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Testimony of Leo J. Delicata, Esq., Legal Services for the Elderly, in favor of L.D. 488 An Act To Improve Access to Home-based and Community-based Care in the MaineCare Program

Senator Craven, Representative Farnsworth and members of the Joint Standing Committee on Health and Human Services,

The MaineCare program described in this legislation gives Maine people and important option. Eligible elderly and disabled adults who are ill enough to qualify for care in a nursing facility may choose to receive care in their own homes instead of moving to a nursing facility.

This was not always the case. For many years, the federal Medicaid program provided assistance with care in institutional settings but it did not have a home health option for the chronically ill. The authority for the creation of alternative home based programs began in 1981 with an amendment to Section 1915c of the Social Security Act. This change allowed the Secretary of Health and Human Services (HHS) to waive certain specific Medicaid statutory requirements. That is why these programs are called "waiver" programs. As a result, States could elect to offer home and community-based services to specific group(s) of Medicaid beneficiaries who needed a level of institutional care provided under the Medicaid State plan.

Maine's 1915c Elderly and Adults with Disabilities Waiver specifically recognizes the requirement that in order to be eligible for this waiver one must qualify for institutional care:

"The purpose of the Elderly and Adults with Disabilities Waiver is to provide services which allow Medicaid eligible persons who need nursing facility level of care to remain at home while receiving the necessary care that allows them to live independently in the community. This waiver is a home and community-based alternative to living in a nursing facility. The

waiver supports Maine's goal of encouraging the use of home and community based services as an effective and appropriate alternative to nursing facility use. It provides Maine citizens with quality care in the least restrictive, most desired setting – their home."
Application for 1915(c) HCBS Waiver: ME.0276.R03.00 - Jul 01, 2008, Brief Waiver Description 2

While this statement appears to allow anyone who qualifies for nursing facility care to become eligible for the waiver this is not exactly the case. Later in the waiver application additional language makes it clear that there is a limit to the amount of care available through the program. In Section B-2-a an institutional limit is accepted as part of the program:

"...Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. "Application for 1915(c) HCBS Waiver: ME.0276.R03.00 - Jul 01, 2008 section B-2-a.

The reference to "the level of care specified for the waiver" is explained in Section F of the Request for Information part of the Application as follows:

"F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):...
Nursing Facility As defined in 42 CFR §440.40 and 42 CFR §440.155"...

One of the attractions of the 1915c waiver programs was that a state, to a large extent, could tailor the population and the services included in the waiver. However, while there is no limit on the number of services that a state may offer in a waiver and no requirement to include specific services, the state must demonstrate "cost neutrality" during the term of the waiver in exchange for the flexibility that a waiver provides.

§1915(c) (2) (D) of the Social Security Act requires that a state assure that the average per capita expenditure under the waiver during each waiver year not exceed 100 percent of the average per capita expenditures that would

have been made during the same year for the level of care provided in a hospital, nursing facility, or ICF/MR under the State plan had the waiver not been granted.

The requirement of cost neutrality and how it is applied is the reason for the legislation before you. LD 488 recognizes that the cost neutrality requirements and the eligibility criteria for the waiver are being confused and that some individuals are not receiving the amount of care that they should be getting under the waiver.

While all who apply for waiver services must meet the medical eligibility criteria for nursing facility care described in our state regulations not all require the same amount of services to meet their particular needs. Some require more and some require less. The same can be said of individuals in nursing facility settings. In fact, nursing facility reimbursement under our Medicaid program recognizes this fact and contains a multiplier for the acuity of each particular resident.

The cost neutrality formula speaks in terms of "average" expenditure. It does not require nor does it expect that services for each member in the waiver will cost the same. If it did it would be an incorrect usage of the term "average". Nor do the calculations that the state must perform in its application for a waiver renewal require the treatment of those averages as a cap or limit on services for a particular individual. Those averages are well below the actual expenses that would be generated in facilities for the same population.

Our waiver states what one must show to be eligible for the waiver and it specifically provides a cost limit. As previously stated the state may refuse entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver.

On the other hand, our state regulations for the waiver state a slightly different eligibility formula:

"A member meets the requirements of this Section when all of the additional following conditions are met:

A. The projected cost of services under this Section needed by the member on a monthly basis is estimated to be less than one hundred percent (100%) of the **average** monthly MaineCare cost of care in a nursing facility; (bold added)"

10-144 Chapter 101, MaineCare Benefits Manual Ch II, Section 19.02-3 Home and Community-Based Benefits for the Elderly and for Adults with Disabilities, Eligibility for Care, Other specific requirements

It appears that while the eligibility language in the waiver is correctly focused on the individual, the formula in the regulations is really a restatement of the cost neutrality statement which by definition is focused on the group "average". As a result, an individual who needs and would receive a high volume of services in a nursing facility would not be allowed more than an "average" amount of services in the individual's own home.

LD 488 asks you to recognize that difference and ensure that our regulatory language is clarified to reflect the concept set out in the waiver itself. The following change to the regulation is another suggestion of how that could be accomplished:

B. The projected cost of services under this Section needed by the member on a monthly basis is estimated to be less than one hundred percent (100%) of the ~~average~~ monthly MaineCare cost of the member's care in a nursing facility;

In any case a change is needed to make the language of our regulations and the way the waiver is managed consistent with the intent of our waiver.

Thank you for letting me share my thoughts with you today.