STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

January 21, 2014

The Honorable Martin O'Malley
Governor
100 State Circle
Annapolis, MD 21401-1925

The Honorable Thomas V. Mike Miller, Jr.
President of the Senate
H-107 State House
Annapolis, MD 21401-1991

The Honorable Michael E. Busch
Speaker of the House of Delegates
H-101 State House
Annapolis, MD 21401-1991

Re: SB 620/HB 946 (Chapters 426 and 427 of the Acts of 2004) and Health – General §15-135(g) – Report on Home- and Community-Based Long-Term Care Services

Dear Governor O'Malley, President Miller and Speaker Busch:

Enclosed please find a report pursuant to SB 620/HB 946 – *Money Follows the Individual Accountability Act*, which passed during the 2004 session of the General Assembly. The report addresses the Department's efforts to promote home and community-based services and to help nursing facility residents transition to the community.

If you have any questions or need more information on this subject, please contact Christi Megna, Assistant Director of Governmental Affairs at (410) 767-6509.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Secretary Gloria Lawlah
Secretary Cathy Raggio
Chuck Milligan
Mark Leeds
Christi Megna
Sarah Albert, MSAR #8421

Money Follows the Individual Accountability Act Report
December 2013

Health-General Article §15-135 requires the Department of Health and Mental Hygiene (DHMH) to report to the Governor and the General Assembly on:

(1) DHMH's efforts to promote home and community-based services;
(2) The number of nursing facility residents referred by nursing facility staff or identified on the Minimum Data Set assessments as expressing a preference to return to the community;
(3) The number of nursing facility residents who transitioned from nursing facilities to home and community-based waiver services;
(4) Any obstacles DHMH encountered in assisting nursing facility residents to make the transition from a nursing facility to a community-based residence; and
(5) DHMH's recommendations for removing the obstacles.

This report is intended to satisfy these reporting requirements.

BACKGROUND

The Medicaid Program has offered home and community-based services as an alternative to nursing facility placement for many years. The range of community options continues to expand as the Medicaid Program implements provisions of the Affordable Care Act. Options began to increase dramatically in 2001 with the implementation of both the Older Adults Waiver (administered by the Department of Aging) and the Living at Home Waiver (administered by DHMH). The Living at Home Waiver, serving working-age adults with physical disabilities, was the first program designed to serve a significant number of people transitioning from nursing facilities back into the community. The Older Adults Waiver, serving individuals 50 years and older, also assists individuals with transitioning back to the community.

DHMH has both initiated efforts and partnered with other State agencies and community organizations to promote home and community-based services. Strategies implemented over the past several years to reach out to nursing facility residents include:

- Peer to peer outreach and support services;
- Distribution of community options fact sheets to nursing facility residents, social workers, and administrators;
- Development and distribution of a booklet which describes Maryland Medicaid Home and Community-Based Long Term Care Services; and
- Minimum Data Set (MDS) 3.0 section Q referral outreach.

Medicaid's home and community-based services waivers are limited by enrollment caps and budget allocations. Since the Living at Home and Older Adults waivers began, they have been inundated with applications – most of them from individuals who live in the community, but some from individuals who live in nursing facilities. As a result, the Living at Home Waiver in December 2002 and the Older Adults Waiver in May 2003

closed to applicants from the community. Since that time, enrollment of applicants from the community has been limited.

As the Living at Home Waiver approached its enrollment cap in November 2002, DHMH announced a new "money follows the individual" policy. Under this policy, an individual who has been a nursing home resident, paid for by Medicaid, for at least 30 consecutive days, can apply for the Living at Home or Older Adults Waiver programs even if those waivers are closed to community applicants.

EFFORTS TO PROMOTE HOME AND COMMUNITY-BASED SERVICES

This section presents some of DHMH's most recent efforts to promote home and community-based services.

Linking consumers with community supports

Hospital discharge project. A majority of all nursing facility admissions immediately follows an acute hospitalization. Hospital discharge planners are pressured to move patients out of the hospital as quickly as possible, and therefore the nature of hospital discharge planning tends to bias discharge planners toward sending patients to nursing facilities. DHMH believes that providing additional information and consultation to patients and their families during hospitalization could prevent some unnecessary, unwanted nursing facility admissions. Also, there may be cases where hospital discharge planners send a patient to a nursing facility for short-term rehabilitation, but the patient does not receive the support necessary to return to the community when his/her condition has improved.

In 2003, DHMH implemented a hospital discharge planning initiative to provide augmented discharge planning services for patients at risk of nursing facility placement. This program began as a federally-funded initiative from a grant received by DHMH and currently continues with State funding in Worcester and Harford Counties. Nurses work directly with patients and family members, prior to the patient's discharge from a hospital, to make arrangements or referrals for services needed when they return home. The Hospital Discharge Project continues to encounter shortages in community-based services to which to refer discharged patients.

Nurses in both jurisdictions continued in 2011 to work with their respective hospitals and nursing facilities, assisting in the diversion of many people from permanent nursing facility residence. These efforts are similar to ongoing work to establish Aging and Disability Resource Centers (ADRCs) in jurisdictions across the State. During the latter months of CY 2011, the programs in Harford and Worcester Counties began meeting and sharing data with a stakeholders group advising a grant obtained by the Maryland Department of Aging to support a Person-Centered Hospital Discharge Planning (PCHDP) effort in six additional counties. The PCHDP has worked with seven hospitals to provide nurse liaisons to work with patients determined to be at high risk of long term nursing home placement and Medicaid spend down upon discharge. An evaluation of the

PCHDP and the DHMH hospital discharge planning initiative has been providing information for evaluation over the last year. The initial evaluation included 334 patients and provided information on number of diagnoses, disability, hospital readmissions and nursing home readmissions. In 2012, the initial evaluation was revised to include additional information and to use a different assessment instrument that will be used statewide to determine risk of nursing home placement and spend down, the interRAI screen. This work continued through June 30, 2013. The University of Maryland School of Nursing is assisting with the data collection and analysis for this project. They anticipate collecting follow up data through December 2013 and project a final report with data analysis and outcomes to be available in January 2014.

Information on Medicaid's community-based services. DHMH continues to offer a booklet that describes all of the long term care community-based services that are available through the Medicaid program. The booklet is designed to provide basic information for health care professionals, consumers, and families to assist them in making decisions about long term care services. DHMH will continue to update this popular resource on a regular basis. The information is also available online at: https://mmcp.dhmh.maryland.gov/longtermcare/SiteAssets/SitePages/Home/2012-2013%20HCBS%20Booklet.pdf

Enrolling individuals from the Waiver Services Registry. Since the Living at Home and Older Adults waivers initially closed to community applicants, DHMH has maintained a Waiver Services Registry. The Registry is a central clearinghouse that collects contact information on individuals interested in receiving waiver services. In fiscal year (FY) 2013, Governor O'Malley provided $9 million from the increased alcohol tax to fund 480 waiver slots for community applicants to the Older Adults and Living at Home Waivers. The slots were filled by eligible individuals from the Waiver Services Registry.

Money Follows the Person Demonstration. The Centers for Medicare and Medicaid Services (CMS) awarded Maryland a demonstration grant to improve the transition process and increase the number of transitions to the community. The goal of the Money Follows the Person (MFP) demonstration is to offer additional resources to individuals in nursing facilities by increasing outreach efforts and decreasing barriers to transition. New services under MFP include peer outreach and mentoring, housing assistance, flexible transition funds, and the addition of waiver services to existing waivers. In order to be eligible for MFP, a person must have resided in an institution[1] for at least 90 days, have at least one day of Medical Assistance eligibility prior to transition, and move into a qualified community residence.[2]

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[1] Qualifying institutions include nursing facilities, State Residential Centers (ICFs/ID), State Psychiatric Hospitals (IMDs), and chronic hospitals.

[2] A qualified community residence is defined as a home owned or leased by the individual or the individual's family member; an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; or a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside. Examples of community-based residential settings in Maryland include Alternative Living Units, Group Homes, Adult Foster Care Homes, CARE Homes, and small Assisted Living Facilities.

The first MFP participant moved to a community residence on March 18, 2008. Since then, 1,850 individuals have transitioned to the community from institutions, including 1,659 individuals from nursing facilities, 146 individuals from State Residential Centers (with 108 from Rosewood) and 45 individuals from chronic hospitals, through the end of November 2013.

After receiving approval from CMS in March 2008, DHMH has worked to implement the plans outlined in the approved Operational Protocol. The Operational Protocol was updated to reflect requested changes to demonstration services and rebalancing initiatives and was approved by CMS in January 2012. The Operational Protocol has been further updated to reflect upcoming changes to the 1915c waivers and the implementation of Community First Choice. The latest draft was submitted to CMS for approval in December 2013. The MFP Grant brought with it significant reporting requirements that required changes to the MMIS system, modifications to several Medicaid waiver tracking systems, and the development of an MFP web-based tracking system. Several efforts for nursing facility residents have been implemented, including peer outreach and support, options counseling, and housing assistance. Nursing Facility residents can receive assistance to complete waiver applications, navigate community resources, identify affordable and accessible housing options, apply for housing subsidies, and move from the facility to a community residence. Since July 1, 2009, DHMH and its representatives have conducted face-to-face outreach visits with 27,318 institutional residents, provided options counseling 9,990 times, and assisted nursing facility residents with 3,751 applications for home and community-based waiver services.

Increased Community Services Program. In September 2009, CMS approved the DHMH request to operate the Increased Community Services (ICS) Program. This innovative program strips away a barrier that now prevents individuals from moving into the community. Specifically, the ICS program allows individuals in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community while also permitting them to keep income up to 300 percent of SSI. The ICS program is an expansion population and is currently capped at 30 individuals.

Since the program's inception, DHMH has extended invitations to apply to over 85 individuals. Eleven individuals are now participating in the program and 11 are pending in the enrollment process (i.e. awaiting medical, technical, or financial eligibility, plans of service, and/or identification of providers).

Maryland Access Point. Funded and supported through a federal Aging and Disability Resource Center initiative of the Administration on Community Living and CMS, the Maryland Access Point (MAP) program operates and maintains a statewide public web-based resource directory that provides an extensive database with a user-friendly search capability, consumer needs assessment and personal folder secure data sharing among agencies, and e-form capability, among other functions. The website offers both virtual and actual single-points-of-entry for people seeking long-term care information, supports, and services. In addition to the statewide website, twenty local MAP sites are providing statewide coverage for all Maryland residents. The MAP expansion has been supported

financially and programmatically from the MFP Demonstration. Standards of operation and partnership development have been established and an assessment of all MAP sites has been conducted. The MAP sites operate as conduits for new federal initiatives like self-directed community-based services, person-centered planning and options counseling, hospital and nursing home transition programs, and other pilots the purpose of which is to create consistent standards across the MAP sites and develop programs that divert people from inappropriate and default transition to nursing homes. In 2012, Maryland Department of Aging received a $2.3 million three year grant to enhance options counseling statewide, to integrate the ADRC initiative with the Balancing Incentive Program and other Affordable Care Act programs, and to develop a strategy for sustainability. A strong partnership between the Maryland Department of Aging and DHMH has allowed for progress on the initiatives of the grant.

Quality improvement efforts

The State continues to move forward with a more comprehensive quality management system across all home and community-based service programs using CMS guidelines. This effort is designed to create a consistent and uniform strategy to use evidence-based measures to enhance performance. The goals of this effort are to: (a) create a more evidence-based quality management system, (b) improve the ability of DHMH and other internal and external stakeholders to effectively monitor service provision, (c) improve the quality of home and community-based care and services, (d) develop better quantifiable quality indicators, (e) improve infrastructure to collect and distribute the data, and (f) create more comprehensive and standardized quality reports in an effort to improve program performance as well as overall operations.

Another component of the quality management process is the Waiver Quality Council which meets quarterly and has representatives from all of the home and community-based services waivers as well as other internal stakeholders. The council members share critical information, discuss best practices, analyze required reporting data, and address identified areas of concern across all the waivers through various interventions including but not limited to training, regulation and policy changes. In July 2011, the Council implemented a revised quarterly Reportable Events summary form used by the waivers to include more detailed and quantifiable quality indicators.

Quality Care Review Team. DHMH has a Quality Care Review (QCR) Team which is responsible for monitoring several waiver programs. The QCR Team conducts annual reviews of a random sample of waiver participants. The review process includes on-site visits, clinical record reviews, observations, and interviews. The team conducts participant interviews to evaluate satisfaction and/or dissatisfaction with provider services and to identify any unmet needs.

Reviews help the administering state agencies ensure that participants' health, safety and welfare needs are addressed, and services are provided as specified in the participant's plan. Provider services must be based on acceptable standards of practice and in accordance with applicable regulations. Referrals are made to appropriate jurisdictional

agencies when problems are identified (e.g., Office of Health Care Quality, Board of Nursing, and Office of Inspector General). The team is comprised of experienced registered nurses and social workers.

Additionally, the team generates findings and reports that may require a provider to submit a corrective and preventive action plan or indicate the need for further investigation by the DHMH Office of the Inspector General. Providers and vendors must submit acceptable plans which are reviewed by DHMH staff. The QCR Team also monitors the performance of case managers and provides on-going guidance, training, and technical assistance as needed.

New Initiatives

Increasing Access to Housing. In February of 2011, in partnership with MFP, four Maryland public housing authorities applied for and were awarded a total of 112 category II housing vouchers for non-elderly disabled individuals transitioning from institutions. As of September 2012 all vouchers have been awarded, allowing these individuals to transition back to the community. A waitlist has been created and is being utilized to fill the vouchers as there is turnover.

In 2012, DHMH's housing work continued on the Real Choice Systems Change Grant titled Building Sustainable Partnerships for Housing. The $330,000 grant was used to assist Maryland in developing strong relationships and a competitive application for funding through the Department of Housing and Urban Development's Section 811 Project Rental Assistance (PRA) Program. In February 2013, the U.S. Department of Housing and Community Development (DHCD), in partnership with DHMH and the Maryland Department of Disabilities, was awarded $10.9 million in funding. The purpose of the funding is to serve 150 individuals with disabilities between the ages of 18-62 within the Baltimore/Washington Metropolitan area by providing project-based housing subsidies. Maryland's target populations are Medicaid recipients who are institutionalized or at risk for institutionalization with incomes at or below 30% of area median income. DHCD and local Public Housing Authorities have also committed to provide local preferences for 102 Housing Choice vouchers or public housing units to support non-elderly disabled participants. A new Memorandum of Understanding is now in place between DHMH and DHCD as part of the HUD Section 811 PRA work that demonstrates the increased collaboration between the agencies.

The Balancing Incentive Program. The Balancing Incentive Program (BIP), offered by CMS and created by the Affordable Care Act, provides financial incentives to States to increase community-based services as an alternative to institutional services. Specifically, States that spend less than 50 percent of their long-term care dollars on community long-term services and supports (LTSS) receive a two percent increase in their Federal Medical Assistance Percentages (FMAP). In order to receive this enhanced FMAP, states must achieve a balance by spending at least 50% of their LTSS budget on home and community-based supports, and implement three structural changes: a No Wrong Door/Single Entry Point System, conflict-free case management systems, and a core

standardized assessment. Maryland applied to participate in the BIP program in February of 2012 and was the second state to be approved to begin collecting enhanced FMAP as of April 1, 2012. BIP structural changes must be completed within the program period ending September 30, 2015. Maryland estimates that an additional $106 million in Federal funds will be generated by participation in BIP.

Maryland is utilizing its history of rebalancing efforts and existing programs to meet the BIP requirements. MAP sites are being utilized to meet the No Wrong Door/Single Entry Point requirements. BIP funded enhancements to the No Wrong Door system of MAP sites will include: a toll-free number that connects to the caller's local MAP site where staff will complete a telephone screen, triage a person into LTSS, and provide referrals to a functional and financial assessment as needed; and improvements to the MAP website. The implementation of the interRAI-HC tool serves as the BIP Core Standardized Assessment for individuals who need a nursing facility level of care. DHMH will review current policies to assure conflict-free case management that mitigates financial or other incentives for the over or under utilization of services by separating eligibility, planning, assessment, and funding activities from direct service provision.

The Community First Choice Program. Community First Choice (CFC) is another program created by the Affordable Care Act and offered by CMS. Maryland convened a CFC Implementation Council in 2012 to advise the Department on program design. In September 2013, the State submitted an application to CMS to implement the CFC program and proposed to offer all mandatory and optional services allowable under the program, including personal assistance services, emergency back-up systems, transition services, and items that substitute for human assistance. The State will collect an enhanced match on these services for the duration of the program. In order to maximize the enhanced federal match, the State intends to consolidate similar services from three existing programs into CFC. This will include removing CFC services from other programs to prevent duplication.

Maryland currently operates three other programs that serve individuals who need personal assistance services. These programs are the Medical Assistance Personal Care (MAPC) state plan option, the Living at Home Waiver program, and the Waiver for Older Adults. The two waiver programs will be merged into a single waiver and MAPC, which will remain in effect for individuals in need of personal assistance services who do not meet an institutional level of care, will be revised to mimic the CFC program. These changes will allow a more seamless experience for applicants and participants who may move between programs, standardization of rates, provider qualifications, and regulations across programs, and offer more choice and self-direction opportunities for participants of all three programs.

Collaboration with other State Agencies

DHMH has collaborated with various State agencies to promote home and community-based services.

DHMH currently serves on or staffs various committees and workgroups, including:

- Maryland Commission on Disabilities;
- Coordinating Committee for Human Services Transportation;
- Maryland Access Point;
- Home and Community-Based Services Waiver advisory committees (Traumatic Brain Injury, Older Adults, and Living at Home);
- Rebalancing Workgroup: MFP/BIP stakeholder advisory group;
- Employed Individuals with Disabilities;
- Community First Choice Implementation Council;
- Maryland Partnership for Affordable Housing; and
- Inter-Agency Committee on Aging Services.

THE NUMBER OF INDIVIDUALS REFERRED BY NURSING FACILITIES OR IDENTIFIED BY THE MINIMUM DATA SET

The Minimum Data Set (MDS) is a federal assessment for all nursing facility residents. MDS assessments, conducted at admission and annually, ask whether the resident has expressed a preference to return to the community. A resident is defined as any person staying within the nursing facility, regardless of their expected duration of stay or if they maintain another official residence elsewhere.

CMS implemented a new MDS assessment on October 1, 2010. As part of the revised MDS assessment instrument, there was a new requirement that states must create a Local Contact Agency (LCA) responsible for responding to requests for information about community living based on the responses to the MDS 3.0 Section Q. To respond to this new requirement, the MFP demonstration was designated as the LCA for Maryland. The MFP demonstration responds to Section Q referrals by providing options counseling to all interested nursing facility residents, regardless of Medicaid eligibility or payment source. In November 2013, a daily MDS electronic feed was implemented into the Long Term Services and Supports (LTSS) tracking system to automate the referral process. Options counselors are directly notified when a new request for information on community living is received. Since its implementation on October 1, 2010 through December 10, 2013, the MFP demonstration has received and responded to 5,098 referrals including 3,427 referrals for individuals who are not eligible for Medicaid.

THE NUMBER OF INDIVIDUALS WHO HAVE TRANSITIONED FROM NURSING FACILITIES TO HOME AND COMMUNITY-BASED WAIVER SERVICES

Since the Living at Home Waiver closed to community applicants in December 2002 through FY13, 920 individuals have transitioned from nursing facilities to the community through the waiver.

The Older Adults Waiver closed to community applicants in May 2003. From FY 03 through FY 13, 2,980 individuals in a nursing facility within the previous three months, transitioned into the waiver.

OBSTACLES CONFRONTED IN ASSISTING NURSING FACILITY RESIDENTS TO MAKE THE TRANSITION FROM A NURSING FACILITY TO A COMMUNITY-BASED RESIDENCE

There remain many challenges to helping nursing facility residents to return to the community.

Housing. Obtaining affordable, accessible housing is one of the more challenging aspects for nursing facility residents to return to the community. A variety of factors contribute to the housing problem including a general shortage of affordable housing, long waiting lists for subsidized housing, difficulty in obtaining rental assistance vouchers, unaffordable rents for persons receiving Supplemental Security Income (SSI), and shortage of accessible housing.

Transportation. A lack of reliable, affordable, accessible transportation makes it difficult for people with disabilities and the elderly to be involved in community activities. For nursing facility residents, a lack of transportation makes it difficult to explore community living or shop for housing. Once an individual transitions from a nursing facility into a home and community-based services waiver program, survey results have shown that transportation continues to be an issue, particularly for non-medical needs.

Information and communication. Many health care professionals do not fully appreciate the range of services and supports that are available to help people with disabilities living in the community. It is often reported anecdotally that nursing facility employees do not think any of their residents can move into the community. Likewise, many consumers and family members are unaware of the full range of community options.

RECOMMENDATIONS FOR REMOVING THE OBSTACLES CONFRONTED IN ASSISTING NURSING FACILITY RESIDENTS TO MAKE THE TRANSITION FROM A NURSING FACILITY TO A COMMUNITY-BASED RESIDENCE

Housing. Nursing facility residents who seek independent housing have access to housing assistance through waiver case management services, including assistance in identifying affordable and accessible housing options in their local communities, completing applications for housing subsidies and housing opportunities, and in overcoming barriers to obtaining community housing. Living at Home Waiver recipients currently receive some assistance in accessing housing resources through waiver case managers. In addition to the case management supports, the MFP demonstration received additional federal funding for three (3) Housing Specialists and a Housing Supervisor who provide assistance in advocating for additional housing resources, overcoming individual barriers such as criminal backgrounds and poor credit history, and linkages with existing housing resources. MFP will continue to work with DHCD and the Department of Disabilities to advocate for increased affordable, accessible housing for people with disabilities.

Transportation. Information is available, through DHMH, regarding various modes of transport for Medical Assistance enrollees to access covered healthcare services. This information assists enrollees to contact their local health department to schedule non-

emergency transportation and report complaints. DHMH will continue to collaborate with the Maryland Department of Transportation and other agencies that fund human services transportation through participation on the State Coordinating Committee for Human Services.

Information and communication. As noted above, through the Money Follows the Person Demonstration, outreach, options counseling, and peer support are available to individuals in nursing facilities.

DHMH will continue to work in the areas of housing, transportation, and access to information and communication in order to remove barriers for nursing facility residents that want to transition to a home and community-based residence.