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Be Careful What You Wish For: The Maryland Medicaid Waiver Experience

Maryland's Medicaid waiver program went into effect in January 2001. It was designed to assist people at risk of nursing home placement; however, over the past year it has faced several obstacles to effectively serving this population. Lawyers and lawmakers can learn from the issues that emerged concerning this program.

By Jason A. Frank

Maryland's eagerly awaited Medicaid Home and Community Based Services Waiver for Older Adults[1] stumbled into reality as of January 1, 2001. The legislation unanimously passed the Maryland Legislature in 1999, despite prior years of opposition by the Maryland Medical Assistance agency providing home and community based services.

The purpose of the waiver is to provide the full panoply of community based long-term care services in order to keep individuals out of nursing homes. As of July 1, 2001, the Maryland waiver program could accommodate 2,135 people. As of November 1, 2001, only approximately 750 were receiving waiver services, with another estimated 2,000 applications pending. The waiver program is intended to serve people at risk of nursing home placement, however many obstacles have stunted its growth.

Problems with the Waiver Program

Inappropriate Level of Care Standard

There is a fundamental problem with the effectiveness of the waiver: Those most at risk of nursing home placement are not being served by the program as a result of its inappropriate medical level of care standard.[2] The program's targeted population includes not only those persons who currently reside in nursing homes but those "at risk" of being institutionalized. The at-risk population is critically

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important because with the proper services in place, nursing home institutionalization can be prevented entirely—and, for many, before it ever begins. However, the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), has not distinguished those at risk of nursing home placement from those already in nursing homes on Medical Assistance (MA). Therefore, the waiver program only affects those persons who are already ill enough to be admitted to a nursing home.

States have a great deal of flexibility in implementing the level of care standard. Nursing Home Transmittal No. 135,[3] the current medical eligibility standard in Maryland, outlines criteria for level of care determinations (heavily weighted toward medical issues and not behavioral and functional issues) by defining "nursing facility services" as services that are...

1. Skilled nursing care and related services, rehabilitation services, or health-related services above the level of room and board;
2. Needed on a daily basis;
3. Required to be provided on an inpatient basis;
4. Provided by a facility that is certified for participation in Medicaid; and
5. Ordered by and provided under the direction of a physician.

In contrast, the definition for "nursing facility" found in the Maryland MA waiver statute[4] is substantially the same definition as that for "nursing facility" found in federal law.[5] The federal definition reads as follows:

In this title, the term "nursing facility" means an institution (or distinct part of an institution) which—

(1) is primarily engaged in providing to residents—
  (A) skilled nursing care and related services for residents who require medical or nursing care,
  (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or
  (C) on a **regular** basis, health-related care and services to individuals who because of their **mental** or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities... (emphasis added)[6]

The federal definition for nursing facility, like the state definition, articulates both skilled and intermediate levels of care. These definitions are the result of federal mandate that intermediate care be covered under Medicaid.[7] Pursuant to the Omnibus Budget Reconciliation Act of 1987 (OBRA),[8] intermediate and skilled nursing care were subsumed into one category B nursing facility services.

Purportedly issued to comply with the requirement of consolidating skilled and intermediate care, the definition in Nursing Home Transmittal No. 135 of "nursing facility services" demonstrates a level of care standard that covers only skilled care. In fact, Transmittal No. 135 requires basically the same standard as the one that is required for Medicare skilled care.[9] Services under Transmittal No. 135 must be provided on a daily basis under the supervision of medical personnel.

CMS will not allow two standards for level of care (i.e., one for the waiver and one for nursing facilities). Maryland chose to keep the nursing facility services standard for the waiver rather than changing the existing eligibility standard to one that complies with the level of care standard outlined in the Maryland Medicaid waiver statute. The problem lies in the "nursing facility" definition under the regulations governing the Maryland waiver program.[10] Instead of following the intent of the waiver program *statute*,[11] the waiver program *regulations*[12] follow the level of care standard as Nursing Home Transmittal No. 135. Therefore, the regulations, which outline the implementation of the statute, use the stricter definition of "nursing facility services" and not the broader definition of "nursing facility" that was intended to govern waiver program eligibility.

Maryland's current medical eligibility standard[13] is arguably the strictest MA long-term care medical eligibility standard in the country and remains the governing eligibility standard for all MA long-term care programs in Maryland, including the waiver. With this standard in place, the waiver program is having difficulty fulfilling its purpose of providing services to allow Maryland residents to avoid institutionalization until absolutely necessary.

Eligibility Gaps

The MA waiver application system, as it is being implemented, creates a classic "Catch 22." A person cannot apply for benefits until he or she is financially eligible. In order to meet this requirement, the individual's countable resources must be either below $2,500 or below $2,000, depending on the category of eligibility, by the first day of the month for which he or she applies for benefits.

Under the current system, it is virtually impossible to have waiver eligibility granted as of the first day of that month. The Waiver Application, Freedom of Choice statement, and Provisional Care Plans would all have to be completed on the first day of the month benefits are being requested. This creates a gap in the service delivery system, a time period in which the person is not eligible for public benefits yet does not have the funds to pay privately for the services. This system is causing untold problems for consumers and providers alike.[14]

Maryland's Medical Assistance agency, the Department of Health and Mental Hygiene (DHMH), has advised that it is impossible to have eligibility for waiver services begin in the month of application, much less three months prior to the application, as mandated by the waiver statute incorporating the MA nursing home long-term care program rules. In addition, there are four dates that govern the eligibility process in Maryland:

1. **Date of Application.** This is the date the application is received by the area agency on aging. The 45-day time period to complete the case begins on this day.
2. **Date of the Freedom of Choice Statement.** This is the earliest date waiver eligibility can be granted. The Freedom of Choice form can be submitted with the application for waiver benefits. The date used is the date the form is signed, not the date it is received by the area agency on aging.
3. **Medical Eligibility Date.** This is the date the physician signs the 3871 form (describing the applicant's medical status) which is approved by Delmarva Foundation for Medical Care, Inc. Medical eligibility can be determined for any month, and the 3871 needs to state that it reflects the patient's condition as of a certain date. If this language is on the 3871, the medical eligibility date will be as of that date.
4. **Plan of Care Date.** This is the date the Maryland Department of Aging approves the care plan. Waiver eligibility can be granted no earlier than the latest of the four dates identified above.

As stated in a State Medicaid Director letter,[15] issued July 25, 2000, "[t]imely home and community-based services (HCBS) waiver eligibility determinations are particularly important to ensure that individuals awaiting imminent discharge from a hospital, nursing home, or other institution are able to return to their homes and communities." However, with the current practices regarding eligibility dates and determinations, the Maryland system is anything but efficient.

The earliest date on which eligibility can be granted is the date the Freedom of Choice statement is signed, as long as the applicant is both medically and financially eligible as of that date. DHMH advised that waiver eligibility could not be granted for a date earlier than the date this form is signed—even if the applicant was both medically and financially eligible and receiving services from an approved waiver provider at an earlier time. If the applicant is receiving services from an approved assisted living provider and meets financial and medical eligibility as of March 1, 2002 but the Freedom of Choice form is not signed until March 17, 2002, waiver eligibility cannot begin until March 17, 2002. The recipient would have general Medicaid coverage for the entire month,[16] but waiver services (including the full cost of assisted living services) would not be covered until the date the form was signed.

Although there is technically no income cap for waiver eligibility purposes, as the statute mandates a medically needy standard (like the nursing home long-term care program), there is a functional exception for those in assisted living facilities. In the context of receiving assisted living waiver services, there is an eligibility problem for those whose countable (not gross) income exceeds 300 percent of Supplemental Security Income (SSI), currently $1,635. An inconsistency exists where individuals whose income is less than 300 percent of SSI must contribute $420 towards room and board within assisted living facilities, while those whose income is more than 300 percent of SSI must spend down to $350 to meet the requirements of the waiver. Consequently, because of this $70 gap, individuals whose

income is greater than $1,635 will not be eligible to receive assisted living waiver services.

Since January 2001, the U.S. Department of Health and Human Services (HHS) has allowed an income disregard for MA eligibility. HHS changed the "requirement that limits on Federal Financial Participation must be applied before States use less restrictive income methodologies than those used by related cash assistance programs in determining eligibility for Medicaid."[17] Maryland DHMH officials claim no knowledge of this change in application of Federal Financial Participation limits. Therefore, Maryland continues to subject its older adults to inconsistent assisted living waiver eligibility rules and an unbridgeable $70 chasm.

Provider Issues

There is also an absence of general service providers, as well as providers offering the expanded range of waiver services introduced in January 2001. The expanded services include personal care, respite care, environmental accessibility adaptations, family or consumer training, personal emergency response systems, home-delivered meals, and dietitian/nutritionist services. Most people in the waiver program are receiving services from assisted living facilities and adult day care centers. Not all local jurisdictions in Maryland can provide all the covered services, as finding and keeping providers continues to be a problem.

In one case in Maryland, an application for Medical Assistance was made for home care benefits where both financial and medical eligibility were established shortly after the month of application, but no provider existed to provide services. In other cases, providers are unwilling and unable to wait until MA waiver eligibility is established. They are demanding payment when no funds are available to make payment. In another instance, an applicant who was medically and financially eligible as of the month of application is facing eviction from a MA participating provider. There are similar cases where providers have been awaiting payment for four months after an application was made and eligibility established.

Furthermore, there is a problem of delaying MA waiver eligibility and payment to providers until the month that technical eligibility is established (i.e., when the care plan is approved by the State Department of Aging), often months after the initial application has been made. State law specifically incorporates into the MA waiver program all of the financial eligibility rules of the long-term care program. Using just plain common sense, denying eligibility to medically and financially eligible applicants while technical eligibility is being established, arguably a mere ministerial act, will mean that countless otherwise eligible applicants will go without covered benefits—many facing eviction as a result of this bizarre circumstance.

Rules Not Understood

Other problems exist in terms of applying MA rules to the waiver program. There is a fundamental absence of understanding of the rules providing protection from spousal impoverishment and how to implement them for the waiver program. Benefits cannot be sought until a spousal resource assessment has been completed, thereby establishing either categorical eligibility or fixing spend-down amounts and a precise determination of protected spousal resources. The rules appear to require two appointments, one to fix the "spend down" and one to establish medical and technical eligibility.

Also, the program, as it is currently administered, seems to be counterintuitive in some of its rules and processes. For instance, MA is refusing to allow unmarried waiver assisted living participants to exempt home property. This is a disincentive for individuals to go from nursing homes to assisted living facilities. In addition, rather than facilitating individuals going from the community to nursing homes and vice versa, MA is requiring re-applications with all supporting documentation (for thirty-six months).

Lessons to Be Learned

There are some lessons to be learned from the Maryland experience with the Medicaid waiver. Hopefully, lawyers and lawmakers in other states can learn from the variety of issues that emerged concerning the waiver program.

The medical level of care standard must be practical in order to be implemented in a community-based setting. With the current medical eligibility standard in place,[18] Maryland's waiver program allows Maryland residents to avoid institutionalization only when institutionalization is absolutely necessary, and not before (arguably defeating the purpose of the program). In order for the waiver program to effectively fulfill its purpose, the medical eligibility standard must be one that is appropriate for the behavioral and functional characteristics of the waiver's targeted population.

Furthermore, the MA agency has to commit to the timely and effective implementation of the waiver program, i.e. actively soliciting providers, facilitating the application processes, following the rules of the program, conducting regular training programs. In Maryland, the MA agency must acknowledge the change in application of Federal Financial Participation limits[19] so that Maryland MA waiver rules are not in violation of federal regulations.

Last, the Centers for Medicare and Medicaid Services (CMS) need to understand and close the eligibility gap in the service delivery system. Applicants should not have to endure this time period in which they are not eligible for public benefits, yet do not have the funds to pay privately for the services.

Lawyers and lawmakers must take an active role in monitoring the MA agency's work. Elder law practitioners must be vigilant regarding their clients' waiver applications in order to recognize any discrepancies between the actions of the MA agency and the rules that govern the waiver program.

Endnotes

1. MD. HEALTH GEN. CODE ANN. §15-132 (2001); MD. REGS. CODE tit. 10, § 09-54 (2001).
2. NURSING HOME TRANSMITTAL NO. 135, MD. DEPT. HEALTH AND MENTAL HYGIENE (April 18, 1994).
3. *Id.*
4. MD. HEALTH GEN. CODE ANN.§15-132 (2001).
5. 42 U.S.C. §1396r(a); 42 C.F.R. § 409.31(a)(1).
6. 42 U.S.C. §1396r(a).
7. 42 U.S.C. §1396r(a); 42 C.F.R. § 409.31(a)(1).
8. OBRA-1987, Pub. L. No.100-203, 101 Stat. 1330.
9. 42 C.F.R. § 409.31.
10. MD. REGS. CODE tit. 10, § 09-54.
11. MD. HEALTH GEN. CODE ANN. §15-132 (2001).
12. MD. REGS. CODE tit. 10, § 09-54.
13. NURSING HOME TRANSMITTAL NO. 135, MD. DEPT. HEALTH AND MENTAL HYGIENE (April 18, 1994).
14. For example, this may result in neglect, self-neglect of the older adult, or inappropriate requirement of family contribution.
15. STATE MEDICAID DIRECTOR , MD. DEPT. HEALTH AND MENTAL HYGIENE, EARLIEST ELIGIBILITY DATE IN THE HCBS WAIVER - POLICY CHANGE, UPDATE NO: 3 (July 25, 2000).
16. For example, general Medicaid coverage includes the cost of the recipient's prescriptions.
17. 42 C.F.R. § 435.
18. NURSING HOME TRANSMITTAL NO.135, MD. DEPT. HEALTH AND MENTAL HYGIENE (April 18, 1994).
19. 42 C.F.R. § 435.