What’s New in Maryland Medicaid

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Overview

- Big Picture
- Health Care Reform
- Long Term Care
  - Current System
  - HCBS Waivers
  - CommunityChoice
  - DRA
Big Picture

- FY2008 Medicaid budget is $5.1 billion
- Medicaid growth is not sustainable
- Over the past several years, the average annual growth rate for Medicaid expenditures has been close to 9% per year (although trends have slowed in the most recent fiscal year)
  - Pharmacy costs up approximately 12% per year
  - Long term care costs up approximately 10% over the past several years
- Medicaid makes up an increasingly large portion of the State budget – approximately 16% (general funds)
- Long term care services: 30% of the Medicaid budget for 5% of population
Public Coverage
(Effective 07/01/06)

Note: This chart is for illustrative purposes only. Each coverage group has specific eligibility and some asset requirements, which are not shown.

Poverty Level:
1 person = $10,210
2 persons = $13,690
4 persons = $20,650

As of 1/24/2007
Medicaid Expenses by Enrollment Category

Enrollees = 594,300  Payments = $5.06 Billion

Excludes data for individuals with partial benefits
Medicaid Long Term Care Today

- Fee for service
- Defined benefits package
- Institutional bias
- Case management is service-specific
- 1915(c) waivers offer better benefits to a limited population
Current Long Term Care System

- Fundamental problems in Medicaid
  - No systemic incentives for cost efficiency, especially if savings accrue to Medicare
  - No coordination with Medicare
  - Not sufficient flexibility to provide services that best meet the needs of consumers
  - System is fragmented, not consumer-friendly
People want to live in the community!

- States are looking for new ways to keep people in the community or transition them from nursing homes
  - Home and Community-based services (HCBS) waiver programs/1915c waivers
  - Managed LTC/CommunityChoice
  - Deficit Reduction Act
HCBS Waivers

- Waiver authority enacted by Congress in 1981
- Expand HCBS access to individuals who meet institutional level of care
- Allow states to waive certain federal requirements
  - Expand covered services to include services not traditionally covered by Medicaid
  - Establish specific financial and technical eligibility criteria for the waiver
- Cost-effectiveness requirement
  - Cannot cost more to serve waiver enrollees in community than in an institution
HCBS Waivers

- Maryland has 7 HCBS waivers; in FY08, waivers will serve more than 16,600 individuals.
- There is a high demand for waiver services.
- Many waivers are out of “slots” and not accepting new community applicants.
- In December 2002, DHMH developed a “Money Follows the Person” policy
  - Individuals in nursing facilities whose services are paid by Medicaid may apply to the OAW or LAH waiver, regardless of the number of available “slots”
## HCBS Waivers

<table>
<thead>
<tr>
<th>Waiver</th>
<th>Funded Waiver Slots - FY08</th>
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<tbody>
<tr>
<td>Older Adults Waiver</td>
<td>3,750</td>
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<tr>
<td>Living at Home Waiver</td>
<td>500</td>
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<tr>
<td>Waiver for Children with Autism Spectrum Disorder</td>
<td>900</td>
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<tr>
<td>Waiver for Individuals with Developmental Disabilities</td>
<td>10,988</td>
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<td>New Directions Waiver (Developmental Disabilities)</td>
<td>300</td>
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<tr>
<td>Model Waiver for Medically Fragile Children</td>
<td>200</td>
</tr>
<tr>
<td>Waiver for Individuals with Traumatic Brain Injury</td>
<td>35</td>
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</tbody>
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Waiver Services Registry

As of September 2007, the Waiver Services Registry has:

- 9,800 individuals interested in OAW
- 1,780 individuals interested in LAH
- 2,125 individuals interested in AUT
CommunityChoice Goals

- Develop alternatives to institutional care
- Coordinate acute and long term care services and financing with Medicare
- Control growth of long term care costs
- Flexibility to provide services specific to the needs of the client (e.g. assisted living, home modifications)
- Accountability for outcomes and quality of care
- Develop consumer-directed options
Proposal

- Managed care program called CommunityChoice
  - Legislation passed in 2003, vetoed by legislature, overridden by Governor

- Mandatory enrollment for dual eligibles and people who need LTC

- Enrollees required to choose a “community care organization” or “CCO” that becomes responsible for all Medicaid services

- Integrate financing and management with Medicare to the extent possible

- Build on concept of PACE program
Population

- All adult dual eligibles (approx. 75,000 statewide)
- All adult Medicaid recipients who qualify for nursing home level of care
- All other Medicaid recipients age 65+
- Includes:
  - All nursing facility residents
  - Participants from two 1915(c) waivers
    - Older Adults Waiver
    - Living at Home Waiver
Proposal

- Services include primary, acute, and long term care services, and flexibility to cover other services to meet enrollees’ needs
- Expanded HCBS services to more people
- Entirely new perspective on quality assurance
  - Aggressive quality assurance and quality improvement
  - Focus on outcomes
Legislative Mandates

- Specialty mental health services are carved out of CommunityChoice
- Revised to pilot in two geographic areas of the State (two-thirds of statewide population)
  - In those areas, enrollment will be mandatory
- Certain provider rate guarantees
Challenges & Opportunities

- Coordination with Medicare and integrating the financing of care
- Protecting consumers’ rights, choice, access to high-quality health care
- Politics and special interests
- Developing capitation rates for population
Now What?

- Sent to CMS in August 2005, CMS denied in March 2007
  - Redo as a 1915 (b) and (c)
- Lessons Learned
- Next Steps: new LTC plan in January 2008
Deficit Reduction Act (DRA)

- Federal government passed DRA in February 2006.
- Expected to save millions of dollars through “reductions” by beneficiary premiums/cost sharing, changes in benefits and stricter asset transfer rules.
- Mandatory and optional initiatives.
- Maryland awarded Money Follows the Person rebalancing demonstration grant.
Money Follows the Person Rebalancing Demonstration

- Creates a new program to offer enhanced services to individuals who transition from an institution to the community
- Enhanced match for participants for one year (75% FFP, 25% GF)
- Eligibility for MFP
  - Six months in an institution, at least one month of Medicaid eligibility
  - Participants must transition from a qualified institution to a qualified community residence
  - Maximum of four unrelated individuals in a single residence
Money Follows the Person Rebalancing Demonstration

- Inclusive stakeholder process, multiple planning meetings
- Operational protocol due to CMS by November 1, 2007
- Program to begin in 2008