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ALTERNATIVES TO NURSING HOME CARE

House Bill 4439 (Substitute H-2)
First Analysis (6-8-88)

Sponsor: Rep. Lynn Owen
Committee: Social Services & Youth

THE APPARENT PROBLEM:

Generally, all persons receiving Medicaid services are entitled to the same services and treatment for comparable needs. However, there are some circumstances in which the federal government allows states to waive normal eligibility requirements for services. Amendments made to the federal Omnibus Reconciliation Act in 1981 gave states the authority to pursue home and community-based services waivers from federal Medicaid regulations. The waivers were, in part, a means of addressing the increase in hospitalization costs and decrease in nursing home and institutional care resources plaguing the health industry. Now that waivers are available for home and community-based services, Michigan should develop a home and community-based services program for Medicaid recipients and seek the waivers as a means of addressing the increased institutionalization costs faced in the health care industry.

THE CONTENT OF THE BILL:

The bill would amend the Social Welfare Act to provide that the Department of Social Services would include, as part of its program of medical services, home or community-based services to eligible persons whom the department determines would otherwise require nursing home services or similar institutional care services. The home or community-based services would be offered to qualified eligible persons who were receiving inpatient hospital or nursing home services as an alternative to those forms of care. For a person to qualify for home or community-based services, the person would have to be eligible for inpatient hospital or nursing home services and the estimated expenditure for the services for the person would have to be determined not to exceed the estimated expenditure that would have been made if the person received nursing home services, inpatient hospital or similar institutional care services instead.

Under the bill, the average per capita expenditure for home or community-based services for eligible persons receiving those services could not exceed the estimated average per capita expenditure that would have been made for those persons had they been receiving nursing home services, inpatient hospital or similar institutional care services instead. The bill would require the department to seek a waiver from the federal Department of Health and Human Services necessary to implement the program. The department would establish policy for identifying the rules for persons receiving inpatient hospital or nursing home services who could qualify for home or community-based services. The rules would contain, at a minimum, a listing of diagnoses and patient conditions to which the option of home or community-based services could apply, and a procedure for reviewing the case of each person receiving inpatient hospital or nursing home services to determine if the person qualified for the services. A review would begin no later than seven days after a person had begun to receive inpatient hospital or nursing home services.

The department would provide a quarterly report to the legislature and the governor, categorized by diagnosis, patient condition, or other criteria established under the rules which showed the detail of its case finding and placement activities. The bill would require the report to contain, at a minimum, each of the following:

- the number of persons reviewed by the department during the quarter;
- the number of persons offered the option of home or community-based services during the quarter, and the number who selected and refused the option;
- the number of patients who were determined to not qualify based on cost considerations during the quarter; and
- the total number of persons receiving home or community-based services during the quarter.

Home or community-based services would include safeguards adequate to protect the health and welfare of participating eligible persons, and would be provided according to a written plan of care for each person. The written plan of care would not be changed unless the change was prospective only and the department consulted with the eligible person (or, in the case of a child, with the parent or guardian) at least 30 days before making the change, and with each medical service provider involved in the change. Consultation would have to be documented in writing. A person who was determined to be eligible for nursing home services or similar institutional care services would be informed of his or her choice of receiving home and community-based services instead. An eligible person who was receiving home or community-based services and who was dissatisfied with a change in his or her plan of care or a denial of any home or community-based service, could demand a hearing and subsequently could appeal the hearing decision to circuit court. The department would provide a quarterly report to the legislature and governor detailing the number of hearings requested and the outcome of each hearing which had been judicated during the quarter.

MCL 400.109a

FISCAL IMPLICATIONS:

According to the Department of Social Services, the fiscal implications of the bill cannot be determined. (6-7-88)

ARGUMENTS:

For:

For people receiving health care, surroundings can have a direct effect on emotional well-being. A person receiving health care often responds more positively in surroundings with which he or she is intimately familiar. The bill would allow Medicaid recipients to choose the option for care which they believe would give them the best quality of life. Many health care experts have noted that home and

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community-based services are frequently as cost-effective as institutional care. In addition, many states have implemented home and community-based services under the federal waiver program with positive results. Further, it appears that the new federal catastrophic health care legislation would allow more liberal Medicaid eligibility standards to be applied when paying for in-home services results in financial strain for couples. This recent change in the federal eligibility standards would reinforce the home and community-based program proposed in the bill.

Against:

One of the reasons that the department has not sought waivers for home and community-based services in the past is that federal waivers are often costly to administer. The federal government imposes strict cost standards and reporting requirements for maintenance of waivers. It is not uncommon for a state to have its waiver revoked because the state could not afford the costs and the staffing needed to maintain federal standards. The requirement to seek a federal waiver would impose unnecessary costs and administrative burdens on the department and should be deleted from the bill, especially since a federal waiver is unnecessary to carry out the concept embodied in the bill. Over the years, the department has explored several ways to use home and community-based services without federal waivers. According to the department, nearly 25,000 persons received personal care and chore services in their homes during fiscal year 1986-87 at a cost of $55 million. Approximately 75 percent of the services were Medicaid funded (chore services are not Medicaid benefits). Waivers should remain an option that the department could pursue, but should not be a requirement.

POSITIONS:

The Department of Social Services supports the bill. (6-7-88)