE	29	16	55.2	0	0.0	5	17.2
	Total	**1,065**	**741**	69.6	**57**	5.4	**335**	31.5
	Total fully eligible*	**807**	**557**		**51**		**305**	
	Number still denied		**508**		**1,014**		**760**	
	Total cases submitted		**20,838**		**20,838**		**20,838**	
	Overall denial rate		**2.4%**		**4.9%**		**3.6%**	

* 50% of NF, 40% of OAW, and 70% of LAH individuals are assumed to meet all applicable State Plan eligibility requirements.

Table 11 shows the additive results of various combinations of the individual screen components for this option. Where the combination of a 2-ADL standard and a lower mini-mental score added relatively few new cases to the ADL standard alone, the introduction of a behavioral test on any of 5 factors adds an additional 90 cases to those based on the ADL standard. Together, the combination of screens proposed under this Option would have led to 831 more approvals on a functional basis, and 637 (78 percent of denials) than occurred in FY 2006 and an overall denial rate of just 1.1 percent. Using percentages discussed under Option 1, above, for those who would meet the community standard financial requirements for State Plan services, 637 new approvals would be eligible for community support services under this Option 3.

Table 11: Additional Approvals Given Combinations of Changes to LOC Criteria (Option 3)

	Review Type	Previously Denied	Additional Approvals Given Combinations of Individual Screens: 2 ADLs & MM		2 ADLs & Behavior		MM & Behavior		2 ADLs, MM & Behavior	
		#	#	% now appd	#	% now appd	#	% now appd	#	% now appd
1	Nursing Facility	172	**127**	73.8	**135**	78.5	**32**	18.6	**135**	78.5
2	Medical Adult Daycare	577	**399**	69.2	**464**	80.4	**289**	50.1	**468**	81.1
3	Nursing Facility OAW	272	**201**	73.9	**201**	73.9	**31**	11.4	**203**	74.6
4	Nursing Facility LAH	15	**8**	53.3	**8**	53.3	**1**	6.7	**8**	53.3
5	Nursing Facility PACE	29	**16**	55.2	**17**	58.6	**5**	17.2	**17**	58.6
	Total	**1,065**	**751**	70.5	**825**	77.5	**358**	33.6	**831**	78.0
	Total fully eligible*	**807**	**562**		**632**		**323**		**637**	
	Number still denied		**503**		**433**		**742**		**428**	
	Total cases submitted		**20,838**		**20,838**		**20,838**		**20,838**	
	Overall denial rate		**2.4%**		**2.1%**		**3.6%**		**2.1%**	

* 50% of NF, 40% of OAW, and 70% of LAH individuals are assumed to meet all applicable State Plan eligibility requirements.

Estimated costs for Option 3 were drawn from FY 2006 data. For Options 1 and 2 the costs were based on existing program criteria or service definitions. However, a new combination of services is defined as the 1915(i) service package for Option 3, and a new composite estimate of costs is needed to estimate the relative financial impact of this option. Moreover, because

Option 3 cannot be targeted to just seniors, or just individuals with physical disabilities, the new 1915(i) criteria also would open the door for additional services to other individuals, such as people with developmental disabilities.

Table 12 was created to estimate the cost, per-person, of an expansion based on Section 1915(i). This Table provides the number of users and expenditures in FY 2006 for each of the services included in the 1915(i) service package for Option 3 (certain individuals qualified for and received these services in 2006 under the existing criteria). Option 3 would ease entry into these services for people who would not meet the current LOC standards, but would meet the new, lower Section 1915(i) criteria. Table 12 shows that, as a package, nearly $105 million was spent in FY 2006 to serve 10,014 individuals in this constellation of services, at an estimated annual cost of $10,446 per person (in FY 2006 dollars).

Table 12: Users and Costs for Selected Medicaid Community Support Services (FY 2006)

Service	Users (per service)	Expenditures	Average Annual $ (per User)
Medical Day Care	6,204	$74,957,040	$12,082
Older Adults Waiver agency respite	281	$256,217	$912
Older Adults Waiver respite in assisted living facility	38	$24,667	$649
Older Adults Waiver respite in nursing facility	2	$1,177	$589
Personal Care Agency level 2	47	$174,152	$3,705
Personal Care Case Monitoring	4,785	$9,355,350	$1,955
Personal Care level 2	3,652	$17,266,521	$4,728
Personal Care level 2B	36	$100,650	$2,796
Personal Care level 3	235	$2,271,904	$9,668
Senior Center Plus	55	$195,126	$3,548
Total Unduplicated Users & Expenditures:	10,014	$104,602,805	
Average Annual Expenditures per User	$10,446		

As before, a number of assumptions are needed in order to apply the data in Tables 11 and 12 to estimate the financial impact of this option. First, the full annual cost estimate suggested in Table 12 reflects the current underlying distribution of services. A new DRA option may result in a change in that distribution such that the average costs per-person under the option may change. If relatively more personal care services are used by clients under this option the average per-person cost estimate would go down. If more Medical Day Care was provided, the average per-person cost estimate would go up. In the absence of more data about the service needs of the actual population who would use services under this option no changes are assumed regarding the underlying distribution of these services.

As indicated in Table 11, the largest number of new participants in Option 3 is 637 individuals, based on a combination of all three functional tests (2-ADLs, Mini-Mental, and Behavioral), and applying estimates of financial eligibility under an existing eligibility category. Simply converting these denials into people receiving services under Section 1915(i) results in a minimum estimate of the cost of Option 3 at $6.65 million in FY 2006 dollars (637 new people, at $10,446 per person from Table 12).

However, other individuals would qualify for Section 1915(i) services beyond merely those people who submitted a 3871B and were denied a NF LOC. One source of this internal group of potential new service beneficiaries is the population of people who never submitted a 3871B, and were slated for enrollment in CommunityChoice. Using the ADL survey sample described above with respect to this population, and including not only the people who identified 2-ADL deficits but also an estimate for the people who would meet the new Section 1915(i) behavioral screen, approximately 3,314 additional people would be eligible for Section 1915(i) services. This translates into an estimated cost, in FY 2006 dollars, of $34.6 million (3,314 people, $10,446 per-person). This does not include administrative costs.

As before, this does not include those people who would meet the criteria for Section 1915(i) but neither submitted a 3871B nor were included in the ADL survey sample because they were not potential CommunityChoice enrollees.[21]

As in Option 1, certain offsets might reduce these costs (perhaps new people might have a lower per-person need and that is why they are not on a waiver, or perhaps administrative or provider capacity issues might slow growth). Other factors might increase these costs (such as the group of potential new service beneficiaries, described below, for whom we do not have data to make estimates).

v. Potential New Beneficiaries External to Our Data Sources

The potential new service beneficiaries described thus far in this study has primary focused on those individuals who are currently enrolled in the Medicaid program. This was previously defined in note 1 as an "internal" group of potential new service beneficiaries – the pent-up demand among current beneficiaries for needed services they cannot qualify for under current standards. There may also be an "external" group of potential new beneficiaries, defined as a group who, because of a change in policy, would apply for and receive Medicaid-funded services for the first time.

As a supplement to the analyses above, U.S. Census and other publicly-available data sources were examined to try to estimate the extent of the broader population that might be (or might become) eligible under the various options discussed above, beyond those individuals who are already enrolled under Medicaid. Unfortunately, no data sources currently available to the Department from outside of Maryland Medicaid appropriately reflect the key circumstances necessary to model the broader population that might be eligible for Medicaid in the state under the options outlined in this analysis.

Data sources that may provide some useful indicators suggest markedly different types of results. U.S Census data, for example, can be used to estimate the number of non-institutionalized individuals with two or more disabilities from households in Maryland who have an income less than the federal poverty level, but that number does not reflect important factors. For instance, income categories do not reflect assets, which play a critical role in Medicaid financial eligibility

[21] See Note 13.

determinations. The number of non-institutionalized individuals with two or more disabilities that would be eligible for Medicaid in Maryland is clearly smaller than what those data suggest but it is not clear how much smaller.

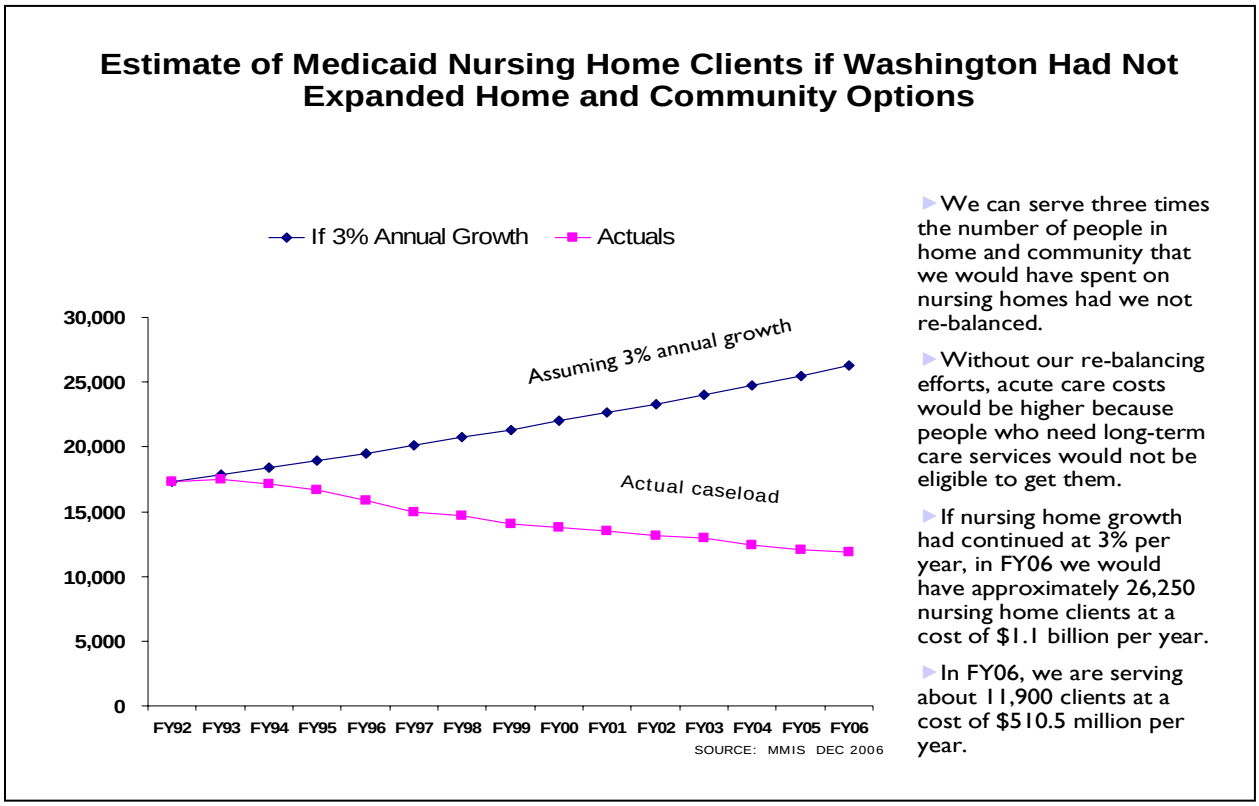
In sum, while each of the options to broaden access to supports for home- and community-based services discussed above may induce individuals who are not now enrolled under Medicaid to apply for services, we cannot reasonably estimate what that effect might be for each of those options using any available data source. At the same time, it is reasonable to assume that some number of additional applications (and subsequent approvals) for individuals who are currently eligible for Medicaid benefits but have not yet enrolled would result to some extent under each of the Options discussed above. That would be particularly true as changes to NF LOC determinations suggest increasingly lower denial rates.

3. **Analysis of Potential for Long-Term Savings by Reducing Level of Care Criteria**

Washington State is the only state that has lowered its NF LOC, and then prepared materials that could be utilized to analyze whether this change saved the state money over time. Many policy makers hypothesize that lowering the NF LOC criteria, which would provide services and supports earlier, to more individuals, at a lower cost per person, might prevent or delay the later use of more expensive nursing facility services. Washington State's experience and data form a basis to analyze this hypothesis.

Our analysis evaluated Washington State's experience for the time period 1992-2006. Figure 1 (and its surrounding text), which was provided to DHMH by Washington State officials in connection with this study, was our starting point. It shows that, had Washington State experienced Medicaid NF caseload growth at its historic rate of growth of 3 percent per year from 1992–2006, then the NF population would have grown from 17,350 residents in 1992 to 26,243 residents in 2006. Instead, as shown in Figure 1, the actual number of NF residents fell to 11,900 by 2006.

Figure 1



Source: Email attachment from Denise Gaither, Aging Disability Services Administration, Washington Department of Social and Health Services, August 27, 2007.

Figure 1 therefore reflects one methodology to estimate the growth in NF cases from 1992-2006, based on historic experience prior to 1992. This methodology yielded an estimated 26,243 NF residents in 2006.

In this study we also modeled two other methods to estimate NF caseload growth during this time period. First, data are available on the national rate of increase in Medicaid-financed NF caseload growth between 1992-2006. On a national basis, the average per-year increase in Medicaid NF recipients between 1992-2006 was just under 1 percent per year; a growth rate of 0.8 percent. Growth in Medicaid NF residents slowed over this period, from the prior period, for a number of reasons, including the emergence of a strong assisted living industry as an alternative to NFs.

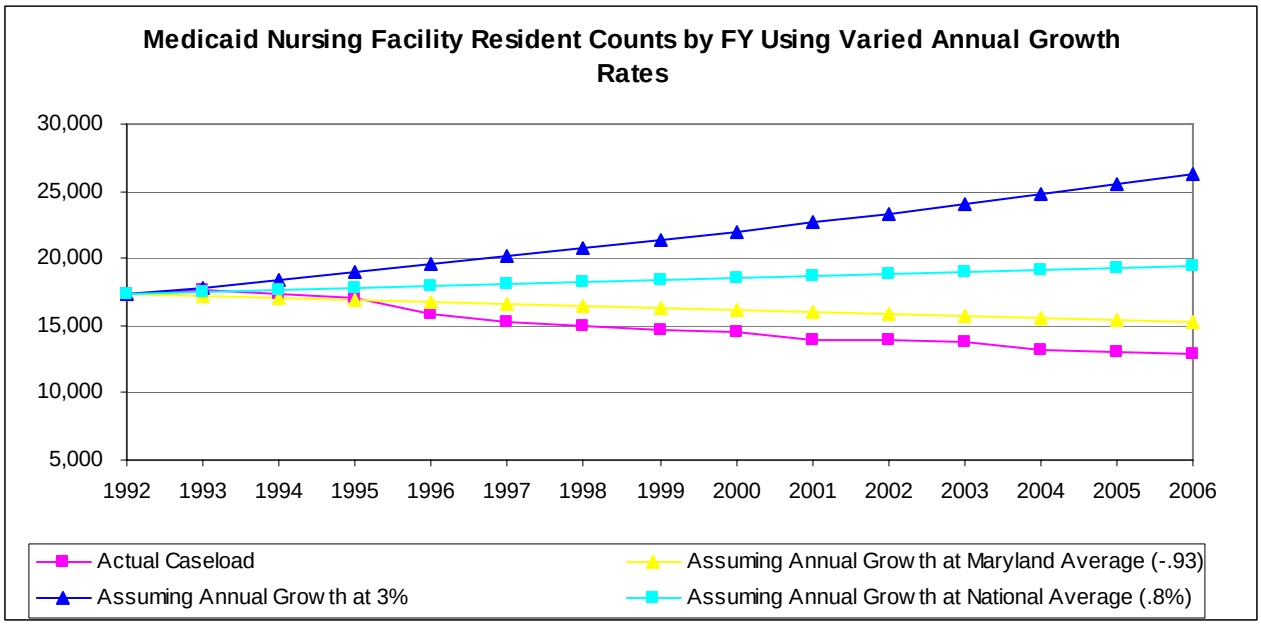
Second, because this study is based on an attempt to estimate what might happen in Maryland, it is useful to consider Maryland's experience during the same period. From 1992-2006, Medicaid-financed NF residents in Maryland actually *declined* at the average annual rate of 0.93 percent per year.

Figure 2 reflects the addition of these two alternative recipient caseload estimates into Figure 1.

Figure 2

Washington State NF Caseload Growth Estimates, 1992-2006,

Using Three Alternative Methods to Estimate Caseload Growth



Washington State's actual NF caseload in 2006 was 11,900 cases, at an average cost per person of $42,899. Table 13 corresponds to the three separate methods we utilized to estimate Washington State's NF caseload, in the absence of reforming the state's NF LOC. *Table 13 shows that no matter what method is used to estimate Washington's caseload in 2006, the reforms that Washington State introduced in the 1990s, when it lowered its NF LOC criteria, saved Washington State a significant amount of money in NF expenditures.* The savings estimates range from a high of $615 million (our calculation based on Figure 1, using the 3 percent estimated annual NF growth rate that Washington State provided in Figure 1) to a low of $143 million in savings (using the method of applying Maryland's annual reduction in cases at the rate of 0.93 percent per year).

Table 13

Estimated Medicaid NF Savings in 2006 in Washington State, under Different Assumptions

Annual Caseload Growth Assumption 1992-2006	Estimated Cases, 2006, from a 1992 starting caseload of 17,350 cases	Cases in Excess of Actual 2006 Caseload of 11,900	Cost Per Case	2006 Savings in NF when compared to actual 2006 caseload (Excess Cases * Cost Per Case, in millions)
3%, based on Washington State experience prior to 1992	26,243	14,343	$42,899	$615
.8%, based on actual national average in the period	19,398	7,498	$42,899	$322
-.93%, based on actual Maryland experience in the period	15,233	3,333	$42,899	$143

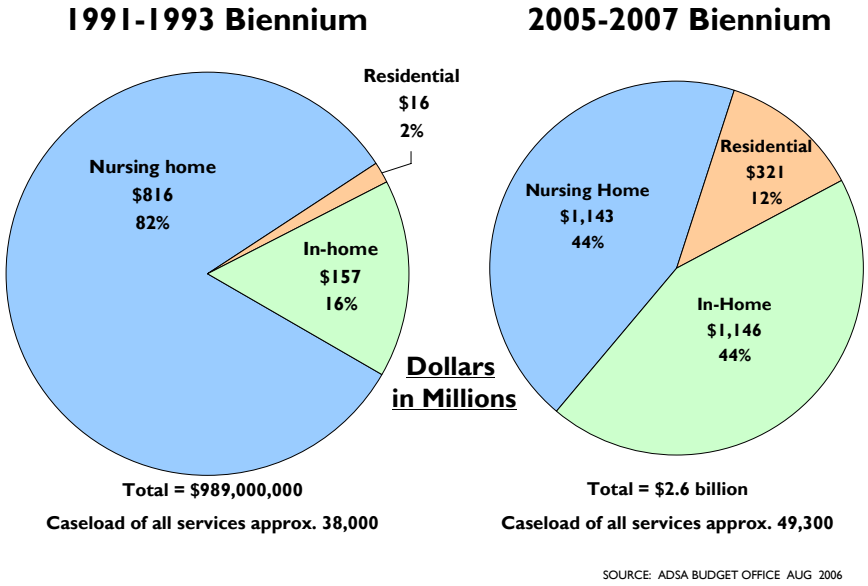
Of course, these savings in NF expenditures are only half the financial picture, because Washington State also was very successful in expanding its home- and community-based services (HCBS) when it lowered its NF LOC criteria, in order to provide earlier services to more individuals in the community to delay or prevent NF utilization. As further described in Appendix E, Washington State served approximately 37,400 people in community settings during the 2005-2007 biennium.

Yet, because we have been asked to address the net aggregate cost effectiveness of changing NF LOC, and not to address which setting is less expensive per capita, nor which policy serves more people, we needed to estimate the cost of expanded HCBS in Washington State that enabled that state to rebalance its nursing home caseload. Therefore, to answer the question whether Washington State saved money in the long run by lowering its NF LOC criteria, it is necessary to estimate the additional HCBS investments that Washington State made as part of its overall reform that helped Washington State to achieve the savings in nursing facilities. Then, it is necessary to compare whether these extra HCBS investments were offset by NF savings.

Figure 3, provided by Washington State in connection with this study, shows that Washington State's biennial (two-year) spending on HCBS grew from $173 million in the 1992-1993 biennial budget (residential care of $16 million plus in-home care of $157 million) to $1.467 billion in the 2006-2007 biennium (residential care of $321 million plus in-home care of $1.146 billion). This translates to an average annual HCBS spending level of $86.5 million in the 1992-1993 biennium, and an average annual HCBS spending level of $ 733.5 million in the 2006-2007 biennium. The total annual spending on long-term care, regardless of setting, grew from $494.5 million in the 1992-1993 biennium (half the left hand pie chart in Figure 3) to $1.305 billion in the 2006-2007 biennium (half the right hand pie chart in Figure 3).

Figure 3

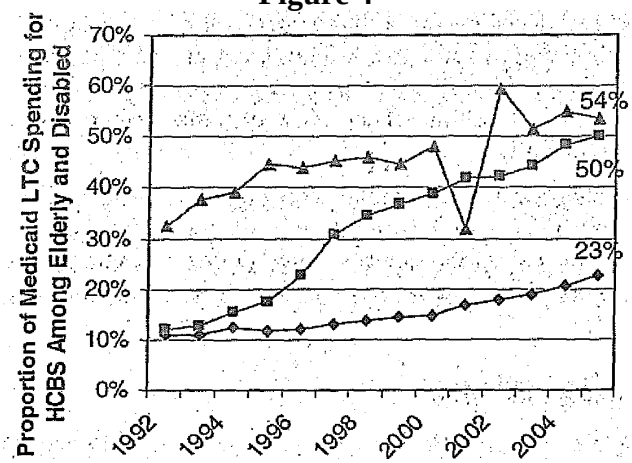
Long-term Care Expenditure Shift



SOURCE: ADSA BUDGET OFFICE AUG 2006

In Figure 4, which came from an unpublished 2006 study on Washington State by The Lewin Group (it was provided to us by Washington State for this study), researchers noted that Washington State rebalanced its long-term care system so that by 2006 fully 50 percent of all its Medicaid long-term care expenditures were in HCBS, whereas by 2006 the national average had only grown to 23 percent of total Medicaid long-term care spending directed to HCBS.

Figure 4



Legend: 23 % = National Average
50 % = Washington State
54 % = Oregon

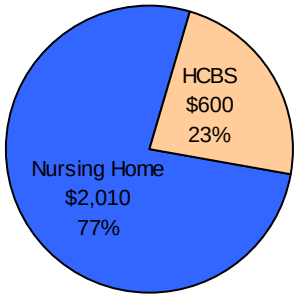
In Figure 5, we took Washington State's overall long-term care spending during the 2005-2007 biennium, $2.61 billion, and assumed it would have been distributed based on the national average of 23 percent for HCBS (from Figure 4). This was our method for estimating what Washington State would have spent on HCBS, had it not pursued LTC reforms. We reasoned that, had Washington State left its long-term care system alone, and not altered its NF LOC criteria, it would have followed national trends, because it began in 1992 at the national average percent allocation for HCBS spending (Figure 4). Using the 23 percent HCBS national figure toward Washington State's actual 2005-2007 biennial long-term care spending of $2.61 billion in 2006 generates the estimates found in Figure 5: $600 million for HCBS expenditures in the biennium, and $2.0 billion for NF expenditures in the biennium, or $300 million annually in HCBS expenditures, and $1.0 billion annually in NF expenditures.

Figure 5

Washington State 2006-2007 Biennium

Distribution of Expenditures Assuming National Average

HCBS Expenditure of 23 Percent



Total = $2.61 billion

Using Washington State's actual HCBS spending in 2006, and comparing it to the estimated HCBS spending had Washington State not undertaken long-term care reforms, Table 14 shows that Washington State spent an estimated $433 million more in HCBS in 2006 than it would have spent, had it remained at the national average in HCBS expenditures.

Table 14

Estimated Additional Investment in HCBS in Washington State, 2006

	Expenditures (in millions)
Actual HCBS Expenditures	$733
Estimated HCBS Expenditures, at National Average	$300
Estimated Additional Investment in HCBS	$433

Finally, to estimate whether its reforms saved money, or cost money, we compare the savings Washington State achieved in reducing its NF caseload against the increased costs it incurred in expanding HCBS following its change in its NF LOC. Table 15 presents the results, based on the earlier analysis in Tables 13 and 14.

Table 15

Net Savings (Cost) in Washington State, Using Three Different Methods to Estimate NF Savings, 2006

Method used to calculate NF Savings, 1992-2006	**NF Savings, 2006, from Table 13 (in millions)**	**Additional HCBS Investment, 2006, from Table 14 (in millions)**	**Net Savings or Expense, 2006 (in millions)**
Washington State's Historic Trend of 3 percent annual growth	$615	$433	+182
National Trend of .8 percent annual growth	$322	$433	-111
Maryland Trend of .93 percent annual reduction	$143	$433	-290

Table 15 demonstrates that using the NF caseload trend line provided in Figure 1, Washington State saved an estimated $182 million in 2006. Table 15 also demonstrates that utilizing the other two methods, we estimate that the aggregate costs were higher. Both of these alternative methodologies, when applied to data from Washington State, show that rebalancing may cost more, primarily due to increased access and numbers of utilizers at a lower NF LOC. The alternative methodologies show a net cost: using the national NF caseload growth rate between 1992-2006 results in estimated additional costs in 2006 of $111 million, and applying Maryland's caseload rate between 1992-2006 results in estimated additional costs of $290 million.

Conclusion

This is the Department's final report, in satisfaction of the requirements of HB 594. The Department submits this report with the goal of advancing Maryland's understanding of the opportunities and costs of expanding HCBS, and to enable the legislature and others to evaluate the importance of promoting HCBS in the context of other important state funding priorities.

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 Baldock	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: Contact List for State and District of Columbia Interviews

HB 594: Maryland Review of the Provision of Long-Term Care Services
Change in Level of Care Criteria

Vermont

Joan K. Senecal
Commissioner
Vermont Department of Disabilities, Aging and Independent Living
Phone: 802.241.2401
E-mail: Joan.Senecal@dail.state.vt.us

Washington

Kathy Leitch
Assistant Secretary for the Aging Disability Services Administration
Washington Department of Health and Social Services
Phone: 360-725-2261
E-mail: LeitcKJ@dshs.wa.gov

Denise Gaither
Special Assistant to the Assistant Secretary for the Aging Disability Services Administration
Washington Department of Health and Social Services
Phone: (360) 725-2262
E-mail: gaithds@dshs.wa.gov

Oregon

Julia A. Huddleston
Manager, Planning Research and Rate Setting
Oregon Department of Human Services
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E-mail: Julia.A.Huddleston@state.or.us

New Jersey

Nancy Day
Director of Community Education and Wellness
New Jersey Division of Aging and Community Services
Phone: (609) 943-3428
E-mail: Nancy.Day@doh.state.nj.us

District of Columbia

Robert Cosby, Ph.D.
Chief, Office on Disabilities and Aging
District of Columbia Department of Health
Phone: (202) 442-5972
E-Mail: Robert.cosby@dc.gov

Michigan

Elizabeth Aastad
Policy Specialist
Michigan Department of Community Health
Office of LTC Supports and Services
Phone: (517) 241-2115
E-mail: AastadL@michigan.gov

Florida

Sam Fante
Program Coordinator
Division of Statewide Home-and Community-Based Services
Florida Department of Elderly Affairs
Phone: 850-414-2164
E-mail: Fantes@elderaffairs.org

New York

Alene Hokenstad
Project Director
United Hospital Fund of New York City
Phone: 212-494-0742
E-mail: ahokenstad@uhfnyc.org

Carla Williams
Deputy Director
Office of Long Term Care
Phone: 518-408-1833

Appendix C: 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 an 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?

Appendix D: Level of Care Criteria in Selected Other States

The State criteria for meeting long term level of care is in addition to needing skilled nursing or rehabilitation

State	Level of Care Criteria for Nursing Facility Services
District of Columbia	Must Qualify in 1 of 2 criteria: 1. 2 ADLs 2. 3 IADLs
Florida[22]	Must Qualify in 1 of 2 criteria: 1. Serious physical or mental impairment ("Intermediate 1") 2. Mild physical or mental impairment, plus a condition that requires medical supervision ("Intermediate 2")
Maryland	Must Qualify in 1 of 2 criteria: 1. Scorable instrument considering: ADLs IADLs Cognitive (Mini Mental exam) Behavior 2. Opportunity for physician review and approval based on other criteria (e.g. medications)
Michigan[23]	Must qualify in 1 of 6 criteria: 1. ADLs 2. Cognitive performance 3. Physician involvement 4. Treatment & conditions 5. Behavior 6. Service dependency
New Jersey[24]	Must qualify in 1 of 2 criteria: 1. 3 or more ADLs with extensive assistance 2. 3 or more ADLs with supervision or limited assistance plus a score of 7 on Folstein Mini-Mental

[22] Telephone Interview - Sam Fante, Florida Department of Elderly Affairs, September 7, 2007
[23] http://www.michigan.gov/documents/MSA-04-15_104506_7.pdf
[24] Telephone Interview - Nancy Day, New Jersey Division of Aging and Community Services, September 7, 2007

New York[25]	3 or more ADLs
Oregon[26]	Need for assistance with at least 1 ADL 1. Service priority level 1-13 depending on level of assistance – individuals with low priority are encouraged to receive services in the community rather than the nursing facility
Vermont[27]	Must qualify in 1 of 3 criteria to meet "high need": 1. Extensive to total assistance on a daily basis with one or more specified ADLs 2. Impaired judgment or decision making skills that interfere with completion of ADLs and one or more behavioral conditions requiring a controlled, safe environment 3. Special circumstances (e.g., loss of caregiver)
Washington[28]	Must qualify in 1 of 2 criteria: 1. Requires assistance with one or more ADLs on a daily basis 2. One or more qualifying psychosocial conditions and need for 24 hour health care

[25] Telephone Interview - Carla Williams, Office of Long Term Care, New York Department of Health, October 9, 2007
[26] Telephone Interview - Julia Huddleston, Oregon Department of Human Services, July 31, 2007 and August 23, 2007
[27] Telephone Interview - Joan Senecal, Vermont Department of Disabilities, Aging and Independent Living
[28] Telephone Interview - Kathy Leitch, Washington Department of Social and Health Services, Aging Disability Services Administration, July 30, 2007

Appendix E: Narratives on Other States

HB 594: Maryland Review of the Provision of Long-Term Care Services
Change in Level of Care Criteria

State: District of Columbia

Review Question	Response
Has the state changed its level of care criteria or process?	Yes
If yes, when?	May 2002
Why?	To streamline administrative procedures and to make the process more transparent for providers and consumers.
How?	Prior to 2002, the District used a process similar to Maryland's 3871 process where clinicians made decisions based on whether the individual needed skilled nursing care, rehabilitation services, or health-related care and services above the level of room and board. In May 2002, the new methodology required individuals to need assistance with 2ADLs or 3 IADLs to be approved for NF LOC.
What has been the result? Describe the impact the level of care standard has had on the delivery of LTC services.	The District has not conducted a study of the impact of the change.
Other?	

HB 594: Maryland Review of the Provision of Long-Term Care Services
Change in Level of Care Criteria

State: Florida

Review Question	Response
Has the state changed its level of care criteria or process?	No
If yes, when?	N/A
Why?	N/A
How?	N/A
What has been the result? Describe the impact the level of care standard has had on the delivery of LTC services.	N/A
Other?	No

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Change in Level of Care Criteria

State: Michigan

Review Question	Response
Has the state changed its level of care criteria or process?	Yes
If yes, when?	November 1, 2004
Why?	Lawsuit/Push from advocates
How?	The Michigan Department of Community Health (MDCH) implemented revised functional/medical eligibility criteria for Medicaid nursing facilities, MI Choice (waivers), and PACE services as of November 1, 2004. The LOC Determination is now an electronic web-based system accessed through Michigan's Single Sign-On System located at https://sso.state.mi.us.
What has been the result? Describe the impact the level of care standard has had on the delivery of LTC services.	The goal for the revised criteria was to make it equitable across all programs and to increase access to services. MDCH reports 1.3% of NF, 12% of waiver, and <1% of PACE applicants are determined ineligible under the current revised LOC standard. They could not provide information on denials prior to the change. Michigan reports that the revised LOC criteria has not streamlined the delivery of LTC services but added another "layer" due to the fact that nothing like this was being done prior. Along with revised LOC criteria, the Long Term Care Connection (LTCC) was designated as the party responsible for performing LOC assessments throughout the state of Michigan.
Other?	No

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Change in Level of Care Criteria

State: New Jersey

Review Question	Response
Has the state changed its level of care criteria or process?	Yes, both its process and its criteria
If yes, when?	2006
Why?	Prior to 2006, New Jersey utilized a scorable instrument. It also allowed agency staff to exercise their own clinical judgment. New Jersey altered its process because there "was a substantial gap between the results of the scorable instrument and staff judgments."
How?	New Jersey learned that one reason staff members determined individuals to meet the level of care criteria (extensive assistance in 3 ADLs), when the instrument did not, was due to cognitive deficits that staff members observed. As a result, New Jersey changed its level of care criteria to allow a Mini Mental score of seven or less in addition to limited assistance in 3 ADLs.
What has been the result? Describe the impact the level of care standard has had on the delivery of LTC services.	Preliminary results are not yet available. This will be evaluated as part of New Jersey's Real Choice Systems Change grant.
Other?	No

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State: New York

Review Question	Response
Has the state changed its level of care criteria or process?	No
If yes, when?	N/A
Why?	N/A
How?	N/A
What has been the result? Describe the impact the level of care standard has had on the delivery of LTC services.	N/A
Other?	No

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State: Oregon

Review Question	Response
Has the state changed its level of care criteria or process?	Yes
If yes, when?	1981
Why?	To promote home and community-based services
How?	Oregon reduced its level of care criteria to assistance with at least 1 ADL. Oregon combined this change with a number of other interventions to re-balance its long-term care system, including aggressive nursing facility diversion programs, creating and licensing new community-based provider types, and improving payment rates for community-based providers.
What has been the result? Describe the impact the level of care standard has had on the delivery of LTC services.	As more people became eligible for institutional and community based services, costs increased. Because only nursing facilities remain a federal Medicaid entitlement, when Oregon faced a state budget crisis in 2003, the state was compelled to eliminate eligibility for about 3000 individuals in the community (i.e., the highest functioning).
Other?	Oregon is exploring non-publicly funded options to shore up their publicly financed long-term care system.

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State: Vermont

Review Question	Response
Has the state changed its level of care criteria or process?	Yes
If yes, when?	October 2005
Why?	Vermont sought and received an 1115 waiver to eliminate the institutional bias (to the extent possible with an 1115 waiver) and to deliver limited community-based services to individuals who did not yet meet the institutional level of care.
How?	In its 1115 waiver, Vermont obtained permission to classify individuals into three groups: 1) highest need – individuals who would be entitled to be served in a nursing facility or in the community at the individual's discretion; 2) high needs-individuals who would have a right to community-based services but not to nursing facility services constitutes the state's nursing facility level of care criteria 3) moderate needs- individuals who did not yet meet the nursing facility level of care, but would be eligible for limited state plan services to the extent funds were available.
What has been the result? Describe the impact the level of care standard has had on the delivery of LTC services.	Vermont reported that the number of people served in nursing homes has continued to decrease, while the numbers of people served in home and community-based settings have continued to increase: 1. Nursing homes: the number of people in nursing homes decreased by 275 (from 2,286 to 2,011) between October 2005 and July 2007. 2. Home and community-based services (Highest/High Needs Groups): the number of people served increased by 342 (from 988 to 1,330) between October 2005 and July 2007. 3. Enhanced Residential Care: the number of people increased by 125 (from 173 to 298) between October 2005 and July 2007. 4. "Moderate Needs": the number of people in this 'expansion' group increased from 0 to 535 between 2005 and July 2007
Other?	N/A

HB 594: Maryland Review of the Provision of Long-Term Care Services
Change in Level of Care Criteria

State: Washington

Review Question	Response
Has the state changed its level of care criteria or process?	Yes
If yes, when?	1997
Why?	Washington State altered its level of care criteria as one component of its overall effort to rebalance its long-term care system to promote community-based services. This change was done in conjunction with numerous other interventions that also supported this overall objective.
How?	Washington reduced its level of care to need for assistance with 1 ADL
What has been the result? Describe the impact the level of care standard has had on the delivery of LTC services.	According to the State, "If nursing home growth had continued at 3% per year, in FY 06 we would have approximately 26,250 nursing home clients at a cost of $1.1 billion per year. In FY 06, we are serving about 11,900 clients at a cost of 510.5 million per year." Also, in the 2005 – 2007 biennium, the state provided community-based services to approximately 37,400 people, at a cost of $1.5 billion (over two years). Based on data from 2005 – 2007, Washington reports that the LOC denial rate varies from 5-10 percent. (See pages 27 – 33 for a full discussion.)
Other?	Washington State emphasizes that it is not sufficient simply to change the level of care criteria if a state's goal is to promote community-based services. A state must also: aggressively divert individuals from nursing facility admissions; increase community-based services provider payment rates; implement active and aggressive utilization controls of both institutional and community-based services (to avoid excessive community-based plans of care in favor of serving more people); implement active and aggressive estate recovery and reinvest funds back into long-term care; develop new community residential settings (such as assisted living and adult foster care); and improve quality management programs for oversight of services in community settings.

HB 594: Maryland Review of the Provision of Long-Term Care Services
Change in Level of Care Criteria

State: Maryland

Review Question	Response
Has the state changed its level of care criteria or process?	Yes
If yes, when?	July 1, 2004
Why?	In order to have an objective, scorable methodology which is more: • Easily understandable • Easily applied • Sensitive to functional and cognitive deficits
How?	The new instrument was developed to include need for assistance with ADLs, IADLs, cognitive, and behavioral problems, enabling the States Utilization Control Agent to more accurately take into account issues other than need for skilled nursing and rehabilitation.
What has been the result? Describe the impact the level of care standard has had on the delivery of LTC services.	There was not a significant change in the numbers of individuals approved for services following the change in the methodology. Therefore, stakeholders continue to be concerned that functional and cognitive deficits are not fully considered under the new methodology.
Other?	

Appendix F: Comparative Populations and Medicaid Long-Term Care Use Rates in Selected Other States

HB 594: Maryland Review of the Provision of Long-Term Care Services
Change in Level of Care Criteria

Tables 1 and 2 that follow provide some context for each state's utilization of Medicaid nursing facility (NF) services and home- and community-based services (HCBS) (defined here as including state plan medical day care, personal care, and Section 1915(c) waiver services) in relationship to each state's adult population as a gross indicator of use rate/per 1,000 population. The most complete data available from the Centers for Medicare and Medicaid Services (CMS) for NF residents are for FY 2004, while the most complete data for HCBS participants are for 2003, defined as the "state waiver year", which can vary slightly from state to state. To provide as much consistency as possible, U.S. Census estimated total (institutional and non-institutional) populations for CY 2004 were used for the NF calculations, and U.S. Census estimated total (institutional and non-institutional) populations for CY 2003 were used for the HCBS calculations.

Comparative Populations and Medicaid Nursing Facility Use Rates

From Table 1 (below), both Oregon and Washington State, the two states which many years ago lowered their nursing facility level of care (NF LOC) criteria and aggressively expanded their use of community-based long-term care programs, had the lowest use rate of the states studied for this report, at 3.9/1,000 and 4.9/1,000 population respectively. States with higher NF LOC requirements, such as New Jersey, Maryland, Michigan, Florida and Vermont, had higher use rates, ranging from 6.5/1,000 in Maryland to 8.5/1,000 in Vermont.[29] The District of Columbia and New York, which have methodologies with NF LOC requirements similar to Oregon and Washington State, have much higher use rates for nursing facilities, at 13.8/1000 and 13.9/1000 population respectively. Therefore, it appears that factors other than the NF LOC criteria are critical in reducing nursing home utilization.

Table 1.
Comparison of Medicaid Nursing Facility Residents per 1000 Population by State, 2004

State	Total Population 18 + (Non-Institution and Institutional) CY 2004*	Medicaid Nursing Facility Residents FY 2004**	Medicaid NF Residents Per 1000, Adult Population
Vermont	484,797	3,997	8.2
Washington	4,650,190	22,555	4.9
Oregon	2,718,801	10,610	3.9
New Jersey	6,583,886	48,404	7.4
Washington D.C.	438,789	6,089	13.9
Michigan	7,594,866	50,431	6.6
Florida	13,366,968	114,134	8.5
New York	14,577,017	200,446	13.8
Maryland	**4,160,059**	**27,109**	**6.5**

* Source: http://www.census.gov
** Source: http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/msistables2004.pdf (NF data not available by CY. Thus, there is a slight discrepancy between the estimated population (CY) and the NF Totals (FY)

[29] The specific NF LOC criteria for each state may be found in Appendix A.

Comparative Populations and Medicaid Home- and Community-Based Services Use Rates

While the data in Table 2 (below) are from FY 2003 (the last year that complete HCBS data are available from CMS), Oregon and Washington State are both low in terms of the use rate for personal care services compared to the other study states, but show a significantly higher use rate of home- and community-based 1915(c) waiver services for aged and disabled adults than any other state. Oregon's 1915(c) waiver use rate in FY 2003 was 11.7/1,000 and Washington State's was 6.5/1,000. The next closest state's use rate was Vermont at 3.3/1,000, and Maryland was next to the lowest at 0.8/1,000. The medical day care and personal care use rates varied across the states studied, with Maryland having the highest use rate for State Plan Medical Day care and close to the lowest use rates for personal care, among the states studied.

Table 2.
Comparison of Medicaid Home and Community-Based Service Recipients per 1000 Population by State, 2003

		HCBS SERVICES 2003**					
State	**Total Population 18+ (Non-Institution and Institutional)* CY 2003**	**State Plan Medical Day Care, Adult Recipients****	**State Plan Medical Day Care, Adult Recipients/ 1000 Population**	**Personal Care, Adult Recipients**	**Personal Care, Adult Recipients/ 1000 Population**	**1915 (c) Waiver, Adult Recipients ***	**1915 (c) Waiver, Adult Recipients/ 1000 Population**
Vermont	478,164	Not covered	Not covered	1,568	3.3	1,580	3.3
Washington	4,613,305	4,400	0.092	21,436	4.6	30,167	6.5
Oregon	2,711,604	Not covered	Not covered	2,376	0.9	31,834	11.7
New Jersey	6,519,368	10,000	0.15	17,707	2.7	8,911	1.4
Washington D.C.	461,046	Not covered	Not covered	2,352	5.1	284	0.6
Michigan	7,516,150	Not covered	Not covered	44,442	5.9	9,144	1.2
Florida	13,157,738	Not covered	Not covered	14,659	1.1	21,563	1.6
New York	14,610,165	12,800	0.09	87,678	6.0	21,443	1.5
Maryland	**4,130,996**	**8,300**	**0.2**	**4,743**	**1.1**	**3,144**	**0.8**

Sources: Kaiser Commission and University of California, San Francisco analysis of Medicaid Home Health Policy Survey: http://www.kff.org/medicaid/upload/7575.pdf. NOTE: Waiver Year 2003 is the most recent year of complete CMS data, on which this report was based.
* Source: http://www.census.gov
**By Year as defined by each State
*** Includes waivers for aged/disabled participants, excluding developmental disabilities waiver participants
****Health Management Associates Issue Brief: July 23, 2007 on Adult Day Health Care Services