Chapter Six

Access To Appropriate Health Care Services: The Role of the State Medicaid Program

A. Current Law

1. *Introduction*

Medicaid, also known as Medical Assistance, is a State and federally funded health insurance program that pays health care providers to provide care to indigent persons and "medically needy" persons.[1] Medicaid is governed by both State and federal laws and regulations. Medicaid-funded services include acute and primary care, long-term and chronic care, and hospice care.[2]

Medicaid is one of the costliest programs in each year's State budget, with an annual appropriation of almost $4 billion. Yet, with a growing rate of inflation in health care costs, Medicaid costs often outstrip the budget. In the 2002 legislative session, for example, the Department of Legislative Services attributed a $277.1 million deficiency appropriation "to enrollment growth, higher than budgeted nursing home and managed care costs, and the payment of fiscal 2001 bills with fiscal 2002 dollars."[3] The Department estimates that Medicaid costs will increase by more than eight percent annually over the next five years.[4]

2. *Financial eligibility*

To obtain medical services under Medicaid, a person must meet specific medical and financial eligibility criteria. The financial eligibility criteria differ depending on whether care is provided in an institutional setting or in a community setting. To illustrate, if a person needs the type of care provided in a nursing home, the financial eligibility rules are that:

- the applicant's monthly income must be less than the monthly amount to be paid to the nursing home (currently on average $3750); and

- the applicant's assets must be no greater than $2500.[5]

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If a person does not need institutional-type care, the financial eligibility rules are quite different:

- The applicant's income must not exceed $350 per month; *or*

- The applicant can "spend down" to $350 per month in this way: If the applicant's income exceeds $350 per month, *and* the applicant has medical bills, paid or unpaid, the amount of those bills can be subtracted from the applicant's income to "spend down" to $350 per month. A person must meet the spend-down rules every six-month period.

- And, the applicant's assets must be no greater than $2500.[6]

Hence, if a person needs care at home or in a community setting, the financial eligibility rules require

that person to be either very poor or made indigent every six months by medical bills. If a person needs care in a nursing home, for eligibility purposes, the person's income can initially be much greater than $350 per month, as long as the nursing home bill per month is more than the monthly income. But no matter which financial eligibility category a Medicaid recipient falls into, each is or becomes indigent because of the burden of paying medical bills.

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The Medicaid Personal Care Program provides in-home personal care services to an eligible individual who requires assistance with one or more activities of daily living (ADL). These include bathing, eating, dressing, toileting and ambulation.[7] In addition to assistance with ADL's, personal care services include household chore services, food shopping, food preparation and other related services.[8]

The Medical Day Care Program serves eligible persons "who have a place to live and a support system in the community" (Community Access Steering Committee 2001, at 30). In a day care setting, this program provides personal care, nursing, social work, and nutrition services, as well as habilitative therapies and other medically supervised health-related services.[9]

Finally, Medicaid pays for all or part of needed nursing home care for eligible persons.[10] Indeed, most Medicaid recipients with long-term care needs are served in nursing homes and other similar facilities. In 1997, nearly 64 percent of total patient days in

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Maryland nursing homes were paid for by Medicaid (Maryland Health Care Commission 2000).

Increasingly, however, long- term care is being provided in community settings rather than institutional ones. In part, this increasing emphasis on community-based care is the result of a Supreme Court decision, *Olmstead v. L.C.*,[11] which held that Title II of the Americans with Disabilities Act requires states, under certain circumstances, to place qualified individuals with mental disabilities in community settings, rather than institutions. Legal considerations to one side, policy makers have also come to recognize, in the words of an executive order issued by President Bush, that "community-based alternatives for individuals with disabilities ... advance the best interest of [all] Americans," not just those with disabilities.[12]

Responding to these developments, the Medicaid Program has implemented several programs designed to provide access to long-term care services in the community. Because these programs are based on approvals from the federal government permitting a state to waive certain restrictions in federal Medicaid law, these programs are called "waiver programs." In a waiver program, a state may pay for additional services not traditionally covered by Medicaid (for example, respite care). A state may also establish more generous financial eligibility requirements.

One of the four waiver programs that Maryland has implemented is of particular interest to those with AD. The Waiver for Older Adults Program, implemented in January 2001, provides assisted living facility services, in-home personal care, and other support services to maintain an elderly person in a community setting for as long as possible.[13] To be eligible to receive these services, an elderly person must require nursing home level of care.[14] Because of the popularity of this program, however, very few openings are available each year.

B. Access to Appropriate Care

Experience with the Medicare program suggests that people with AD are at risk of being denied necessary and appropriate care based solely on the misapprehension that those with AD cannot benefit from the particular service.

Most acute and primary care services for people with AD are covered by Medicare, not Medicaid, because most people with AD are aged 65 or over and thus qualify for Medicare. It is possible, however, that some people with early-onset AD (or other causes of early dementia) are covered by the Medicaid program for their overall medical needs. As described in the regulations governing the Medicaid Managed Care Program, an enrollee is entitled to "medically necessary and appropriate" primary, specialty, hospital, and primary mental health services, as well as specialty mental health services provided through the State's public mental health system.[15]

Experience with the Medicare program, however, suggests that people with AD are at risk of being denied necessary and appropriate care based solely on the misapprehension that those with AD cannot benefit from the particular service. For example, some Medicare fiscal intermediaries denied access to rehabilitative and psychotherapeutic services solely because of an AD diagnosis. Such a policy is based on the mistaken premise that no one with AD could benefit from these services. The proper policy is one of individualized determination, based on the premise that while some people with AD indeed cannot benefit from these services, others can. To make this point clear, the Centers for Medicare and Medicaid Services (CMS), the administrator of the Medicare program, has issued a transmittal instructing its fiscal intermediaries and carriers that they may not deny services based solely on a diagnosis of dementia.[16]

RECOMMENDATION 6-1: The Medicaid Program should take steps to assure that its participating managed care and utilization review organizations do not deem a service to be medically unnecessary or inappropriate for a patient based

solely on the fact that the patient has been diagnosed with AD.

C. Level of Care Determinations

To be eligible to receive nursing home care or community-based services under the Waiver for Older Adults Program, an applicant must be approved by the Medicaid Program as needing "nursing facility services".[17] This "level of care" determination process raises issues about barriers to care for people with AD.

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The term "level of care" refers to the intensity of medical services a person needs based on the degree of impairment (Center for Health Program Development and Management 2000, at 9). For example, at the moderate stage of AD, a person may need minimal assistance with activities of daily living such as bathing, eating, or taking medication. This level of care usually can be provided at home or in an assisted living facility, often by a personal care aide. As the disease progresses, however, the person's need for care will likely intensify. At advanced stages of AD, the person may need the level of care provided in a nursing home. Under Medicaid regulations, this level of care refers to the services "provided to individuals who do not require hospital care, but who, because of their mental or physical condition, require skilled nursing care and related services, rehabilitation services, or, on a regular basis, health-related care and services (above the level of room and board) which can be made available to them only through institutional facilities under the supervision of licensed health care professionals."[18]

A person's physician ordinarily recommends what the physician believes is the appropriate type and level of care. The Medicaid Program may review that recommendation. If a physician decides that nursing home level of care is medically necessary, the

Program conducts an independent assessment of the person's medical condition, mental impairment, and ability to perform ADLs. This assessment is conducted under the criteria in Transmittal 135, the official policy statement of the Medicaid Program describing and explaining the eligibility criteria for nursing home level of care (Center for Health Program Development and Management 2000, at 4).

Some advocates believe that, under Transmittal 135, the level of care assessment is too restrictive, discourages people from applying for Medicaid at all, or fails to address adequately cognitive and functional impairments (Center for Health Program Development and Management 2000, at 22). Yet, this Office has concluded that Transmittal 135 is not inconsistent with the requirements of federal and State law.[19] Indeed, one study found that, although the Medicaid Program's eligibility determinations under Transmittal 135 were challenged in 200 contested cases, the Program ultimately prevailed in *every* case (Center for Health Program Development and Management 2000, at 49).

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Regardless of the Program's success in defending Transmittal 135, the controversy about it is itself dispiriting. Negative public perception is inconsistent with the fostering of community-based care and may discourage applications from those who legitimately need a high level of care (Center for Health Program Development and Management 2000, at 22). Ultimately, what counts is the accuracy and fairness of the level of care assessment process. Eligibility for nursing home care opens the door to much more than a placement in a nursing home. It also opens the door to the option of community-based care such as Medical Day Care or services through one of the Medicaid waiver programs. These programs are unavailable to persons who are not in immediate need of nursing home care. Hence, until a person meets this level of care standard, as applied through Transmittal 135, an array of Medicaid community-

based services is not available. In light of this barrier, the Community Access Steering Committee recommended that "the State develop a new, more consistent medical eligibility determination (level of care) process that is easily understood and includes a more detailed assessment of cognitive and functional needs." (Community Access Steering Committee 2001, at 75).

If the current assessment process is indeed flawed with respect to the manifestations of AD, some people with AD are not receiving Medicaid long-term care benefits to which they are entitled, whether those services are provided in nursing homes or in community settings.

For persons with AD, the current assessment process may be particularly problematic. In 1991, the Advisory Board on Alzheimer's Disease recommended certain level of care assessment criteria to the Medicaid Program. Three years later, in consultation with representatives from the Alzheimer's Association, the Medicaid Program added new criteria to the assessment process, including indicators for memory and orientation, behavior issues, and mini-mental examination scores.

Despite these additions, the current assessment process may not be as responsive to individuals with AD as it could be (Center for Health Program Development and Management 2000, at 11). If the current assessment process is indeed flawed with respect to the manifestations of AD, some people with AD are not receiving Medicaid long-term care benefits to which they are entitled, whether those services are provided in nursing homes or in community settings.

RECOMMENDATION 6-2: The Medicaid Program should take appropriate steps to revise the level of care assessment tool as promptly as possible and should work in collaboration with the Alzheimer's Association to enhance the sensitivity of the tool for AD patients.

RECOMMENDATION 6-3: The Medicaid Program should promptly review whether Transmittal 135 has outlived its usefulness and should be replaced.

Despite Medicaid's relatively small part in the financing of hospice care, federal requirements create at least one barrier to this care that adversely affects AD and other nursing home patients.

D. Hospice Care

1. Overview

Although Medicaid finances a wide range of services to meet the long-term care needs of eligible persons, it plays a much smaller role in financing hospice care. Medicare, rather than Medicaid, plays the major funding role for hospice care because, at age 65, a Medicaid recipient usually becomes eligible for Medicare. In the publicly-funded health benefits system, Medicare is considered the "payer of first resort."[20] For persons dually eligible for Medicare and Medicaid needing hospice care, therefore, Medicare pays for the hospice service and the Medicaid Program pays only the co-payment and deductible that Medicare imposes.[21] If the dually eligible person is in a nursing home when the need for hospice care arises, as would often be true of AD patients, the Medicaid Program will also pay the nursing home's room and board charge.[22]

2. *Payment system*

Despite Medicaid's relatively small part in the financing of hospice care, federal requirements create at least one barrier to this care that adversely affects AD and other nursing home patients. Section 1905(o)(3) of the Social Security Act specifies that the payment of nursing facility room and board costs may not be paid directly to a nursing facility but, rather, must be paid to the hospice provider. In turn, the hospice provider must make a "pass through" payment to the nursing facility for the room and board. Maryland's Medicaid Program pays the hospice provider an amount equal to 95 percent of the per diem rate that Medicaid would have paid to the nursing facility for that patient. The hospice program then pays the nursing home. This system, commentators have pointed out, is neither fair nor efficient:

> Several problems result from this payment system. Reportedly, nursing homes rarely accept less than 100 percent of the Medicaid room and board payment. As a result, hospices generally pay full room and board costs, which means that they suffer a financial loss. In addition, the nursing home's payment can be disrupted or payment to the hospice can be delayed when the Medicaid program switches from paying the nursing home for people who are already residents to paying the hospice. Finally, it is not clear who should collect the spend down payments (i.e., the contributions toward the cost of care) that medically needy and other nursing home residents pay when they are Medicaid.

(Tilly and Wiener 2001, at 17-18.)

This payment policy creates a disincentive for nursing homes to offer hospice services in their facilities. Some nursing homes refuse to contract with hospice providers, in part because of this cash flow issue. If a nursing home does not have a contract with a hospice provider, a nursing home resident who wants hospice care must relocate to another nursing home to receive hospice services. This is obviously disruptive and potentially very distressing to the resident and the family.

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In addition, a recent study of Maryland hospices and nursing homes reported the view that delay in Medicaid payments to hospices is a "major obstacle": "While the nursing home can get paid from Medicaid within a few weeks, it can take three or four months for the hospice to get paid from Medicaid. Some larger hospices have the ability to pay the nursing home upfront while they wait to receive Medicaid payments, but smaller hospices typically do not have the financial

surplus for these types of arrangements" (Hoffmann and Tarzian 2004).

RECOMMENDATION 6-4: The Medicaid Program should consult with representatives of nursing homes and hospice to consider how to remove financial disincentives to the use of hospice in nursing homes.

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(Hoffmann and Tarzian 2004).

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Hoffmann, D.E. and A.J. Tarzian 2004. "Obstacles to Hospice Utilization in Nursing Homes: The Impact of the OIG Fraud Alert." Unpublished manuscript.

Maryland Health Care Commission 2000. *Long Term Care Chartbook 2000*. Baltimore: Maryland Health Care Commission.

Tilly, J. and J. Wiener 2001. *Medicaid and End-of-Life Care*. Washington: The Urban Institute.

Endnotes

1. Health-General Article, §15-102 of the Maryland Code.

2. The federal regulations governing Medicaid are to be found at 42 C.F.R. Subchapter C; the State regulations, at COMAR 10.09. As noted later in this chapter, however, many of the detailed specifications for Medicaid are in manuals and transmittals, not codified regulations.

3. Operating Budget Analysis Documents, Medical Care Programs Administration (MQ.00), http://mlis.state.md.us/2002RS/budget_docs/All/Operating/M00Q_-_DHMH_Medical_Care_Programs_Administration.pdf (accessed September 5, 2002).

4. Office of Policy Analysis, Fiscal Briefing, http://mlis.state.md.us/Other/2003_Fiscal_Briefing/Fiscal%20Briefing_071503.pdf (accessed August 8, 2003).

5. COMAR 10.09.24.10.

6. COMAR 10.09.24.09.

7. COMAR 10.09.20.01A(1).

8. COMAR 10.09.20.04.

9. COMAR 10.09.07.01A(5) and .06(A).

10. COMAR 10.09.10.

11. 527 U.S. 581 (1999).

12. Executive Order 13217, 66 Fed. Reg. 33155 (June 21, 2001). A comparable point of view is expressed in the executive order creating the Community Access Steering Committee. Executive Order 01.01.2000.13 (July 26, 2000).

13. COMAR 10.09.54.

14. COMAR 10.09.54.03A(1). The Medicaid Program advocated to the federal government that Maryland's Older Adult Waiver should be open to those "at risk" of needing nursing home care. Unfortunately, federal authorities would not approve the proposed "at risk" criterion.

15. COMAR 10.09.67.02, .03, .05, .07, .08, and .26 and COMAR 10.09.70.

16. CMS Transmittal AB-01-135 (September 25, 2001).

17. COMAR 10.09.10.06.

18. COMAR 10.09.10.01B(31).

19. Advice letter from Assistant Attorney General Robert McDonald to Senator Paula Hollinger (February 16, 1999).

20. COMAR 10.09.03.07.

21. *Id.*

22. *Id*.