MARYLAND
Money Follows the Person

Operational Protocol v 1.2

MONEY FOLLOWS THE PERSON

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I. Required Contents of the Operational Protocol

A. <u>Project Introduction</u>

The Money Follows the Person Rebalancing Demonstration (MFP), offered through the Centers for Medicare and Medicaid Services (CMS), was created as part of the Deficit Reduction Act of 2005, a law passed by the U.S. Congress. Originally set to end in 2011, the passage of the Affordable Care Act of 2010 extended the demonstration until 2016. The purpose of the demonstration is to promote a series of rebalancing objectives written in the statute. The term "rebalancing" refers to efforts to minimize or eliminate barriers to individuals receiving long-term supports and services in home and community settings, rather than in institutional settings.

The Department of Health and Mental Hygiene (DHMH) administers Medicaid in Maryland. In accepting the Money Follows the Person (MFP) award, Maryland reinforced its ongoing commitment to serving individuals in the most integrated setting. This commitment is apparent in the State's existing policies and programs, including the Money Follows the Individual policy and the three home- and community-based services (HCBS) waivers that will serve MFP participants. Maryland is also fortunate to have a vibrant community of advocates and consumers who push the State to continue to improve its efforts. With the approval of this operational protocol, the State will use lessons learned in the first six years of MFP implementation to improve upon current rebalancing initiatives, as well as support the Department in exploring and implementing new options authorized in the Affordable Care Act (ACA).

In the community, MFP demonstration participants access services through three of Maryland's existing home- and community-based services (HCBS) waiver programs and the Community First Choice state plan program:

> The Home and Community Based Options Waiver (HCBOW) serves individuals 18 and older and provides case management, assisted living, and family training as part of its service package. HCBOW combines and replaces two waivers with overlapping eligibility criteria and similar services, the Living at Home Waiver that served adults with disabilities between the ages of 18-64 and the Waiver for Older Adults that served adults 50 and older. A number of previously covered services will be moved to the Community First Choice state plan program and as such will continue to be available to waiver participants that live in community residences.

- The Traumatic Brain Injury (TBI) waiver serves adults with traumatic brain injuries and provides day habilitation, family and individual support services, supported employment, and residential rehabilitation. This waiver is available to MFP participants that are transitioning from the three State owned and operated nursing facilities or Commission on Accreditation of Rehabilitation Facilities (CARF) accredited chronic hospitals.[1]

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[1] COMAR 10.09.46.03.B.4 cites the technical eligibility requirements for the TBI waiver as follows. *An applicant or participant shall be determined… to meet the waiver's technical eligibility criteria if the individual: (4) Is receiving: (a) Care in a State psychiatric hospital that is determined to be inappropriate because the individual does not need that level of care; (b) Traumatic brain injury community placement funded by the MHA with all-State funds; (c) Care in a nursing facility owned and operated by the State or an out-of-State rehabilitation institution funded by the Program; or (d) Care in a Maryland licensed special hospital for chronic disease accredited by CARF in brain injury inpatient rehabilitation.*

- The Community Pathways (CP) waiver serves adults with developmental disabilities and provides personal supports, case management, day habilitation, environmental modifications, and a wide variety of other support services offered through the Developmental Disabilities Administration (DDA).

- The New Directions (ND) waiver provides the same services available through Community Pathways, ND participants are able to self-direct those services. The DDA has submitted an application to CMS to merge the current New Directions and Community Pathways Waivers. DDA expects this application to be finalized and the waiver approved for an additional five year period.

- Starting in 2014, the Community First Choice program will offer personal assistance services, nurse monitoring, personal emergency response systems, transition services, home delivered meals, environmental adaptations, assistive technology, and other items that substitute for human assistance. HCBOW participants that live in a community setting will also be eligible to receive CFC services.

These waivers and the Community First Choice State Plan Program all require institutional level of care and have financial eligibility requirements. For details of the services available through each of these programs, please contact dhmh.mfp@maryland.gov.

Increasing Use of HCBS. Of the four federal goals for the MFP program, Maryland's MFP program focuses on increasing the use of home- and community-based services (HCBS) by streamlining and supporting transitions from institutions to the community. The State's Money Follows the Individual policy ensures that funding for waiver slots is made available to individuals who transition from an institution. The Money Follows the Individual Act is codified in the Annotated Code of Maryland, Health General §15–137 which states that:

The Department may not deny an individual access to a home- and community-based services waiver due to a lack of funding for waiver services if:

> *(1) The individual is living in a nursing facility at the time of the application for waiver services;*

> *(2) At least 30 consecutive days of the individual's nursing facility stay are eligible to be paid for by the Program;*

> *(3) The individual meets all of the eligibility criteria for participation in the home- and community-based services waiver; and*

> *(4) The home- and community-based services provided to the individual would qualify for federal matching funds.*

While the law only references nursing facilities, the Departmental policy includes all institutions. Therefore, capacity in the waivers does not need to be reserved for individuals transitioning from institutions to the community through the MFP demonstration. Individuals transferring from an institution to a community residence will not be placed on a waiting list. Additional slots will be requested each year according to the number of slots needed to continue serving individuals who transition onto the waivers under MFP.

Beyond the MFI policy, the Waiting List Equity Fund (WLEF) will be utilized to fund services for individuals transitioning out of Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICFs/ID), called State Residential Centers (SRCs) in the State of Maryland. The waiting list equity fund (WLEF) was created using monies saved by the closure and downsizing of state operated residential centers. The WLEF also receives additional funding through donations made by Marylanders via their State income tax returns.   WLEF is a nonlapsing fund established to ensure that when an individual leaves the State residential center to be served in the community, the net average cost of serving the individual in the SRC is applied to: (1) The individual's community placement; (2) Community services needed to sustain the individual's community placement; and (3) Provide community-based services to individuals not yet receiving services.

The eligibility criteria for individuals to access this fund are cited in COMAR 10.15.22.06, which states:

> To be eligible for services funded from the waiting list equity fund, an individual shall: (1) Be a resident of Maryland; (2) Have an appropriate evaluation that finds that the individual: (a) Has a developmental disability, or (b) Is eligible for support services; (3) Leave a State residential center on or after October 1, 1994, to be served in community-based services.

Traditionally, the WLEF has been used to fund services for individuals on the waiting list who have older caregivers (currently age 69 and above). However, the regulations for the funds allow them to be used on individuals who are transitioning out of institutions and these funds will be available to MFP participants who are not required to be placed on the Waiting List for DDA services.

Ongoing Efforts to Rebalance and Divert from Institutional Placement

The MFP demonstration will complement ongoing rebalancing efforts in Maryland as well as support research, development, and implementation of new opportunities the Department chooses to pursue that were authorized as part of the ACA. These and other efforts are described below.

Maryland is one of 54 states and territories that are funded by the Administration for Community Living and CMS to develop a program to streamline access to long-term care information and community-based services. The federal program is the Aging and Disability Resource Center (ADRC) initiative. In Maryland, the program is called Maryland Access Point (MAP). MAP is also supported by General State funds. The goals of MAP are to streamline access to long-term care information and streamline eligibility and access to services in order to help redirect long-term care from institutions to the community. The MAP program has developed recommendations for best practices, including co-location of the different agencies involved in coordinating eligibility for Medicaid services and all State funded long-term care services. MAP has twenty local operational and developing sites providing statewide coverage. Each site provides coordinated front-line assistance for people seeking alternatives to institutional long-term care. At the State level, MAP is working through an executive level interagency work group to address structural and operational systems changes in the way people access long-term care information and the speed with which community options can be explored prior to institutionalization. The MAP project expanded statewide with support from the MFP

demonstration and will continue to be an integral part of Maryland's rebalancing efforts. MAP also constitutes the core of the Single Entry Point/No Wrong Door effort as required by the Balancing Incentive Program and adopted by Maryland as part of the State's LTSS reform plan.

In addition to the Maryland Access Point project, Maryland received grant funding from the Administration on Aging for the Community Living Program. This grant is designed to: (1) develop a targeting and assessment protocol for identifying older adults who are at high risk of Medicaid spend down and placement in a nursing home; (2) prioritize those individuals for access to non-Medicaid funded State long-term care service programs; (3) offer them an opportunity for a flexible benefit under which they or their families can self-direct services and services providers; and (4) encourage and measure the informal supports that assist with community-based care and living. The targeting and assessment protocol and the prioritization of high risk individuals will contribute significantly to Maryland's efforts to divert people from institutional settings as well as Medicaid spend down. This essential diversion program will increase the number of individuals who can remain in their homes and receive services, thereby reducing the need for facility-based care and expenditures and it will provide a model for expansion. There is also a State-only funded program that supports nurses working in local hospitals to divert individuals from long-term nursing facility stays after a hospital discharge. Two counties currently participate in this program with DHMH which ends December 31, 2013.

Another project affecting long-term care rebalancing efforts was House Bill 594 (Chapter 244, Laws of Maryland 2007). This bill requires DHMH to analyze options to increase access to long–term care services, including home and community-based services for individuals at high risk of institutionalization because of cognitive impairments, mental illness, traumatic brain injury, or other conditions. DHMH committed to review the practices of other states, to study options for revising the current level of care determination, and to cost out other options for increasing access to long term care services. The final report, submitted December 1, 2007, influenced changes to the level of care determination process that occurred in 2008. The Department revised the nursing facility level of care criteria which resulted in fewer denials and an expanded group of eligible individuals.

Two additional bills regarding long-term care were passed in Maryland's 2009 legislative session. House Bill 782 requires the Department to consult with nursing facilities and other stakeholders to assess the State's long-term care reimbursement methodology and consider alternative reimbursement mechanisms. A report on the evaluation was submitted to the General Assembly on October 1, 2010. The report included plans to continue work with stakeholders on rate reform issues. House Bill 113 requires that the Department consult with stakeholders to evaluate the feasibility of submitting a federal waiver application for a coordinated long-term care program. The final report on feasibility was submitted to the legislature December 1, 2010 and recommended that the group continue to further study options available in the Affordable Care Act. The Long-term Care Reform workgroup was reconvened in August of 2011 to review Community First Choice, the Balancing Incentive Program, Health Homes, and revisions to the 1915(i) option. In 2012, the large workgroup merged with the MFP stakeholder group to form the MFP/BIP Rebalancing Stakeholder group. A new Community First Choice Implementation Council was also created. One of the recommendations of previous stakeholder groups has been to develop a single standardized assessment instrument to be used across programs. An instrument that is evidence-based and tested for validity and reliability could improve the quality of community support plans and reduce the effects of the programmatic silos. DHMH invested,

outside of MFP, in two (2) full-time staff that researched existing evidence-based instruments and made recommendations for moving to a new assessment tool in 2012. These staff hosted focus groups to review assessment options with stakeholders. The staff also ensured that the new instrument meets the requirements for a Core Standardized Assessment as outlined in the Balancing Incentive Program Implementation Manual released on October 14, 2011 to ensure Maryland's eligibility for the program. MFP used rebalancing funds to fund the initial costs to finance the implementation of the selected tool, interRAI-Home Care. Thus far it has been implemented across two waiver programs that require a nursing facility level of care and the Medical Assistance Personal Care Program.

Maryland also implemented a new system for assuring that home and community-based services are provided as outlined in person-centered plans of service. The In-home Supports Assurance System (ISAS) requires that personal care and other in-home service providers call-in to an automated system when providing services in a participant's home. The system compares service calls to the individuals support plan and document provider time in the home to automate billing. Although the effort was initiated outside of the MFP demonstration process, MFP rebalancing funds were used to support the start-up costs as the effort is focused on improving HCBS and quality. Phased-in implementation began in 2013.

In addition to these efforts, Maryland successfully applied for a Real Choice Systems Change Grant titled, Building Sustainable Partnerships for Housing. Maryland's proposal, Maryland Partnerships for Affordable Housing (MPAH), is a joint effort of Medicaid, the Department of Disabilities (MDOD), the Department of Housing and Community Development (DHCD), the Mental Hygiene Administration (MHA), the Developmental Disabilities Administration (DDA), Centers for Independent Living (CILs), disability advocates, consumers, and other community service providers. MPAH was a one year grant with a subsequent one year extension that assisted Maryland in developing strong relationships and a competitive application for funding through the U.S. Department of Housing and Urban Development (HUD) Section 811 Project Rental Assistance Demonstration Program (811 PRA Demo). As part of the MPAH work, the Department provided person-centered planning training for housing case managers using MFP rebalancing funds. In February 2013, HUD announced the award of Section 811 PRA Demo funding to 13 states, including Maryland. MFP allocated $1,000,000 in rebalancing funds to support the Section 811 PRA Demonstration.

Where We've Been, Overview of MFP Demonstration Program to date

The initial goal of the MFP demonstration in Maryland was to encourage rebalancing by improving the existing transition process from an institution to community living through increasing outreach and decreasing barriers to transition. New efforts under MFP included peer outreach and mentoring, program education, application assistance, enhanced transitional case management including housing assistance, flexible transition funds, and the addition of waiver services to existing waivers.

The Developmental Disabilities Administration (DDA) had existing Community Placement Teams that were enhanced to support residents of SRCs as they transitioned from Maryland's (ICFs/ID) to the community. At the state level, the SRC Transition Coordinator works on addressing systemic barriers to transition. The SRC Transition Coordinator also tracks data for

the MFP demonstration, works on housing policy related to SRC and NF transitions, and oversees two additional positions that were created and titled Community Placement Specialists. The Specialists work on individual transitions and enhance the existing Community Placement Teams that include Regional Office staff, Resource Coordinators that serve as case managers, the SRC residents and their families, SRC staff, and the peer mentors. The Community Placement Specialists develop relationships with residents, families and SRC staff to facilitate communication and to develop solutions to individual barriers to transition. The Specialists also oversee the peer mentoring project in SRCs.

When MFP began, there were 331 people living in Maryland's State Residential Centers. Under Governor Martin O'Malley's leadership, the Rosewood State Residential Center was closed and 168 residents transitioned to the community. Brandenburg, a second SRC, was closed in 2011. As of this writing, there are now 121 individuals in SRCs, in contrast to 13,640 DDA waiver participants being served in the community. Less than 1% of the people being served by DDA remain in institutional settings.

The Mental Hygiene Administration (MHA) administers the Waiver for Adults with Traumatic Brain Injury, which is on track to triple in size by the end of the MFP Demonstration, and has already grown from 33 to 75 participants served since the demonstration began. Of the 75 TBI Waiver participants, 42 were enrolled through MFP. In 2012, MHA modified their Brain Injury Resource Coordination Program by developing a contract with the Brain Injury Association of Maryland (BIAM) to provide outreach to individuals in institutions, application assistance, and enhanced transitional case management services to individuals who apply for the TBI waiver program. BIAM staff assist with outreach to residents in CARF accredited Chronic Hospitals and State owned and operated nursing facilities as well as to their family, guardians, and other supporters. BIAM provides education and support in making decisions about pursuing community living, application assistance, coordination of needed community resources and supports for the individual, and enhanced transitional case management to ensure successful transitions to the community.

MFP Rebalancing Initiatives

Under MFP, the State receives additional funds for services provided under the demonstration. To date, the increased funds associated with the MFP demonstration have been used to enhance community based services available through the existing waiver programs by adding additional services and supports that were identified by the stakeholders. These additional services are available to all waiver participants and will continue past the MFP demonstration. In addition, the funds sponsored pilot programs to enhance outreach and transition services. These pilot programs produced data that has been used to study their efficacy through measured outcomes. Based on the outcomes of the pilot projects to date, changes were made to several of Maryland's rebalancing initiatives effective January 1, 2012.

Peer outreach workers were employed to staff a statewide outreach campaign to nursing facility residents, informing individuals (or their legal guardians) of the option to receive long term supports and services in the community. Over 20,000 contacts were made with nursing facility residents and their representatives. MFP funding enhanced an existing peer mentoring program for State Residential Center (SRC) residents and created a new family mentoring initiative. A peer mentoring service was created for nursing facility residents as well. However, utilization

has been so low that sufficient data is not available to quantify and evaluate the outcomes for the mentoring services. Maryland remains committed to using peers to perform outreach and provide support to institutional residents. These peer initiatives have been redesigned to promote increased participation and overcome challenges identified during the initial demonstration period. The revised peer support model is described in detail in section 1.3 Recruitment Efforts.

In addition to the peer outreach and mentoring, program education and application assistance were offered to nursing facility residents through the MFP demonstration. Professional staff of the local Area Agencies on Aging (AAAs) received referrals from peers, facility staff, ombudsman, and the MDS Section Q and then provided in-depth education on the services available in the community. Assistance in completing and submitting a waiver application was also provided when requested. Since July of 2009, 9,685 people have received program education and 4,385of those individuals also received application assistance for one of the HCBS waivers. The number of waiver applicants has increased tremendously based on the outreach, education, and application assistance available through MFP. In 2012, the education and application assistance were integrated into Options Counseling to further streamline the entry into LTSS. Details of Options Counseling services are in section 1.4 Enrollment in MFP from a Nursing Facility.

MFP has funded training for its partners and providers. Specifically, transitional case managers received training on person-centered planning, which was designed to educate case managers on the philosophy and specific planning tools that can be used to guide the process. Housing training was also provided in order to provide basic housing information and assistance to all residents of qualified institutions seeking independent housing. The housing training was open to anyone working with MFP and was also attended by MAP staff, disability partners working at CILs, and consumers.

MFP housing specialist positions were created and staffed at the Department in order to work with applicants, their supporters, case managers, housing authorities, and landlords. These housing specialists work closely with housing staff at The Coordinating Center, the case management providers for the Living at Home waiver. In February of 2011, Maryland was awarded 112 category II vouchers for non-elderly disabled individuals transitioning from institutions. The Coordinating Center took the lead role in assisting eligible MFP applicants in accessing these vouchers. As of this writing, all vouchers have been awarded.

MFP also supported the development of the statewide network of MAP sites. To improve the processes by which individuals learn about and access long-term care services, MFP assists the statewide network of MAP sites in two ways. First, an ADRC liaison contract was awarded in 2011 and the contractor assessed existing and developing MAP sites for their capacity to integrate MFP services within the MAP structure, and identified existing structural, staffing, and funding barriers. The liaison developed action plans for MAP sites to facilitate the incorporation of MFP services and overcome identified barriers and developed a State-level action plan to guide policy decisions. Technical assistance to developing MAP sites was provided in order to implement the action plans. The second way MFP supports MAP is by providing funding support to individual sites to help them modify their models to accommodate MFP service provision. Funding to individual sites also supports MAP staff and co-location of disability partners.

In addition to the ADRC Liaison, MFP will support the evaluation of the MAP-based Community Living Program and the parallel DHMH hospital diversion program. These pilot models need to be evaluated for best practices and standardized so that they can be expanded. This evaluation has not previously been funded as MDoA grants only support their programs, thereby excluding the DHMH grant programs. After an evaluation of current diversion efforts and national models, Maryland will work to implement a statewide nursing home diversion program.

New Services. The MFP demonstration added services to several of the existing waivers to enhance the service package available to individuals who use these programs. In the first phase of MFP, environmental assessments, nutritionist/dietician services, and home delivered meals were added to the LAH waiver and transition services were added to the WOA. An MFP demonstration service was created to provide enhanced transition services to nursing facility (NF) residents interested in transitioning to the community through one of the participating home and community based services waiver. Peer mentoring was created as an MFP demonstration service and will continue to be a demonstration service during the extension (See B.5.4).

The clubhouse model of services will also be added to the TBI waiver as an alternative to day habilitation or as a modification to the day habilitation service. This service, which was identified by stakeholders as an area of need, will be available to all TBI waiver participants and will continue past the MFP demonstration.

A new service called *flexible funds* was offered through the MFP demonstration and was initially administered by the transitional case managers to further address barriers to transitioning. This MFP supplemental service includes funds for groceries, transportation, and other needed items that could not otherwise be funded by Medicaid. While the funds are designed to cover a wide array of goods and services needed at the time of transition, they have primarily been used to pay for groceries. Starting in 2014, a fiscal management agent will administer flex funds with the support of the case managers.

Information Systems. During the first phase of MFP, the State developed a web-based tracking system to assist in communication and reporting by tracking the processes shared among all partners of the demonstration. At the time, the tracking system was minimally compatible with the existing tracking systems for the Older Adults and Living at Home waivers and was accessible by case managers, DDA, MDoA, MDOD, and DHMH. The web-based tracking system tracked an individual from initial contact through transition. While the information stored in the system could be used to identify barriers in the transition process and store reasons for reinstitutionalization, while promoting quality, timeliness, and accountability, it was not fully integrated with the existing waiver tracking systems. In 2012, work began to incorporate all three existing tracking systems and expand functionality of a single long-term supports and services system called LTSSMaryland. The modified system was built such that it could expand to incorporate the new standardized assessment instrument (interRAI-Home Care), provide a flexible, self-directed budget for Community First Choice participants, and link to the ISAS to automate billing and increase real-time quality monitoring. Future additions will include the State Plan personal care program, the TBI waiver, and the Quality of Care Review Team functions, and streamline Reportable Events submission.

MFP has partnered with the MAP program to support the on-going development and maintenance of a statewide, web-based, searchable database that provides comprehensive, accurate, and user friendly information about long-term care planning, programs, and services. Launched on December 1, 2010, the site helps consumers, providers, and advocates quickly access information and connect with appropriate programs and providers. MFP may provide future support to enhance the system with back-end data functionality and integrate its client data into the LTSS tracking system.

Behavioral Health. During the development of the initial operational protocol, some stakeholders expressed concerns about the availability of and access to the current community-based behavioral health services including supports for mental illness, dementia, cognitive behavioral disabilities including brain injury, and co-occurring physical, cognitive, mental health, or behavioral health diagnoses. Specific concerns expressed were the need for improved behavioral health services, as well as an overall lack of access to adequate and/or existing supports, or a mechanism through which to serve individuals transitioning out of Institutions for Mental Disease (IMDs). As a result, the State convened a parallel stakeholder group to further investigate and address these concerns with the goal of enhancing screening, increasing community capacity, and providing comprehensive behavioral health supports to individuals receiving long-term care services in the community. One of the primary goals of this group was to develop recommendations for improving behavioral health services in the community for all individuals in need of those services.

The MFP Behavioral health workgroup met regularly through September of 2008 and developed a list of recommendations for the Department to better serve individuals with behavioral health needs (Appendix G). These recommendations were delivered to the advisory bodies for the LAH, OAW, and TBI waivers and the Aging in Place Task Force. These existing groups were charged with advocating for the implementation of these recommendations, but to date, none of the recommendations have been implemented.

The work group reconvened in July of 2009 and met through March of 2010, but once again efforts to implement recommendations stalled. In 2011, MFP successfully procured a Behavioral Health Consultant to reconvene and lead the behavioral health workgroup, analyze the gaps in the existing service system, research best practices nationwide, report findings on best and promising practices for the state to consider, and present recommendations for new services along with an action plan for implementation. The reconvened work group held a series of stakeholder meetings and incorporated feedback into the final recommendations report. The final recommendations were submitted during the process of behavioral health integration in Maryland. The Mental Hygiene Administration and the Alcohol and Drug Abuse Administration are in the process of merging into the Behavioral Health Administration. This transition time in the system provided a challenge for the Behavioral Health Consultant to move forward with technical assistance for recommended changes.

In order to provide support at the consumer level, MFP hired a behavioral health specialist/policy analyst to work with MFP applicants, participants, their representatives, and case managers in order to coordinate available mental health services. The specialist also acts as a liaison for MFP with MHA and the local mental health authorities.

New Efforts to Rebalance and Divert from Institutional Placement

In 2013, Governor O'Malley provided $9 million from the increased alcohol tax to fund a total of 480 new waiver slots for applicants to the Living at Home Waiver and the Waiver for Older Adults. The slots were offered to individuals that had expressed interest in services by placing their names on the waiver services registries. In addition to the slots, the State is also implementing a 1915i and a Health Homes program to expand and improve coordination of available home and community based services.

While not an MFP funded effort, advocating for the allocation of funding for waiver slots to divert people from institutions so they do not have to enter the NF before applying for a waiver would allow for targeted use of limited funding resources. This initiative would require budgetary authorization from the Maryland Department of Budget and Management (DBM) because of the ongoing state cost that cannot be covered by MFP. When they become available, a number of slots could be set aside for diversion, based on need as determined by the standardized assessment tool.

In order to truly rebalance the system, an increased and targeted effort needs to be initiated with institutions and the inconsistencies in reimbursement trends for institutional versus community providers must be eliminated. For example, Maryland will explore several options for reducing use of institutional services such as implementing equal rate cuts and/or increases to create payment parity between service providers; changes to institutional rate setting methodologies and policies allowing growth of institutional beds, voluntary bed closure incentives, and incentives for institutional providers to expand into HCBS. Financial incentives for bed closures will be used only if other efforts are unsuccessful and would be limited to short-term payments that results in the permanent closure of beds.

Nursing Facility (NF) Expansion to HCBS. The nursing facility provider community possesses many resources that could successfully be re-invested to increase HCBS capacity. Pilot projects that encourage institutional providers to expand their business model to include home and community-based services can increase consumer choice and expand the pool of HCBS providers, especially in rural areas. Working with institutional providers to shift their focus and ultimately change their business model is an important part of rebalancing efforts and crucial to meeting the goals of MFP. Maryland will explore options with the professional organizations representing facility providers including the Health Facilities Association of Maryland (HFAM) and LifeSpan, in addition to conducting outreach directly with providers. MFP will seek proposals for possible pilot projects. One example of a pilot proposed by a provider is to fund facilities at a capitated rate to provide transition services, assistive technology and electronic health monitoring, emergency response services, personal care, and nursing supervision to individuals who transition out of their facilities and into a community setting. Pilot models could include PACE-like models, financial incentives to NF providers who create MFP-qualified residences or assisted living facilities, and/or for providing traditional waiver services. Pilot projects will be awarded through a competitive procurement process in consultation with consumers.

Self Direction

The three HCBS waivers that MFP participants will primarily use to access community-based services offer a variety of self-direction opportunities that vary with each waiver. The Community Pathways and Traumatic Brain Injury Waivers have the fewest opportunities for

self-direction, incorporating the consumer in the care planning process but not offering additional self-direction options. Personal assistance services are provided to Home and Community Based Options Waiver participants through Community First Choice (CFC) which offers a self-directed model of personal assistance services as well as an optional self-direction training. The self-direction training is provided through a partnership with the Maryland Department of Disabilities and funded through MFP rebalancing funds. The New Directions waiver offers the greatest number of options for self-direction, including support brokerage, supported employment, community supported living arrangements (personal supports), assistive technology, accessibility adaptations, and transportation. For additional information on these self direction options, please see section B.7.

MDoA, through a partnership with the U.S. Department of Veterans Affairs, is administering the Veteran-Directed Home and Community Based Services Program (VD-HCBS). This program provides veterans with a flexible cash benefit that they self direct in order to purchase community-based long term supports and services. Implementation began in Baltimore County in 2011 and the program has now expanded to include Howard, Prince George's, Dorchester, Wicomico, Worcester, and Somerset Counties and Baltimore City. Both the Community Living Program referenced above and the VD-HCBS programs use a cash and counseling model with a fiscal intermediary and support for consumers in managing their budget. The VA Medical Center in Perry Point, Maryland receives referrals of potential participants from the veterans' medical team. The VA then screens and sends the referrals to MDoA for further follow-up. Staff at the participating local Area Agencies on Aging meet with the veteran and, together with the fiscal intermediary, provide training and support to enroll the individual into the program. The veteran receives a monthly cash benefit, which he or she self-directs to purchase services and supports, such as personal assistance services or home-delivered meals, that allow them to maintain independence and live in their home.

As the Departments implement CFC; rebalancing funds will be used to support the start-up administrative costs associated with the change such as supports for consumer participation in the Implementation Council, technology, training, and outreach. Maryland's existing Medical Assistance Personal Care Program (MAPC) will continue to be available to individuals that do not meet a nursing facility level of care, but do meet the one ADL standard. MAPC will make changes to remain consistent with CFC and will offer a self-directed model of personal assistance services to participants that remain in the program.

Stakeholder Involvement in the LTC System

Maryland's initial application for the MFP demonstration was based on stakeholder input. Once the grant was received, an announcement was posted on the DHMH website, and the State engaged in an extensive process to convene, listen to, and respond to stakeholder concerns, questions, and recommendations that continued throughout the planning process. Since the beginning of Maryland's MFP program, meeting schedules have ranged between biweekly and quarterly. Currently the group meets bi-monthly to discuss implementation issues, hear presentations on topics of interest, and provide input for future planning. In 2010 the group changed meeting locations in order to provide audio and video conferencing capabilities for stakeholders that are unable to attend meetings in person.

In addition to the MFP Stakeholder Group, there are stakeholders involved in the various Medicaid Waiver Advisory Committees, the CFC Implementation Council, the MAP Advisory Board, and the Long Term Care Reform Work Group (which merged with the MFP Stakeholder group). Once CFC is implemented, the Implementation Council will be consolidated with the Home and Community Based Options Waiver Advisory Committee. For additional information on stakeholder involvement in the MFP demonstration, see section B.4.

Description of the Demonstration's Administrative Structure

The Department of Health and Mental Hygiene administers Maryland's Medicaid program. Within DHMH, MFP is housed within the Office of Health Services, in the Long Term Supports and Services Administration. There are thirteen dedicated positions for the MFP Demonstration that are paid for by the grant, the MFP Project Director, Associate Project Director, Data Specialist, Behavioral Health Specialist/MFP Policy Analyst, MAP Specialist, Housing Supervisor, three Housing Specialists, Finance Specialist, Statewide (DDA) Transition Coordinator, and two Community Placement Specialists. All thirteen positions are full time positions in the Office of Health Services, Long Term Care and Community Support Services Administration and 100% of these positions are dedicated to the MFP Demonstration. The MFP Project Director also fills the same role for BIP which has one dedicated BIP Coordinator.

Collaboration with sister State Departments has been invaluable to the demonstration. Strong leadership from MDoA and MDOD has allowed for quick implementation of rebalancing initiatives and additional quality oversight and monitoring. DHMH will continue to work with both Departments, specifically with MDoA in order to provide options counseling and to strengthen the MAP sites in order to meet the Single Entry Point/No Wrong Door BIP requirements and MDOD for peer supports, CFC self-direction training, and systems-level housing advocacy.

A new Memorandum of Understanding is in place between DHMH and DHCD as part of the HUD Section 811 PRA work that demonstrates increased collaboration between our agencies. Stronger partnerships with the Departments of Human Resources and Housing and Community Development will also become a priority during the extension period.

State University systems have provided important support to the MFP demonstration. The Schaefer Center, a policy institute within the University of Baltimore, administers the Quality of Life Survey to MFP participants through a Memorandum of Understanding (MOU) with DHMH. The Hilltop Institute, a research institute housed within the University of Maryland, Baltimore County, developed the initial web-based MFP tracking system and acts as a subject matter expert with the current developer, as well as provides data analysis to assist in the decision making process. The Hilltop Institute activities are also funded through an MOU with DHMH.

1. <u>Benchmarks</u>

Each year of the demonstration, the State will report on its progress in transitioning individuals and rebalancing the long-term care system. CMS requires each proposed measure to include annual targets that are measurable, achievable, and realistic.

1.1 Required Benchmarks

Benchmark 1: The projected number of eligible individuals in each target group of eligible individuals to be assisted in transitioning from an inpatient facility to a qualified residence during each calendar year of the demonstration[1].

Table A.2.1 Benchmark 1: Projected Transitions in Each Calendar Year

Projections	CY2013	CY2014	CY2015	CY2016	TOTAL
Elderly	190	199	209	219	817
Physically Disabled	115	121	127	133	496
Other: Brain Injury	7	8	9	10	34
ID/DD	20	20	20	20	80
Total Transitions	**332**	**348**	**365**	**382**	**1427**

Benchmark 2: The projected increase in qualified expenditures for all HCBS.

In the context of MFP, qualified expenditures are those waiver and State Plan services for which the State will seek an enhanced match. The table contains the projected costs of these services for all individuals in the given year. Should an application for the Balancing Incentive Payments Program be pursued, this benchmark will be expanded or supplemented to report *increased HCBS percentage of total Medicaid LTSS spending* required by BIP. The dollars and percentage data could include both totals and breakdowns between non-DD and DD spending as in Table A2.3 to track accelerated rebalancing of spending toward HCBS in the non-DD LTSS systems

Table A.2.2 Total Projected HCBS Expenditures by Calendar Year

CY 2013	CY 2014	CY 2015	CY 2016	TOTAL
$1,019,259,852	$1,075,312,473	$1,134,447,621	$1,196,834,816	$5,391,983,839

The projected annual increase in total HCBS funding is based on historical data for each HCBS service category trended forward with an increase in waiver spending growth based on MFP transitions.

1.2 Maryland's Benchmarks

System-wide Rebalancing

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[1] Though Maryland intends to transition individuals in IMDs and chronic hospitals during the period of the MFP demonstration, currently there is no mechanism through which to serve them in the community. The State will submit an update to the Operational Protocol before transitioning these individuals. Benchmark 1 will be amended to include IMD and chronic hospital transition targets when a service mechanism is chosen (Section B.1.1).

Benchmark 3: The percent of all Medicaid long-term care service days that are provided in the community each year.

This benchmark is calculated by dividing the days of long-term care services provided in the community by the total number of days of long-term care service provided (institutional plus community). For example, if Medicaid served a total of 100 people, and 40 people received services for a year in the community and 60 received services the same year in a nursing facility, the benchmark would be 40.0% (40 people * 365 community days) / (100 people * 365 days).

This benchmark is intended to capture the progress in system-wide rebalancing of long-term care based on the days of service in each setting. The HCBS days are for all services, both waiver and State plan. More days of service provided in the community and fewer provided in an institutional setting leads to a larger percentage in the benchmark. The days used in the analysis are based on claims data and provide an unduplicated count of days of service. If Medicaid served only one individual in a year and that individual received services for 200 days in the community and 165 in a nursing facility, the benchmark would be 54.8% (200 community days / 365 total days). The actual benchmark represents the projected days of service for all Medicaid long-term care recipients in the given year. These estimates are based on current efforts toward rebalancing and new initiatives under MFP. Future long-term care reforms could accelerate these changes.

Table A.2.3 Percent of Medicaid Long-term Care Service Days Provided in the Community

	CY 2013	CY 2014	CY 2015	CY 2016
All HCBS Days / Total Days	**68.81**	**71.84**	**74.87**	**77.90**
Without DD Waivers and SRCs	54.8	59.1	63.4	67.7
Only DD Services and SRCs	99.0	99.0	99.0	99.0

This benchmark reflects Maryland's goal to increase the proportion of long-term care services provided in the community rather than in institutions. The State has already made considerable progress in rebalancing the system through which individuals with developmental disabilities receive services. While continuing to build on this progress, the State hopes to accelerate rebalancing in the other long-term care service delivery systems.

Progress with Transitions

Benchmark 4: Number of nursing facility residents informed of their community care options through Options Counseling each year.

This benchmark reflects the number of facility residents who receive Options Counseling in each year. The State will use its existing data tracking system to log referrals and service provision and require the contractor to document contacts with each resident.

Table A.2.4 Number of nursing facility residents educated about HCBS through Options Counseling

	CY 2013	CY 2014	CY2015	CY2016
	2,434	2,604	2,786	2,981

Though this benchmark is more process oriented, the State believes that the central goal of the peer outreach and support and options counseling is to provide information about options for receiving community services to as many potentially eligible individuals as possible. Based on the current number of program education referrals from peers and completed program education sessions, the State anticipates that contractors will document over 2,000 Options Counseling sessions with nursing facility residents next year.

Benchmark 5: Number of participants that secure community housing each year.

This benchmark intends to measure the effectiveness of housing assistance provided through the demonstration. The measure reflects the number of individuals who secure housing with assistance from transition coordinators and MFP housing specialists in a given year. In an effort to measure overall rebalancing through MFP initiatives, individuals who are determined ineligible for MFP after receiving housing assistance will be counted in this benchmark (e.g., if an individual transitioned after less than 90 days in the institution or if they selected a non-qualified assisted living facility after receiving housing assistance).These numbers also reflect that not every individual who transitions will need or request housing assistance.

Table A.2.5 Number of individuals securing community housing

	CY 2013	CY 2014	CY 2015	CY 2016	TOTAL
	120	126	133	143	522

These projections are based on data gained during the initial years of MFP implementation. It is estimated that 55% of LAH participants and 30% of OAW participants will access community housing with support from transition coordinators and/or MFP housing specialists.

B.   Demonstration Implementation Policies and Procedures

In the first six years of Maryland's MFP demonstration, over 1,789 individuals transitioned from institutional settings to the community as MFP participants and hundreds more transitioned through parallel programs. The MFP demonstration will help the State further reduce barriers to receiving services in the community as well as target limited state resources to those most at risk of institutional placement. Specifically, the State intends to use lessons learned from the first six years of the demonstration to continue to improve the transition process, enhance community-based supports, create new initiatives to build community capacity, and focus on diversion from institutional placement. This work is done in conjunction with the State's Balancing Incentive Program as well as other ACA efforts such as Community First Choice in order to coordinate efforts and funding wherever possible. This section of the protocol outlines the State's policies and procedures as envisioned once the new reform efforts are fully implemented. Individuals

interested in pre-existing policies and procedures may request details by contacting dhmh.mfp@maryland.gov.

1. Participant Recruitment and Enrollment

1.1 Eligibility for the Demonstration

The populations that will be transitioned through the demonstration are:

- Elderly and disabled adults residing in Medicaid nursing facilities (NFs)
- Adults with developmental disabilities residing in intermediate care facilities for individuals with intellectual disability (ICFs/ID), also known as State Residential Centers (SRCs)
- Adults 65 years and older residing in institutions for mental disease (IMDs)[1]
- Adults residing in chronic hospitals

Maryland will adopt the least restrictive MFP eligibility criteria permitted by the authorizing legislation:

- One day prior Medicaid eligibility
- 90 days residence in a qualifying institutional setting (or settings), excluding rehab stays[2]

1.2 Qualified Institutions

All Medicaid-licensed nursing facilities (NFs), institutions for mental disease (IMDs), chronic hospitals, and public intermediate care facilities for individuals with intellectual disability (ICFs/ID) in the State of Maryland will be included in the demonstration, regardless of geographic location. The State will focus on developing the capacity to provide outreach to all eligible institutional residents as described above. All Medicaid-licensed NFs meet the statutory definition of a qualified institution (section 6071(b)(3), "inpatient facility", of the Deficit Reduction Act of 2005). All Medicaid-licensed ICFs/ID, institutions for mental disease (IMDs), and chronic hospitals also meet the statutory definition of a qualified institution.

1.3 Recruitment Efforts

Minimum Data Set 3.0

The Minimum Data Set (MDS) 3.0 is an assessment tool that is used with residents in all Medicare-licensed nursing facilities, regardless of payer source. Section Q of the MDS relates to goal setting and discharge planning. If a person wants to speak to someone about the possibility of returning to the community, a referral to the local contact agency (LCA) is indicated. In Maryland, MFP is the LCA. MFP has worked with the State's CMS MDS liaison, the Office of

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[2] While the least restrictive MFP eligibility will be used, in order to be eligible to apply for an HCBS waiver without accessing one of the registries, Maryland's MFI act requires at least 30 days of the individual's nursing facility stay are eligible to be paid for by the Program (Medicaid).

Health Care Quality (OHCQ), in order to automate the MDS referral process. Currently, when a referral to the LCA is indicated, a referral to the local Area Agency on Aging or Center for Independent Living is made through the LTSSMaryland tracking system and options counseling is provided to the nursing facility resident, regardless of Medicaid eligibility status. Options counseling is described in detail below in 1.4 Enrollment in MFP from a Nursing Facility.

Peer Outreach and Support for NF Residents. In addition to MDS referrals, the State receives referrals through regional peer outreach and support contracts, procured through a Memorandum of Understanding with the Department of Disabilities. The previous iteration of peer outreach focused only on Medicaid-eligible residents and did not support an on-going relationship between peers and facility residents or staff. The new peer outreach and support model requires peers to establish relationships with nursing facility residents and staff as well as family and resident councils. The peers will have an on-going presence in the facilities in order to share personal experiences with community living and provide support to individuals and their guardians throughout the decision-making and transition process.

For the purposes of this work, a peer is an older adult or individual with a disability who has utilized long-term care services or an individual who has non-professional life experience with long-term care services, disability, or aging

In the facilities, peers describe opportunities for community living, examples of others who have successfully transitioned to community living (including age and disability sensitive examples), how the basic process of transitioning works, and the community-based supports and services available. The peers have access to written materials, including informational flyers about HCBS and video presentations about the transition process with examples of individuals living successfully in the community. The peers themselves can draw on their own experiences with transition and community living to provide additional information as appropriate. Peers will share this information with residents; guardians; family members and supporters of residents; and facility staff including social workers, nurses, direct support staff, and other medical professionals. Peers will also attend and educate participants of family and resident council meetings. The State and peer outreach and support contractors will help peers develop positive working relationships with facility staff. Peers will be expected to schedule their visits and to identify themselves when visiting a facility.

When an individual resident or guardian indicates an interest in further exploring HCBS options, the peer makes a referral via the LTSSMaryland tracking system for options counseling. Options counseling is described in detail below in 1.4 Enrollment in MFP from a Nursing Facility

The Department of Disabilities and their peer outreach and support contractors are responsible for recruitment and training of peers, monitoring the work of the peers, and collecting and reporting data as required by the State. Training for peers will include information about MFP, basic information on Medicaid –funded home and community-based service options, and the State's protections from abuse, neglect, and exploitation. The Department also partnered with the Long-Term Care Ombudsman Program for training peers. The Department approved all training material for the peers to ensure accuracy in presentation of the information and materials regarding community living options, protections against abuse or neglect, and exploitation and the process to report these experiences. The State will ensure availability of alternative formats

for all MFP outreach materials and other MFP materials as requested, including audio recordings, captioning, large print, and electronic versions.

Peer mentoring is also offered to nursing facility residents via an MFP demonstration service provided by Centers for Independent Living (CILs). CILs provide peer mentoring as one of their four core services and have well established peer networks. Peer mentors from the CILs may provide ongoing support, for example through community integration activities, during the final stages of the transition process and after the transition to community living at the discretion of the individual. The CILs may provide opportunities for volunteer mentors within the peer mentoring roles.

SRC and Chronic Hospital Outreach
The Family mentoring project ended in 2012 however a variety of strategies continue to be implemented to address family opposition.   Person Centered Planning was an effective tool in the 2008 Rosewood (former ICF/ID) closure. A new generation of professionals received person centered planning facilitation via the now ended family mentoring project.   Person centered planning exercises continue to be available for SRC families by SRC social workers or DDA Community Placement Specialists.

A separate peer mentoring process was implemented for people with intellectual disabilities residing in SRCs and is described below.
Peer Mentoring for SRCs. Maryland currently contracts with the Arc of Maryland's Self Advocacy Network (SAN) for peer mentoring, now called People Connections. People Connections is a peer mentoring initiative where individuals with disabilities with a strong background in deinstitutionalization who live in the community (referred to as People Connection Peers) are paired with individuals who live at one of the two remaining State Residential Centers. The goal is for the person who lives in the community to share personal experiences about life in the community as well as reinforce individual rights, self-determination, and to provide community connections so that individuals living at the SRC can make informed choices about the community. Referrals are received from SRCs, MFP Community Placement Specialists and day programs that SRC residents attend.   This effort was expanded in 2010 to provide opportunities for individuals to spend additional time with their Community Connector in the community, to increase the number of available peer mentors, to expand access to peers to all of the SRCs, to allow for peer mentoring opportunities for 6 months following transition to the community. In 2013 SAN continues to provide peer mentoring at the SRCs and/or day programs in individual or small group gatherings with periodic experimental off campus community outings related to a person's interests and/or preferences. Current peer mentoring efforts link current SRC residents with previous SRC residents via the delivery of welcome to your new home or community baskets or return to the SRC for special activities.

Chronic Hospital Outreach. Maryland created a pilot resource coordination program in 2003 for individuals with acquired brain injuries to assist them with accessing services and supports that they need in the community, transitioning out of long term care facilities and/or diverting them from institutional care. Resource Coordinators assist individuals with accessing entitlements, finding housing, accessing clinical services, organizing their homes and finances, obtaining employment services and linking with other needed supports in the community so that the

individuals can live as independently as possible in their own homes. Maryland's Traumatic Brain Injury Advisory Board, which reports to the Governor and Maryland's General Assembly, recommended expansion of the program statewide. In 2012, MHA made a decision to maximize the resources available through Maryland Access Point by utilizing MFP rebalancing funds to contract with the Brain Injury Association of Maryland (BIAM) to provide brain injury specific information and referrals to individuals with brain injury and their families who access Maryland Access Point, provide outreach and education to individuals in institutions, application assistance, and enhanced transitional case management services to individuals who apply for the TBI waiver program. BIAM provides outreach to residents in CARF accredited Chronic Hospitals and State owned and operated nursing facilities as well as to their family, guardians, and other supporters to provide education and support in making decisions about pursuing community living and offer application assistance for the TBI waiver.

Access to Facilities and Residents. MFP has worked to gather feedback from nursing facilities related to the new peer outreach and support model. Drafts of the proposed changes to the model of peer outreach and support were sent to both nursing facility industry groups, and facility representatives and both groups were specifically invited to participate in the stakeholder discussions related to the new model. Prior to implementation in nursing facilities, a letter from DHMH was sent to each Medicaid licensed facility to announce the changes to the demonstration, and its initiatives in Maryland, its goals and objectives, and the methods of communicating with facility residents. The letter requires that NFs allow peers to have access to residents in order to offer information about community-based living options. The letter includes assurances of the privacy of the residents' personal information and that no resident will be compelled or coerced to participate in any discussion or effort to transition to the community. The letter also includes a process for reporting concerns to DHMH about peers and their access to facilities. The peer outreach and support contractors also received this letter and have the ability to report concerns about access through the same reporting mechanism. Facility representatives currently on the stakeholder advisory group had the opportunity to participate in reviewing the letter and to assist in disseminating information to their partners throughout the State. DHMH will continue to include the nursing home providers on its ongoing advisory committee, seek out their input, and ensure that the interests of the facilities are respected during the demonstration.

DDA MFP Community Placement Specialists work collaboratively with SAN staff devising and supporting People Connections activities. DDA MFP Community Placement Specialists frequently attend SRC individual annual meetings, often discussing MFP related activities such as peer mentoring with SRC residents and their families. MFP activities are often depicted in SRC newsletters. DDA MFP Community Placement Specialists frequently attend SRC activities such as community provider fairs or picnics, People Connections specialty themed activities, or new SRC staff orientations.

Targeting. As the State plans to develop a comprehensive outreach program to reach NF residents through MDS 3.0 Section Q referrals, as well as peer support contracts as described above, the only targeting criterion used for this population will be residency in a Medicaid-licensed nursing facility.

For residents of SRCs, Written Plans of Habilitation will be used to identify individuals for whom the community has been determined to be the most integrated setting. MFP activities will

build upon existing processes for identifying SRC residents that choose to move into the community, the details of which are included below, in Section B.1.5 State Residential Center Participant Enrollment.

1.4 Enrollment in MFP from a Nursing Facility

Transition Coordination. The enrolled supports planning agencies for each waiver are responsible for assisting individuals during the period of transition and will coordinate community services, assist the individual with securing providers for the approved waiver services, and assist with the administration of waiver transition funds and MFP flexible funds (through the Fiscal Management Agent) available for demonstration participants up to 60 days after the day of transition. The transition coordinators are highly knowledgeable about community living and resources, including but not limited to: housing options, home health providers, disability specific resources, assistive technology, medical equipment and supplies, and other local area resources, as well as Maryland Medicaid, including its programs, services, medical and financial eligibility criteria, complaint and fair hearing processes, and administrative processes. The transition coordinators will have access to the State-generated training and informational materials as well.

Starting in 2014, applicants and participants will have a choice of supports planning (case management) providers for the Home and Community Based Options Waiver, Community First Choice, and Medical Assistance Personal Care program. The Area Agencies on Aging are designated supports planning providers and additional providers have been identified through a competitive solicitation process. Applicants will receive information on the available providers in their region and will be allowed to select a provider. If an applicant does not select a provider, one will be auto-assigned to them through a randomized selection process.

Maryland directs funding to the statewide network of MAP sites to serve as single points of entry into the long-term care service system. All MFP service providers will be MAP partners and collaborate to provide a wide array of options to individuals who seek assistance. For individuals in institutions, the process begins with a referral to the local MAP. Anyone may make a referral, including the individual; however, the majority of referrals are likely to come from peer outreach and support staff, facility staff, MDS referrals, and family members.

Options Counseling. Residents that want to explore the option to return to the community will be referred for options counseling. Options counseling replaced and merged the previous model of program education and application assistance services. The 19 local Area Agencies on Aging (AAAs) in partnership with the seven Centers for Independent Living (CILs) provide options counseling to nursing facility residents that indicate an interest in community living. Referrals for options counseling will come from the peer outreach and support partners, the Minimum Data Set 3.0 (MDS 3.0) Section Q, ombudsman, waiver staff, nursing facility staff, information and assistance staff, family members, etc. Generally, options counseling for individuals aged 49 years or younger is performed by the local CIL and for individuals aged 65 and over, is performed by the AAA. For individuals ages 50 to 64, the options counseling is a collaborative effort between the aging and disability partners which is determined at the local level.

All staff providing options counseling will meet minimum qualifications and training requirements. Shared training between local aging and disability partners will be conducted and

the same information will be provided, regardless of which partner conducts the options counseling.

Options counseling provides further program information about each of the home- and community-based services (HCBS) waivers for which the individual may be eligible and assist the individual in understanding his or her options. The information can be shared with other interested people at the resident's request, such as family members, guardians, and other supporters.

If the individual wishes to apply to receive services through the Home and Community Based Options Waiver (HCBOW), the options counselor will provide assistance with completing the application, including providing assistance in obtaining needed supporting documents. The options counselor will also provide the packet of materials related to supports planner selection. As some residents of NFs may be more appropriately served through the TBI or DDA waivers, individuals who meet the technical eligibility criteria and wish to apply for the Traumatic Brain Injury, or Community Pathways waivers will be referred to the Brain Injury Association of Maryland or Statewide SRC Transition Coordinator.

Medicaid Eligibility. Once the options counselor completes and submits the HCBOW application, they will document its completion in the LTSSMaryland tracking system. This will trigger the DEWS (Division of Eligibility Waiver Services), UCA (Utilization Control Agent), and AERS (Adult Evaluation and Review Service) processes. The DEWS eligibility process establishes financial eligibility for the waivers. The UCA verifies medical eligibility. AERS completes a medical assessment (interRAI-Home Care) and recommends services needed by the individual in the community. The AERS assessment is then forwarded to the waiver transition coordinator who will use it to develop a plan of service with the resident that details the waiver and/or Community First Choice services and budget. As the last part of the eligibility process, this plan is then approved by DHMH or their designee for the Home and Community Based Options Waiver. e A letter of waiver eligibility called a Waiver Advisory Opinion Letter is then sent to the resident and states the six month eligibility period for transition. A letter of denial will be sent to the applicant if the person is determined not eligible, as is the current practice.

Housing Assistance. As housing is one of the main barriers to community living, housing assistance may greatly increase the number of people that are able to make the transition. In 2009 and 2010, housing training was provided through the MFP demonstration to develop housing expertise among waiver case managers and MAP partners who will provide information about types of housing options, the availability of housing, and the housing subsidy systems. Due to the feedback that housing assistance should be provided by individuals with housing knowledge and expertise, housing specialist positions were created within the MFP administration at DHMH specifically to work with consumers, family members or representatives, and case managers to assist individuals to access affordable, accessible housing. They provide intensive support to complete applications, acquire needed documentation, and secure housing. Housing assistance may also include opportunities for MFP participants to visit potential houses using their supplemental service funds (Section B.5.4). In addition to this individual assistance, the MFP housing team is responsible for monitoring and working to improve the housing situation for MFP demonstration participants. The MFP housing team has developed relationships with local housing authorities, developers, and other partners working on the same goals to increase

housing opportunities and to more efficiently identify and access housing as it becomes available. This service will be vital to those seeking independent community housing.

MFP Eligibility Determination. Once an individual is determined eligible for waiver services and/or Community First Choice, the transition coordinator will determine whether the individual is eligible for the MFP demonstration and its supplemental services. It is estimated that only a fraction of the individuals who apply for waiver services will meet the eligibility criteria for the demonstration. In order to verify that the individual has 90 days of residence in an institution or institutions, the transition coordinator will use data from current and former facilities of residence. This data can include admission and discharge dates. MFP participants may be eligible for additional services, but the State will in no way discourage MFP ineligible individuals who meet the waiver eligibility requirements from transitioning to the community.

1.5 Enrollment in MFP from a State Residential Center

Relevant Legislation. In July 2005, Maryland House Bill 794, entitled *Developmental Disability – Written plan of Habilitation – State Residential Centers,* was passed requiring independent resource coordinators to be part of the development of a Written Plan of Habilitation for all individuals residing in State Residential Centers. The Written Plan of Habilitation (WPH) is developed by the individual, an independent resource coordinator, and a treating professional designated by the SRC facility Director on an annual basis or more frequently as requested. The plan includes recommendations from both the treating professional and the resource coordinator regarding the most integrated setting appropriate for the individual. As of June 2009, if no individual or family opposition to transition has been identified, a referral to the Regional Office is to be generated by the team.

The current WPH Information Form was modified in 2011 to reflect decision making for the person, his/her participation during the meeting, and how opposition was determined as recommended by the Advisory Committee.   Training on the new WPH Information form was provided to treating professionals and resource coordinators in February 2011 and the new form was subsequently enacted. In 2013, the DDA modified the WPH Information Form to capture integrated setting recommendations of treating professionals and resource coordinators. The previous form only included the recommendation of the person completing the form. In addition, a text box was added to enable the treating professional and resource coordinator to reflect the efforts to address barriers to the most integrated setting when the plan was previously developed.

As noted in the July 2013 WPH Report, 96% (110 of 115) of SRC residents were recommended for community residential services as the most integrated setting by both resource coordinators and treating professionals. These 110 people reside in Western Maryland (51) and on the Eastern Shore (59).

Community Placement Teams. For persons with developmental disabilities residing in SRCs, the Community Placement Teams will be utilized to assist in the process of moving into community-based services. Each Community Placement Team will include the SRC resident, an experienced Resource Coordinator (case manager), a community placement specialist, SRC staff, family, guardians, peer mentors from People Connections, and others as identified by the individual. The Resource Coordinators are case managers who are knowledgeable about Developmental

Disabilities Administration (DDA) processes, Medicaid HCBS and State Plan services, and community living options and resources. On July 1, 2013 the DDA announced the selection of two additional providers for resource coordination. The two providers join several local health departments across the state to serve a critical role providing resource coordination which covers a wide range of assessment, planning and coordination, referral, and monitoring activities to assist individuals with intellectual and developmental disabilities in obtaining and retaining services. The DDA is transitioning the current resource coordination service delivery methodology for all people receiving services from the DDA to Medicaid Targeted Case Management for all Medicaid eligible and DDA rate base service for non-Medicaid eligible. The transition will provide standardized scope of services, deliverables, and rates. The Resource Coordinators will complete the application and eligibility process with the residents and their families. The community placement specialist will visit the SRCs, develop relationships with the residents, the center staff, the residents' families, and other interested parties in order to facilitate transition planning. This Specialist will be an essential member of the Community Placement Team who will identify barriers to transitioning for an individual and develop solutions. The DDA Regional Offices will continue to complete the eligibility process. DDA learned a great deal from the experience of closing several SRCs, including the importance of developing very close relationships with families who have concerns about moving their loved ones into the community. The community placement specialist will be a key figure in determining the root concerns of families and working to alleviate those concerns.

Essential Lifestyle Planning
Essential Lifestyle Planning is one of several person-centered planning processes that helps to identify, organize, and communicate what is important to an individual who needs support services. Essential Lifestyle Plans (ELPs) that are generated through this planning process incorporate the individual's priorities into the service plan.

As people transition out of SRCs and into home and community-based services, person-centered planning is crucial to determining high quality services in the most integrated setting of choice. In order to ensure each individual directs their service plan and that their values are respected, person centered plans will be completed with residents prior to the development of their service plan for transition. Several staff involved in the closure of Rosewood (SRC) are now certified to complete ELPs and have received training and certification to do so. Additional people throughout the state have been trained to facilitate other nationally recognized person-centered planning systems (i.e. PATH, Circles of Support, etc.) These staff will be utilized to complete person-centered planning for other residents of Maryland SRCs as they plan their transition to the community.

Budget Allocations

The Supports Intensity Scale (SIS) measures support requirements in 57 life activities and 28 behavioral and medical areas. The SIS measures support needs in the areas of home living, community living, lifelong learning, employment, health and safety, social activities, and protection and advocacy. The Scale ranks each activity according to *frequency* (none, at least once a month), *amount* (none, less than 30 minutes), and *type* of support (monitoring, verbal gesturing). Finally, a Supports Intensity Level is determined based on the Total Support Needs Index, which is a standard score generated from scores on all the items tested by the Scale.

As part of MFP rebalancing, the DDA completed a pilot of the use of the SIS with an initial 100 transitioning SRC residents. This sample has been expanded to include an additional 900 individuals living in the community. DDA intends to further explore use of the tool to develop appropriate funding allocations based on people's support needs by working in concert with the American Association on Intellectual and Developmental Disabilities (AAIDD) and the Human Services Research Institute (HSRI) to develop a valid and reliable link between SIS scores and individualized budgets, and replace the Individual Indicator Rating Scale assessment with the SIS on a system-wide basis. On going analysis and algorithm development for individuals in SRCs and in community settings will form the basis for budget allocations that meet the needs of individuals with severe disabilities in the community.

Ask Me! Surveys
Maryland MFP Stakeholder Advisory Group expressed many concerns about the national Quality of Life survey tool that is required as a part of the MFP demonstration; particularly that it was not an effective tool for assessing quality of life for people with significant intellectual disabilities. In Maryland, the Ask Me! Survey has been used annually since 2002 to collect information from people receiving community-based services through Developmental Disabilities Administration (DDA). The Ask Me! Survey measures people's perceptions of the quality of their lives and allows people with intellectual disabilities to define quality of life for themselves. People with intellectual disabilities helped develop the survey instrument and procedures, promote the survey, and conduct the interviews. The Ask Me! Project has demonstrated that people with intellectual disabilities elicit and provide data on quality of life that are valid, reliable, and useful for program enhancement. As Maryland has already been using an effective tool for measuring quality of life and has historical data on people receiving supports in the community, DDA chose to administer the Ask Me! survey to people who transitioned out of Rosewood through MFP. This survey was conducted in addition to the MFP Quality of Life survey. While this survey provided valuable information, the response rate and follow-up surveys for the Ask Me! were not as high as those achieved by the MFP QoL surveyors and the separate, second survey will not be implemented for future transitions.

In April 2012, the DDA was funded through the National Association of State Directors of Developmental Disabilities Services (NASDDDS) to support Maryland's ability to measure and track state developmental disabilities service outcomes and performance. The DDA indicated it would track the service outcomes and performance through the use of the National Core Indicator's (NCI) Quality of Life Survey. The data obtained by the NCI is essential in DDA's goal of improving the quality of services offered to our people receiving DDA funded services. The information revealed by the indicators will assist the DDA in improving areas such as employment, rights, service planning, community inclusion, choice, and health and safety.

1.6 Enrollment in the TBI Waiver

BIAM will assist with outreach to residents in CARF accredited Chronic Hospitals and State owned and operated nursing facilities as well as to their family, guardians, and other supporters to provide education and support in making decisions about pursuing community living, application assistance and coordination of needed community resources and supports for the individual, and enhanced transitional case management to ensure successful transitions to the community.

Provider Incentives. As the capacity of the waiver has increased and more people are accessing services in the State, provider capacity has become an increasing issue. Currently, individuals in institutions must wait for an opening with a provider in order to transition and moves are sometimes delayed by lack of capacity in the system. Also, there are less than 10 waiver providers in the State, which limits the individual's choice of provider. In order to overcome these limitations as the waiver grows, increasing provider capacity is essential. While there are many high-quality providers in the community, many of them are unwilling to become waiver providers as the start-up costs are prohibitive. In an effort to overcome this barrier, the Department will offer a one-time only incentive payment of $25,000 to providers who open a new qualified residential site to offset the costs of provider start-up. Start-up costs covered by the incentive payment may cover costs such as environmental modifications to a group home, modifying a vehicle for accessibility, recruiting and training staff, and or furnishing a residence.

1.7 Reenrollment and Reinstitutionalization Policies

Reenrollment. If a demonstration participant must return to an institution for more than 30 days prior to the completion of the 12 month demonstration period, the individual may re-enter the demonstration upon return to the community and participate for the unexpended duration of the demonstration period for that individual. If an individual must return to an institution for less than 30 days, they will continue to be participants in MFP while in the institution.

If an individual completes 12-months of participation in the demonstration, and, for whatever reason, returns to a NF, chronic hospital, IMD, or SRC, the individual may return to the community as a demonstration participant if he or she meets the same initial demonstration requirements: 90 days of continuous residency in the institution, is Medicaid eligible on the day prior to participating, and returns to a qualifying residence.

Reinstitutionalization. For each individual that is reinstitutionalized and is referred to the local MAP site, TBI Resource Coordination, or Community Placement Team for transition back to community living, the MAP or Community Placement Team will be responsible for identifying reasons for reinstitutionalization and addressing them to the extent possible. The State will track reasons for reinstitutionalization through the tracking system, determine trends, and develop remediation and improvements strategies in accordance with the Waiver Quality Council.

1.8 Ensuring Informed Choices about Care

Participants in the Maryland Money Follows the Person Demonstration will receive home- and community-based services through the existing and ongoing 1915(c) waivers that are currently in place, as well as the Community First Choice program. These programs all require institutional level of care and participants are re-evaluated annually for medical eligibility. Therefore, an individual participating in a HCBS waiver or CFC remains eligible to receive their long-term care services in an institutional setting and can choose to utilize institutional services rather than community-based services at any time. Maryland's HCBS programs are voluntary and the participant is informed of their options for care by the program's case manager during the enrollment process and indicates their preference for services on the informed consent form.

MFP applicants will be provided with information about the Division of Waiver Programs' Reportable Events Policy and the Developmental Disabilities Administration's Policy on

Reportable Incidents and Investigations which outline policy and process information concerning the consumer's protections from abuse, neglect, and exploitation. These policies also include information about notifying appropriate authorities or entities when abuse, neglect, or exploitation is experienced.

For NF residents, transition coordinators will be providing this information regarding choices about care and protections from abuse, neglect, and exploitation, including notification information, at the time of application. For SRC residents, the Resource Coordinator will furnish this information at the time of application to the HCBS waiver program. This information will also be discussed and reviewed during the annual review of the plan of service by the program case managers.

2.   Informed Consent and Guardianship

2.1 Informed Consent Procedures

MFP participants will utilize the same consent procedures that are used for HCBS waiver participants. Currently, waiver applicants (and as appropriate, family members, guardians, etc.) are provided the information needed to understand what they are applying for, how the process works, and what their options are for receiving care. Individuals are also informed that they may at any time choose to return to the institutional setting. The consent forms for each waiver are provided in Appendix A. Under MFP, the options counselor or DDA/TBI Resource Coordinator will provide consumer education and materials prior to asking applicants or guardians to sign consent forms. The options counselor and/or Community Placement Specialists will manage the informed consent process for MFP eligible residents of nursing facilities during the options counseling process. Resource Coordinators contracted through DDA and/or Community Placement Specialists will manage the informed consent process for residents of SRCs and their representatives.

The consent form for MFP demonstration participants is below in Table B.2.1. It includes a description of what constitutes a "qualified residence" so that participants understand the types of residences they may choose under MFP. Applicants that wish to receive services from an Assisted Living Facility (ALF) shall be made aware that their residence cannot serve more than four unrelated individuals in order to be eligible for the MFP demonstration. They are free to choose a larger ALF, but will not meet the MFP requirements. Individuals with developmental disabilities moving from SRCs or NFs will have the choice of moving into Alternative Living Units (ALUs) of no more than three residents, to their own home, or to their family's home. The MFP consent form will also describe the services available only to demonstration participants and information about the Quality of Life evaluation.

The State currently does not have a statutory or regulatory basis for determining who can and cannot provide informed consent without a formal adjudication process. Thus, in most instances, informed consent is a process where there is agreement that the person involved is aware and is making an express choice to live in the community.

Table B.2.1. Consent Form for MFP Participation

Consent Form for Money Follows the Person

I freely choose to participate in the Money Follows the Person program. I understand that this program allows me to receive a limited amount of flexible funds for expenses related to my transition from the facility where I currently live to a new home in the community. I understand these funds may be used for groceries, transportation expenses, and other costs directly related to my transition. I understand that my transition coordinator will help me access and document my use of these funds. I understand these funds are available only after I am determined eligible for the Money Follows the Person program and up to 60 days after I transition to the community. I understand that I will receive no additional benefits or services under the Money Follows the Person program beyond the flexible funds.

I understand that agreeing to participate in the Money Follows the Person program has no impact on my eligibility for any other program, meaning that I will continue to receive other services for which I am eligible regardless of my Money Follows the Person program eligibility. I understand that there are no additional risks anticipated based on my participation in the Money Follows the Person program beyond the risks related to receiving services in a community setting, for which I have already provided my consent.

In order to participate in the Money Follows the Person program, I have been informed that I must meet all of the eligibility requirements specific to the Money Follows the Person program, which include 90 days living in a qualified institution (excluding rehab stays), such as a nursing facility or State Residential Center, one (1) day of Medicaid eligibility prior to my date of transition to the community, and finally that I must choose to live in a qualified residence, defined as:

1. A home owned or leased by myself or a family member;
2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which myself or my family has domain and control.
3. A residence, in a community-based residential setting, in which no more than 3 other unrelated individuals reside.

As an MFP participant, I will be asked to complete three short surveys about my quality of life. I will still be eligible to receive flexible funds for transition even if I do not complete the surveys.

My signature below indicates that I agree to participate in the Money Follows the Person program if I am determined eligible and that any questions that I may have about the program have been answered.

Printed Name: _____ Social Security #: _____ MA#: _____

Signature: _____ Date: _____

During the informed consent process participants will receive information about the complaint process and procedures that are associated with the waiver to which they are applying. The complaint processes for the waivers that MFP participants may access are as follows:

The complaint process for participants of the HCBOW will be governed by the Reportable Event Policy and Procedure as found in Appendix B-1. This policy will be updated to reflect the combination of the two programs. The Division of Waiver Programs (DWP) shares oversight responsibility with the Administering State Agencies (ASAs) for the HCBOW. . The Maryland Department of Health and Mental Hygiene (DHMH) is the ASA for the HCBO Waiver. Under the Reportable Events Policy and Procedure, a complaint is defined as any communication, oral or written, from a participant, participant's representative, provider, or other interested party to any employee of the DWP or ASA, a Case Manager (CM)/Support Planner (SP), or waiver providers, etc., expressing dissatisfaction with any aspect of the program's operations, activities, or an individual's behavior. All entities associated with the waivers, including DWP, ASA Case manager/supports planner (CM/SP), and waiver providers are required to report real or alleged reportable events in full on the Reportable Event Form. All incidents of alleged or actual abuse, neglect, or exploitation must be immediately reported to Adult Protective Services and the ASA. All complaints and reportable events are forwarded to the CM/SP, who will work with the participant to resolve the complaint and take immediate action to resolve health and safety issues, if necessary. For example, if the complaint involves an absent attendant care provider, the CM/SP can work to resolve the issue immediately by contacting emergency back-up providers. All Reportable Events are then submitted to the ASA and are logged into the Reportable Event database and reviewed to determine if further action is needed. If further review is needed, the ASA shall follow up with appropriate parties, determine and implement appropriate action involving the participant and/or waiver provider, request a corrective action plan from the provider if deemed necessary, send a status letter to the participant or authorized representative regarding the review within 7 calendar days, and summarize the findings on the Reportable Event Review form. The ASA compiles monthly summary reports of all events and submits the reports to the DWP for review. The DWP compiles a consolidated report containing analysis of the reportable events data and makes recommendations for improvement. Please see the attached Reportable Event Policy and Procedure in Appendix B for additional details.

The New Directions, Community Pathways, and TBI waivers utilize DDA's Reportable Incidents policy to monitor quality and manage the complaint process. Appendix B (effective 1/15/13) includes the Policy on Reportable Incidents and Investigations that is used for the CP and ND waivers. Self-reported incidents and complaints are reviewed upon receipt by the Office of Health Care Quality (OHCQ) to ensure that those incidents posing immediate jeopardy to the individual are immediately investigated. A triage specialist reviews each report and notifies the DDA Investigations Unit manager of the need to evaluate the report for appropriate assignment based upon the severity and scope of the incident. Incidents are prioritized on a scale of one to six with one being an incident that presents immediate jeopardy. OHCQ responds based on the severity rating and responses range from an on-site investigation within 2 days to providing referrals. Please see the sections labeled Administration Prioritization and Investigation Procedures in the Policy on Reportable Incidents and Investigations in Appendix B for details. Incidents or complaints that have not been acted upon are reviewed weekly by the Incident Screening Committee at OHCQ. Further, DDA Regional Quality Assurance Teams conduct site visits, review quality assurance plans, and provide technical assistance to providers to improve

quality assurance and ensure that systems are in place for preventing the reoccurrence of incidents and complaints.

2.2 Guardianship under MFP

In Maryland, there are two types of guardianship, Guardian of the Person and Guardian of the Property. A Guardian of the Person makes decisions about medical and personal care and decides where the person will live. As this type of guardian has the authority to make decisions about place of residence, Guardians of the Person will be able to sign the informed consent form for the MFP demonstration.

A Guardian of the Property manages the money, assets and property for another. Estates & Trusts sec. 13-201(c)(2) describes a general guardianship of the property as including power over "property or benefits which require proper management." Thus, a guardian of the property, unless limited by the language of the specific court order, would ordinarily be in charge of managing the MA benefit, including switching between institutional long term care and a waiver program, especially since there may be more than one waiver option to consider. Therefore, a guardian of the property will be asked to sign the MFP application form along with the resident. If the guardian of the property refuses to sign the consent form with the resident, the State may seek redress to the court that appointed the guardian.

 In all other cases, the resident of the institution will be the person providing the signature for the MFP consent form. However, other individuals who are representative payees or other legal representatives associated with the individual will be contacted by the transition coordinator or community placement specialist at the time of referral so that representatives can be involved in the process of planning for transition. Guardians and other interested parties identified by the individual will be an ongoing part of the transition planning process.

The State requires that the guardians have a known relationship with the person and that the person must interact with the individual. The law states that guardians "shall maintain appropriate records to document the care and maintenance services provided directly to the disabled person to receive any payment under this subsection" (Annotated Code of Maryland, Estates and Trusts Article § 13-708. Rights, duties and powers of guardians). The state does not have a specific visitation requirement for non-public guardians. However, non-public guardians are required to report on their activities at least annually to the court that appointed them. This current reporting practice will serve to fulfill any requests for information from CMS regarding MFP participants.

For most individuals residing in SRCs, family members act as guardians. However, on occasions where a family member is unavailable and some manner of guardianship is necessary, a public guardian is appointed. The Area Agencies on Aging (AAAs) and the Department of Human Resources (DHR) serve as public guardians for many people with disabilities, including some individuals currently living in nursing facilities and SRCs. The AAAs are required to visit those for whom they serve as guardians at least quarterly, and DHR is required to visit at least every six months. The AAAs and DHR maintain their own records of their contacts and will provide information on recent visits to the transition coordinator or community placement specialist at the time of application when the guardian signs the consent form for demonstration participation. Private guardians will be encouraged to visit individuals for whom they have been awarded

guardianship and to provide information on the frequency of their visits to the transition coordinator or community placement specialist at the time of application. The MFP project does not have the legal authority to compel private guardians to provide visitation data. It is the court's responsibility to ensure that guardians meet their obligations. If the project staff have reason to believe that a private guardian is not acting in the best interests of the demonstration participant, the State may seek redress to the court that appointed the guardian.

Additional information about the guardianship laws in Maryland can be accessed using the resource list included in Appendix E.

3.   Outreach / Marketing / Education

3.1 Outreach and Marketing

The State intends to implement an intensive outreach and marketing program that will reach institutional residents and staff, community providers, and many other interested parties including guardians and families. There will be no geographical targeting for this outreach as the State intends to transition individuals statewide, nor will the State target individuals based on length of stay. Everyone in a facility should have the opportunity to explore options for receiving services in the community.

As described in targeting section B.1., to reach institutional residents and staff, the State will provide extensive outreach via peer support contracts that will reach all institutions, residents, and staff. The Maryland Department of Disabilities (MDOD) will lead the peer supports efforts for people in nursing facilities. Peer support includes peers developing relationships in nursing facilities with residents, family members, nursing staff, social workers, administrators, and family and resident councils. Peers will refer interested individuals to options counseling and, at the request of the individual, will maintain relationships throughout the application process for Home and Community-Based Services. These peers will use materials that are approved by the State. Outreach materials will consist primarily of a general informational flyer and handouts from the Maryland Medicaid Home and Community-Based Long Term Care Services booklet, or "blue book," of information distributed by the Department of Health and Mental Hygiene each year. Attached is the 2012-2013 informational booklet that will be used during the outreach and marketing of services to institutional residents (Appendix C). The general informational flyer will include information about the peer supports in facilities to inform residents of their community-based care options, the assistance available to assist with the transition, and contact information for additional questions or assistance. The materials will be provided to CMS upon completion. Additional information on peer outreach contracts is detailed in Section B.1.3.

Peers will work with institutional residents, family members, guardians, and facility staff. Outreach will be provided through marketing materials approved by the State and will be disseminated through letters to the institutional providers, educational articles in industry publications such as the Health Facilities Association of Maryland (HFAM) and LifeSpan Network newsletters, and through State-sponsored trainings for providers. The State will require alternative formats for all MFP outreach materials and other MFP materials as requested, including audio recordings, captioning, large print, and electronic versions. Individuals will also be able to access the outreach materials for MFP and the waiver programs through the MAP website. This site will serve as a web-based single point of entry for information about available

programs and services in Maryland. DHMH will partner with the MAP program to ensure that MFP related materials are accessible through this site.

Outreach materials and advertisements will describe how individuals with significant disabilities live successfully in the community and have transitioned from an institutional setting into the community. Other materials will provide information on services available through waivers, basic financial and medical eligibility, and guidance on how to request additional information and application assistance.

3.2 Training Professionals

Outreach will be expanded to hospitals in order to provide training for hospital discharge planners on available community options. Many people in nursing facilities came from a hospital stay and if there is more awareness about home and community based options, discharge planners can explore other options prior to institutional placement and educate individuals about options prior to a rehabilitation stay at a nursing facility so rehab stays are less likely to be prolonged.

Additional outreach and in-service training will be provided for MFP partners including discharge planners, MAP staff, peers, ombudsman, and others on topics related to MFP such as quality requirements, opportunities, and supports available in the community.

MFP will work to develop collaborative relationships with nursing facilities and their trade associations. Training and outreach will be provided to nursing facility owners, administrators, and staff to encourage their enrollment as providers in existing HCBS programs and promote the expansion of NFs into community-based personal care, nursing supervision, and other services.

Trainings relevant to MFP will be offered for health care providers and professionals working with persons with disabilities. Trainings will include information about MFP initiatives, affordable and accessible housing, and person-centered planning. The trainings will be extensively advertised through licensing and professional organizations such as the National Association of Social Workers (NASW) and the MFP stakeholder Advisory Group. The State will work with a local college to provide CEUs for attending the training program as an incentive for professionals to attend.

Statewide Training for Staff at DDA Licensed Providers

Quality training for direct support staff is a critical component in ensuring the availability of staff to provide supports to individuals with developmental disabilities in community settings. Quality training is based on core competencies and skill standards, and results in a more competent and effective workforce. DDA is looking for a recognized and validated training program with skill standards developed with input from direct support professionals, consumers, trainers, agency administrators, educators and others interested in the quality of services. The goals for implementing a new training system are to improve the quality of supports, as well as to improve retention of staff, job satisfaction, training satisfaction and to decrease provider costs associated with high staff turnover rates. DDA would like to utilize a training system that includes valuable management and human resource tools which assist states and licensed providers with tracking and recording all training and assessment activities.

The Developmental Disabilities Administration (DDA) will explore the purchase a state license for a new training system through MFP. A state license could ensure that the same high quality, competency-based training is available to all of the staff that supports the more than 22,000 individuals who receive direct support professional services funded by the DDA.

Behavioral Health Provider Training
Stakeholders identified behavioral health as an area in need of additional provider training. There are several existing trainings including The Alzheimer's Association of Maryland's training program on dementia for care providers, Maryland's Work FORCE Promise's online training program on the recovery model of treatment for mental illness, and the Maryland Coalition on Mental Health and Aging's training for care providers. Existing trainings such as those listed above will be used to educate providers about co-occurring mental, cognitive, and behavioral health issues of those they serve. They will be advertised and sponsored by the MFP demonstration to increase the numbers of providers who know about and access these trainings in order to become more qualified to serve individuals with co-occurring physical and behavioral health disabilities. Again, the professional organizations and local media outlets will be utilized to advertise the trainings.

Some stakeholders suggested that these trainings were not adequate to address the need for increased screening and diagnosis of mental and behavioral health disorders such as brain injury, mental illness, and dementia in persons living in nursing homes and SRCs. Maryland currently uses the Pre-Admission Screening and Resident Review (PASRR) to screen for mental health issues at intake into a facility or when transferring facilities. The State also uses a brief interview for mental status within its interRAI-HC assessment that evaluates level of care needs annually for individuals in institutions. Stakeholders were also concerned that the existing behavioral health services available in the community would be inadequate to serve individuals with co-occurring physical, cognitive, mental or behavioral health disabilities transitioning out of institutions and that those in need of behavioral support services would not be able to access them.

A parallel stakeholder group to the current MFP Stakeholder Advisory Group was formed by DHMH to further investigate and address these concerns. Some of the suggestions that this group evaluated include using the 1915(i) option or another waiver to serve the IMD population and others in need of behavioral health supports, adding additional behavioral supports to the existing waivers, and developing alternative payment rates for home based mental health services. The group was led by DHMH staff and developed recommendations to address these concerns in August 2008. The recommendations of the group were distributed to other advisory groups for further action. Recommendations for service changes to the waiver programs were presented to the waiver advisory committees while recommendations for the mental health service system were presented to the Aging in Place Taskforce and Traumatic Brain Injury Advisory Board. MFP stakeholders who attended the behavioral health workgroup meetings were tasked with following up on the recommendations presented to each group and reporting back to the larger MFP Stakeholder Advisory Group.

However, due to budget constraints, advocacy efforts to add services were not successful. The MFP Behavioral Health Workgroup reconvened in July of 2009 and met through March of 2010, but once again efforts to implement recommendations stalled. In 2011, MFP procured a Behavioral Health Consultant to reconvene and lead the behavioral health workgroup, analyze

the gaps in the existing service system, research best practices nationwide, and present recommendations for new services along with an action plan for implementation. The reconvened work group held a series of meetings with state agency representatives, consumers, providers, and advocates to analyze the current service system and provide recommendations for change. The consultants presented a final report with recommendations in three specific areas: improving the transition process, strengthening behavioral health supports for home and community based waiver participants, and training. The final report was submitted during the process of behavioral integration in Maryland. The changes occurring in the behavioral health system created challenges for the consultant to move forward with technical assistance.

In order to provide support at the consumer level, MFP hired a behavioral health specialist to work with MFP applicants, participants, their representatives, and case managers in order to coordinate available mental health services. The specialist also acts as a liaison for MFP with the Mental Hygiene Administration and the local mental health authorities. Rebalancing funds also support a person-centered planning and TBI training position within MHA. The trainer works with across programs to educate case managers on various issues related to TBI and person-centered planning. In 2013 this position updated training materials such as TBI-Focus on Behavior and Strategies, TBI and Older Adults, Brief TBI Training for MAPS Specialists and other MFP & BIP Partners, Brain Injury Resources 2013. Training on Mental Health First Aid and person-centered planning will be offered in the future.

4. Stakeholder Involvement

4.1 Stakeholder Involvement in Demonstration Planning

Maryland's initial application for the MFP demonstration was based on stakeholder input. Once the grant was received, an announcement was posted on the DHMH website, and the State engaged in an extensive process to convene, listen to, and respond to stakeholder concerns, questions, and recommendations that continued throughout the planning process. This operational protocol is a direct product of that process.

MFP Stakeholder Advisory Group. Following the grant award in January 2007, the State formed the MFP Stakeholder Advisory Group to guide the creation of the operational protocol. The State encouraged stakeholders and stakeholder groups already organized around various issues to nominate individuals to discuss policy and administrative issues related to the demonstration. The Advisory Group is made up of consumers, advocates, community providers, professional organizations, institutional providers, State staff, and representatives from various organizations. The State would like to have at least one participant or family member from each waiver participate on the advisory group. Expense vouchers and transportation assistance are offered to consumers and families to allow for their full participation. The advisory group does not currently have consumer representatives from the OAW or TBI waivers although there are six active members representing the aging community and one representative for persons with brain injury. As the waiver for persons with TBI is limited in size, the small pool of individuals has presented a challenge in finding a consumer representative for the advisory group. DHMH continues to actively seek consumer and family representatives for the advisory committee. The list of organizations that routinely participate in stakeholder meeting is provided below in Section B.4.6.

During the planning process, the Advisory Group met bimonthly. All meetings were open to the public, and people attending the meetings were given opportunities to raise their issues to the group. Each meeting was also broadcast through a toll-free number for interested parties who could not attend the meetings. In the first months, the group discussed the many issues raised by the MFP demonstration and how the State should address them in the operational protocol. When the group decided to explore issues surrounding the availability of housing in more depth, the State hosted an MFP Housing Day, a full day of training and brainstorming about increasing the availability of affordable and accessible housing options. As the protocol submission date grew nearer, the group's focus shifted to reviewing specific plans for implementation and then drafts of the protocol. The stakeholders received and reviewed 4 drafts of the operational protocol prior to its submission to CMS and were able to monitor the incorporation of their suggested edits into the draft that was submitted to CMS on November 1, 2007.

Current consumer advisory group members will be encouraged to continue participating in the advisory group. Consumers and their families will continue to be welcomed to the advisory group to collaborate on the demonstration as it progresses.

Since the implementation of Maryland's MFP program, meeting schedules have ranged between biweekly and quarterly. Generally the group meets monthly to discuss implementation issues, present on topics of interest, and provide input for future planning.

The MFP Demonstration was extended through the passage of the Affordable Care Act of 2010 and Maryland began a series of discussions regarding revised MFP rebalancing initiatives and their inclusion in the operational protocol rewrite in July of 2010, when a time line and plan for completing the rewrite were presented to the Stakeholder Advisory Group. The topic has been on the agenda for the group every month since that time, and there have been at least 18 stakeholder meetings that addressed components of the operational protocol since. Each meeting offered a call-in option and the ability to view a video broadcast of the meeting via the internet. There were between 20 and 45 attendees, including at least 3 consumers, at each meeting.

In the fall of 2010, based on stakeholder input, Maryland developed a set of metrics with the Hilltop Institute in order to provide adequate information to the stakeholder group about the outcomes of our current rebalancing initiatives. The Hilltop Institute conducted research and presented the metrics to the stakeholder group five times over the course of four months between October, 2010 and January, 2011. Subsequent stakeholder meetings were used to discuss how existing initiatives could be modified or enhanced in the operational protocol re-write. In April, stakeholders were presented with a compilation of ideas and a list of proposed rebalancing initiatives. At the April 5, 2011 meeting, the stakeholders broke into small groups in order to discuss and gather feedback on rebalancing priorities. A survey on rebalancing priorities was developed and given to the group at that meeting. The survey was then put online and sent to the 200+ names on the MFP stakeholder email list, in order to gather feedback from a larger audience. This feedback was used by the Department to develop Maryland's proposed rebalancing initiatives, which reflects stakeholder ideas and includes the requested details of each proposed initiative.

Current consumer advisory group members will be encouraged to continue participating in the advisory group. Consumers and their families will continue to be welcomed to the advisory group to collaborate on the demonstration as it progresses. In January of 2012, the MFP

Stakeholder Group joined with the newly formed BIP sub-group and the expanded group has continued to work on rebalancing.

MFP Project Director. Following the promotion of the initial Project Director, the State's 2011 search for the MFP Project Director resulted in the selection of Devon Mayer who previously served as the MFP Associate Project Director. Ms. Mayer brought her social work background and four years of Medicaid experience to the MFP demonstration project. She encourages all stakeholders to contact her directly by email or phone. Regular updates about the demonstration are sent by email to over 200 people who have asked to be notified.

4.2 Diagram of Stakeholder Influence during the Demonstration
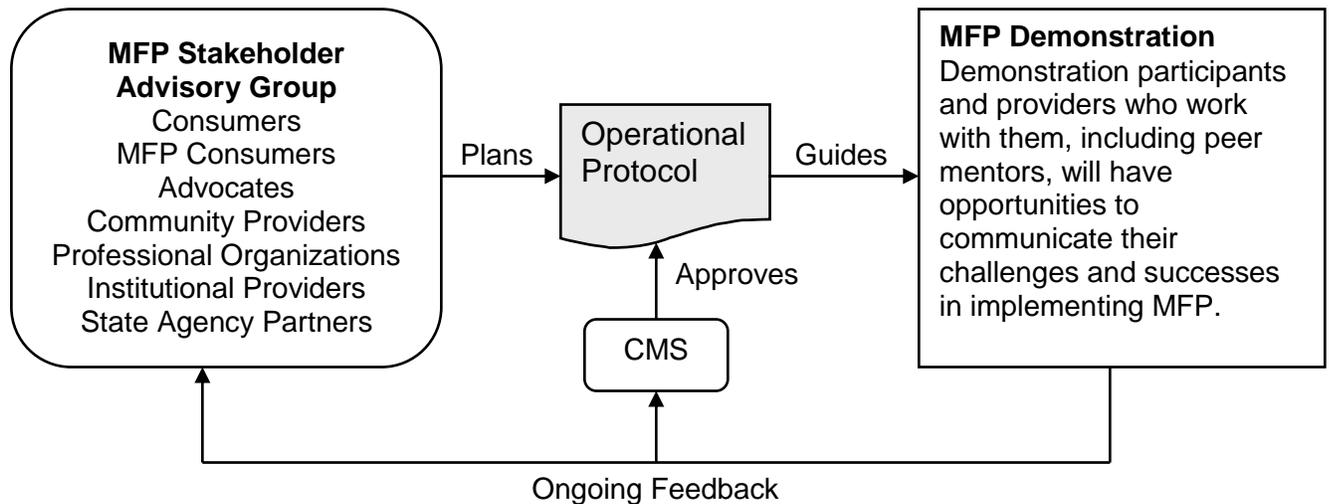
4.3 Ongoing Stakeholder Input

The MFP Stakeholder Advisory Group has continued to meet at least bi-monthly and continues to provide advice and recommendations. The State continues to request referrals for MFP demonstration participants interested in serving as members of the group. The State has also convene an additional group to address issues related to behavioral health, including serving individuals transitioning from IMDs with complex behavioral and physical needs, enhancing existing community-based services, and improving behavioral health screening.

The State will continue to provide lunch, transportation, and any other necessary accommodations to enable non-professional stakeholders to participate in its meetings.

4.4 Specific Roles for Consumers

Maryland is fortunate to have many consumers, advocates, and advocacy organizations that ensure a range of consumer voices are heard. Within the demonstration, consumers will continue to serve as members of the MFP Stakeholder Advisory Group to provide input and feedback into the demonstration as it progresses. Consumers have played an active role in the planning process through the advisory group by reviewing the operational protocol and making suggestions for the demonstration. It was the consumer advocates that proposed and supported the idea of using peers to provide outreach to institutional residents. It was disability advocates that suggested

broadening the role of peers to include ongoing mentoring support as is reflected in the operational protocol. Another significant contribution from consumers and disability advocates is the aggressive projection of numbers of transitions. It is with the encouragement of the consumer advocates that the State has maintained such aggressive growth and transition projections for the demonstration.

Consumers will also play a role in assisting individuals during their transition out of institutions. Consumers may be identified by institutional residents and participate in the transition process as a mentor. More formally, these consumers with experience in transitioning and/or the waiver programs will be ideal candidates to act as peer mentors. The peer mentoring contractors are likely to employ current consumers and their families in the role of peer mentors so that consumers and advocates will have a direct role in the outreach and marketing of Maryland's community-based care options and in the direct support of individuals who are seeking to transition. This will provide an avenue for consumers to directly influence the process and better inform the Advisory Group of transition challenges and successes. Consumers will continue to be involved through the Advisory Group and may assist the process by including advertisements and articles in their publications regarding the MFP demonstration. These publications may help to educate consumers and families while promoting the goals of the demonstration.

4.5 Specific Roles for Institutional Providers

Institutional providers are an essential element of the MFP demonstration. They will continue to provide care for their residents as well as play a role in the transition process for those individuals who pursue community living. Direct care staff at facilities often advise residents and inform nurses about elements of care that will be needed in the community. In addition, direct care staff of the SRCs may participate in trainings and be encouraged to pursue employment as community providers in order to continue supporting the individuals whom they serve as they move to a new setting. Nurses who develop institutional plans of care may be consulted in the process of developing the community plan of care. Social workers at the facilities will be providing direct assistance to the residents in the transition process by helping to secure needed documentation, such as prescriptions from doctors and copies of medical records, and will be helping to obtain durable medical equipment needed prior to and at the time of transitions. The cooperation of all staff working with residents at institutions will be required to facilitate a smooth transition and continuity of care between settings. Institutional administrators will need to understand and support the MFP demonstration so that they can assist in disseminating the information and encourage facility staff to fully participate in the process. The professional organizations that represent the staff at facilities may help support the project by allowing advertisements and articles about MFP in their newsletters and websites.

4.6 List of MFP Stakeholder Organizations

- o   HCBS Consumers
- o   AFSCME (Union that represents independent personal care workers)
- o   Baltimore City CARE Service (AAA)
- o   Baltimore City Health Department
- o   Baltimore County Office on Aging (AAA)
- o   Behavioral Health Systems Baltimore (Local mental health authority)
- o   The Brain Injury Association of Maryland (Advocacy Organization)

- o Community Behavioral Health Association of Maryland (Professional organization for community mental health providers)
- o The Coordinating Center (Non-profit Waiver Case Management Provider)
- o The Freedom Center (CIL)
- o Harford County Health Department
- o Health Facilities Association of Maryland (Nursing Facility Provider Association)
- o The Hilltop Institute (Research Center)
- o Howard County Office on Aging (AAA)
- o The Image Center (CIL)
- o Independence Now (CIL)
- o Johns Hopkins University (State Affairs, School of Nursing, PACE)
- o Legal Aid (Non-profit law firm that provides free civil legal services)
- o LifeSpan Network (Nursing Facility and Senior Care Provider Association)
- o Maryland Association of Community Services (Non-profit Association for agencies that provide DD services)
- o Maryland Association of Core Service Agencies (Association for the local mental health authorities)
- o Maryland Disability Law Center (Protection and Advocacy Organization)
- o Maryland Senior Citizens Action Network (Advocacy Organization)
- o The Mental Health Association of Maryland (Advocacy Organization)
- o Montgomery County Aging and Disability Services (AAA)
- o People on the Go (Statewide Self-Advocacy Organization)
- o Prince George's County Administration on Aging (AAA)
- o Resources for Independence (CIL)
- o Southern Maryland Center for Independent Living (CIL)
- o The Sunshine Folk (Advocacy Organization)
- o United Seniors of Maryland (Advocacy Organization)
- o Voices for Quality Care (Advocacy Organization)

4.7 List of State Agency Partners

- Maryland Department of Health and Mental Hygiene (DHMH)
  - o Developmental Disabilities Administration (DDA)
  - o Mental Hygiene Administration (MHA)
  - o Healthcare Financing/Medical Assistance
  - o Office of Health Care Quality (OHCQ)
- Maryland Department of Aging (MDoA)
  - o Ombudsman Program
- Maryland Department of Disabilities (MDOD)
- Maryland Department of Housing and Community Development (DHCD)
- Maryland Department of Human Resources (DHR)

5.   **Benefits and Services**

5.1 Benefits of MFP for Demonstration Participants

The primary benefits associated with the MFP Demonstration are peer support and mentoring, options counseling, housing assistance, and one time only transition funds. These priorities were identified through the stakeholder process to assist individuals in transitioning into the community.

The peer supports program is designed to provide outreach and education about community living to institutionalized persons and their families in a comprehensive and accessible way. Peers are able to reach out to individuals and share information about choices, opportunities, and challenges associated with leaving an institution in a personal and accessible format through sharing their own experiences. In addition, regionally based peer mentors will enhance the connection to the local community and the option of ongoing peer support will assist institutionalized individuals gain comfort, knowledge, and skills in accessing and navigating their communities while in the process of transitioning and throughout their year of MFP eligibility.

Peer support is available to residents of SRCs. Currently; peers spend time with SRC residents at the facilities and occasionally participate in community-based events with SRC residents and staff. There is little data to demonstrate that this effort is having an impact on the residents' comfort in the community and desire to transition and stakeholders have questioned its efficacy due to the structured facility-based events and limited amount of mentors available. The DDA intends to conduct an evaluation of the service in early 2012 and explore the option of merging this effort with the peer supports available to individuals in nursing facilities. The NF peer efforts could be expanded to include all SRC residents and residents of nursing facilities with intellectual disabilities, and increase the focus on community activities, integration, and exploration of HCBS. The DDA continues to explore the efficacy of the current peer mentoring contract at SRCs. Data derived by the peer mentoring activities delineated in the current work plan in 2013 will be essential to evaluate with stakeholders input the continuation, end, or integrated participation in existing MFP program system-wide peer mentoring activities.

In 2012 the family mentoring contract ended however strategies to address opposition by families continue to be devised and reflected in the DDA's annual Report on Written Plan of Habilitation for Individuals in State Residential Centers (HB 794 – Chapter 396 of the acts of 2005).

TBI peer support is a new initiative that would build on the current peer support models and pilot peer support for TBI waiver applicants, participants, and their families. This model is carved out from the NF model because the TBI waiver includes chronic hospitals and requires a more narrow definition of a peer with specialized knowledge, training, and support.

Options counseling, as described above in the Project Introduction on page 11 and in section 1.4 *Enrollment in MFP from a Nursing Facility* on page 24, will aid individuals in learning more about community options and increase access to the current home- and community-based services.

As housing is one of the main barriers to community living, housing assistance may greatly increase the number of people that are able to make the transition. MFP housing specialists work with potential and enrolled MFP participants to provide information about types of housing options, the availability of housing, and the housing subsidy systems. They provide intensive support to complete applications and acquire needed documentation.

Transitional waiver case managers/supports planners are responsible for coordinating the administration of transition funds in conjunction with the fiscal intermediary, another key support for a successful transition into the community. Assistance in identifying needs and paying for security deposits, utility hook ups, and other needed household items will facilitate transitions.

For MFP Demonstration participants there are also one-time only funds available to assist at the time of transition. This service includes up to $700 in flexible funds to pay for an initial supply of groceries when they transition, for transportation that will allow an individual to attend housing interviews and run errands related to the transition, and to allow provision of needed goods or services that are not otherwise available.

These services utilize different mechanisms for implementation and have varying timelines. The contract for peer supports is managed by the Maryland Department of Disabilities and began a phased-in implementation process in August 2012. The new options counseling model began on January 1, 2012 and is provided through MAP sites via a collaborative effort between the local AAA and their disability partner.

For SRC residents, Community Placement Specialists and a Statewide Transition Coordinator will work to enhance community placement efforts. During the demonstration these positions will be funded through the federal funds received through the demonstration and be billed as an administrative cost, not as a waiver service. The State proposes to transition 20 individuals with intellectual disabilities out of SRCs and nursing homes each year to further expand community-based services by the end of the demonstration period. As the system has less than 3% of consumers in institutional settings, there will no longer be a need for these positions after the demonstration and they will not continue. However, the knowledge and skills gained through the project will enhance the capacity of the DDA Regional Offices and Resource Coordinators to continue deinstitutionalization work for SRC residents.

The State added services to the waivers during the first years of the MFP demonstration. Home delivered meals, dietician and nutritionist services, and environmental assessments were added to the Living at Home Waiver and transition services were added to the Older Adults Waiver. Some individuals remain institutionalized because they cannot receive in-home personal support services for more than 12 hours per day within the cost neutrality of the waivers. Adding a roommate service, shared attendant care, a supervision rate, or daily rate to the waivers could offer options outside of the institution. *This initiative would require budgetary authorization from the Department of Budget and Management because of the ongoing state cost that cannot be covered by MFP. However, MFP stakeholders and members of the MFP Behavioral Health Workgroup continue to advocate for the addition of these services with the legislature and budget officials.*

The clubhouse model of day program services will be added as a service to the TBI waiver during the extension.

In order to assist MFP participants to integrate successfully at home or in new housing, MFP may support pilots of evidence-based programs. Programs to be explored include, but are not limited to, the Living Well Program (Chronic Disease Self Management Program), PEARLS, and a modified bundle of existing services such as occupational therapy, environmental modifications, and assistive technology.

5.2 Continuous Case Management

The case management and supports planning services for demonstration participants will be the same as those that are currently offered to all waiver, Community First Choice (CFC), and Medical Assistance Personal Care Program (MAPC) participants. Supports planning is replacing traditional case management and the name change reflects a change in philosophy, that individuals are not "cases to be managed," but are individuals that need supports to plan the services that allow them to live a healthy and meaningful life. Supports planning has a person-centered focus and includes assistance to plan for both Medicaid and non-Medicaid services, goal planning, and risk mitigation. Applicants to and participants in the Home and Community Based Options Waiver, CFC, and MAPC will have a choice of enrolled providers for supports planning. Participants will receive monthly visits from the support planner; however, with the focus on self-direction, participants can waive supports planning, except for the annual visit that is required to update the plan of service and maintain eligibility. For the Community Pathways waiver that will be serving individuals discharged from the SRCs and individuals with intellectual disabilities leaving nursing facilities, the Resource Coordinators (case managers) are required to have contact a minimum of twice per year and complete new Individual Plans annually with the individual. The DDA provides Unified Funding Agreements with 13 local health departments and contracts with additional case management agencies to provide Resource Coordination services to waiver participants.

For individuals transitioning onto the Traumatic Brain Injury waiver, the Mental Hygiene Administration will provide waiver case management services. Quarterly face-to-face visits with the participant and an annual review of the plan of service are required as part of the ongoing case management services.

5.3 Receiving Services in the Community

Maryland has chosen to offer MFP demonstration participants services primarily through three existing HCBS waivers and Community First Choice. On the day of transition to the community, an individual will use a slot in one of the waivers. As noted in the Project Introduction, Maryland's Money Follows the Individual policy and Waiting List Equity Fund assure that anyone transitioning from an institution who meets the eligibility criteria for a waiver will be able to access the waiver program, regardless of caps or waiting lists. As part of their enrollment in the waiver, individuals may access any of the approved waiver services as well as any services available through the State Plan, including Community First Choice[1]. Fiscal intermediary services are available to CFC and HCBO Waiver participants, but those services are covered as a

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[1] Using current CMS guidance, the State intends to provide the Community First Choice services to eligible MFP participants and claim the enhanced MFP FFP, but not the additional 6% FFP. Should CMS guidance change, the State will claim both enhanced matches as an additive amount.

Medicaid administrative activity and therefore are not listed in the charts below. See B.5.4 for a list of services available through each waiver and the State Plan.

In some cases, individuals may meet the MFP eligibility criteria, but will receive their qualified home and community-based services through the State Plan. These specific State Plan services are detailed in *Table B.5.4* Qualified HCBS State Plan Services.

Prior to their transition date, all MFP participants may access the supplemental services available only to demonstration participants; however, reimbursement to the providers will only be made after successful transition as an MFP participant. See sections B.5.1 and B.5.4 for a description of the supplemental services and their administration.

All demonstration participants will have access to acute care services through current Medicaid programs, but these acute care services will not be included as demonstration services in accordance with current CMS guidelines.

On Day 366, MFP demonstration participation ends, but waiver and State Plan services continue uninterrupted. Once an individual ends their MFP participation, they will no longer have access to the supplemental and demonstration services of flex funds and peer mentoring, but their waiver and/or state plan services will continue as long as they maintain eligibility. From the perspective of the individual, apart from flex funds and peer mentoring, there will be no difference in the services available once they are no longer MFP participants.

5.4 List of Waiver, State Plan, and MFP Services

Service Category 1: Qualified Home and Community-Based Services

Table B.5.4.1 Qualified Home and Community-Based Waiver Services

Waivers*

Service Type	Service	HCBO[1]	CP	TBI
Home and Community Based Services	Assisted Living	X		
	Assistive Devices / Equipment / Technology		X	
	Attendant Care / Personal Care / Personal Supports/CSLA		X	
	Behavior Consultation/Supports	X	X	
	Case Management / Service Coordination / Resource Coordination	X	X	
	Clubhouse Model of Day Supports			New
	Day Habilitation		X	X
	Dietitian / Nutritionist Services		X	
	Environmental Accessibility Modifications		X	
	Environmental Assessments		X	
	Family and Individual Support Services		X	X
	Family and/or Consumer Training	X	X	
	Fiscal Intermediary		X	
	Home-Delivered Meals			
	Medical Day Care	X	X	
	Nurse Monitoring for Personal Care Services		X	
	Personal Emergency Response System		X	
	Residential Habilitation		X	X
	Respite Care		X	
	Senior Center Plus	X		
	Supported Employment		X	X
	Supports Brokerage		X	
	Transition services		X	
	Transportation		X	

*<u>Note</u>: HCBO-Home and Community Based Options, CP – Community Pathways, TBI – Traumatic Brain Injury

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[1] HCBO combines the Living at Home Waiver and the Waiver for Older Adults. Community First Choice will provide all allowable services under the State Plan which is accessible by waiver participants; therefore those services have been removed from the HCBO Waiver.

Table B.5.4.2 Qualified HCBS State Plan Services

State Plan Service
Community First Choice

Supports Planning
   Personal Assistance Services
   Personal Emergency Response Systems
   Consumer Training
   Nurse Monitoring
   Transition Service
   Items that Substitute for Human Assistance
      Home Delivered Meals
      Assistive Technology
      Environmental Assessments
      Environmental Modification
      Other

Medical Assistance Personal Care (MAPC) Program
Disposable Medical Supplies / Durable Medical Equipment
Home Health
Psychiatric Rehabilitation Program

The qualified HCBS services offered under the demonstration will receive a 75% federal match for a period of one year for each MFP participant. This means instead of paying 50% of the costs, the State will only be responsible for 25%. The 25% that the State saves will be used to further the goals of the MFP demonstration.

During the initial phase of MFP, the State chose to add four additional qualified HCBS services as part of the MFP demonstration based on stakeholder feedback. Specifically, home delivered meals, dietician and nutritionist services, and environmental assessments were added to the Living at Home waiver and transition services were added to the Older Adults Waiver. CFC will offer a rate for shared personal assistance services for individuals that are living together and both enrolled in the program. This is a new service structure that was recommended in previous OP revision periods. The Mental Hygiene Administration would like to add services to the TBI waiver during the MFP extension period, pending budget allocations for the increased services. Proposed new services for the TBI waiver include the clubhouse model of day supports, and specialized occupational, cognitive and speech therapy services that are needed by individuals with brain injury to increase independence and quality of life. If these services are added directly to the waiver they will be available to all waiver participants, not just MFP participants. There is no cost to the demonstration to add the services as the increased service plan cost associated with the additional services would need to be authorized in the State's ongoing budget.

Clubhouse Model of Day Services

The TBI waiver currently offers day habilitation as a service to participants. While this model provides valuable supports, there is an alternative model of service that has shown to have positive outcomes for individuals with brain injury. This model is called the Clubhouse model

and it provides a variety of comprehensive support services to individuals with brain injury including development of work skills and behaviors, exploration of vocational interests, development of compensatory strategies, social and recreational programs, and participation in a "work ordered day." The clubhouse model is a consumer driven model of care with support from staff. The State would like to offer this model of service to waiver participants to increase the choice of services and possibly improve the quality of life of participants who have access to this service.

However, the model is not currently available in Maryland and providers have indicated that training and start-up costs have been prohibitive. As incentive to bring the model to Maryland, provider incentives will be offered through MFP for costs associated with efforts to replicate the model. These costs may include travel to other states to visit existing program sites, consultation, training for administrators, recruitment and training of direct support providers, and modifications to clubhouse sites. It is estimated that incentives will be offered to at least two providers to encourage the development of the model in Maryland and provide participants with choice of provider.

Service Category 2: Demonstration Home and Community Based Services

Peer mentoring for nursing facility residents was created at the beginning of Maryland's MFP demonstration program as a demonstration service provided by the Centers for Independent Living. It was believed that offering this service through the demonstration would provide an evidence base for its efficacy and outcomes so that at the end of the demonstration, it would be added as a permanent waiver service with any willing provider. However, the service has had a very low utilization rate in the first few years of the demonstration, and there is not sufficient data about efficacy and outcomes to justify the budget initiative necessary to add the service to the waivers permanently. Peer mentoring will continue to be a demonstration service during the extension period in order to build the evidence-base. The service will be more extensively advertised through the revised peer supports and new options counseling models. A service description is attached in Appendix F.

Enhanced transitional case management was created as a demonstration service for applicants of the Older Adults waiver. The Living at Home waiver chose to add case management as a service during its renewal in the spring of 2009 and applicants to this waiver did not need to access the demonstration service. The Older Adults waiver funded case management administratively and did not offer comprehensive transitional support. In the initial phase of the demonstration, MFP offered enhanced transitional case management as an MFP demonstration service for OAW applicants to ensure transition supports. As noted in Section 5.2 *Continuous Case Management* above, the case management for the Older Adults waiver changed from an administrative function to a waiver service beginning in 2012, eliminating the need for MFP support. Effective January 1, 2012, enhanced transitional case management ceased to be an MFP service.

Demonstration Services

Demonstration Service	Provider	Rate	Caps on utilization
Peer Mentoring	Centers for Independent Living	$7.78/unit	48 hours per person

Service Category 3: Supplemental Demonstration Services.

Supplemental Demonstration Service:

- Up to $700 in Flexible Funds
    - Initial groceries
    - Transportation
    - Other transition necessities

MFP participants will be able to access supplemental demonstration service as listed above. The service will be administered by the fiscal intermediary, with the assistance of case managers/supports planners, and with oversight from DHMH. After the demonstration, the service will not continue to be available unless the State chooses to fund it with 100% state funds. During the demonstration, the service will receive a 50% federal match. The State is aware that no MFP federal dollars may be expended until the date of transition to the community. If a prospective MFP participant uses supplemental services but does not transition under MFP, the State will not claim matching funds.

Supplemental Services

Service	Provider	Rate	Caps on utilization
MFP Flexible Funds	Fiscal Intermediary	Varies	Up to $700 per participant[1]

5.5 Funding Mechanisms for Peer Mentoring

The State will offer the peer mentoring services under the authority of the MFP demonstration. This initiative will receive funding as a demonstration service. Peer supports and options counseling will be funded as MFP administrative costs. As outreach activities that will reach many more individuals than those that will transition under MFP, these activities will be funded entirely through MFP rebalancing funds.

Demonstration services receive a 75% match through the demonstration. Supplemental services and administrative expenses both receive a 50% federal match under the demonstration. Supplemental and demonstration services may only be paid for individuals who become MFP participants, and administrative expenses are capped on a per participant basis.

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[1] For individuals that meet the MFP eligibility criteria, but transition and receive their qualified home and community-based services through a State Plan program that does not offer transitions funds, up to $3000 of flex funds may be expended.

6.   Consumer Supports

As demonstration participants are primarily utilizing the existing waiver programs for community-based services and support, the current systems for consumer supports that are approved and in place will be used by the demonstration participants as well. Community First Choice, though not a waiver program, will follow the same Reportable Events policy that is in place for the HCBO Waiver.

Standards for other services are outlined in service descriptions, provider qualifications, and the contracting process. Peer outreach and support contracts secured through the State's procurement process include definitions of peers and staffing standards to adequately support outreach activities.

6.1 Back-up systems

As individuals receiving peer supports, options counseling, and peer mentoring services prior to transition will be institutional residents, the institutional provider will be expected to provide critical back-up services. After the individual transitions to the community, the program through which the individual is receiving services will be responsible for providing, documenting, and reporting requests for critical back-up. Please see Section B.2 Informed Consent and Guardianship, for details of the State's Reportable Events Policy and other procedures for complaints that will be available to MFP participants.

The emergency back-up systems for the different waivers and CFC that are accessible to MFP participants are similar in their first two levels of back-up. For each participant, the first level of back-up is identified on the plan of service as a list of alternate providers for services vital to health and safety. The second level of back-up is the case management provider. If the back-up provider on the plan of care/service is not able to resolve the issues for the participant, the case manager is contacted for assistance as the second level of back-up. There is some variation among the waivers for the third and fourth levels of back-up for participants.

For the HCBO waiver and Community First Choice, the third level of back-up consists of the emergency or crisis services available to them through the Department of Human Resources (DHR). DHR maintains a 1-800 number for Adult Protective Services, which provides crisis intervention services to vulnerable adults. The statewide number for this service is 1-800-91 PREVENT (1-800-917-7383). Several jurisdictions in Maryland have yet another level of back-up through their local crisis centers housed at the local departments of social services. For example, the Montgomery County Crisis Center provides immediate responses to crisis situations for all residents of Montgomery County, Maryland. The Center provides goal-oriented crisis intervention, brief crisis stabilization, and help in obtaining services for individuals and families with a mental health crisis or experiencing other crisis situations. Case managers are responsible for providing information about local crisis resources to HCBO waiver participants and Community First Choice participants as a 4th level of back-up.

Maryland's DD waiver utilizes additional supports and services identified by the DDA Regional Offices available in their locality as their third level of back-up in the event that both the first and second level of back-up fail. DDA Regional Office staff are knowledgeable about behavioral &

crisis oriented supports and services available after normal business hours, including evenings, weekends, and holidays.

Educational Materials

During application to one of the HCBS programs, educational materials about the program and its supports and services are provided to the participant. For the Home and Community Based Options, Traumatic Brain Injury, and Community Pathways waivers, and Community First Choice, the MFP options counselor or case management agency provides detailed information about the program, the case management agency, contacting the case manager, reporting complaints and incidents, and emergency procedures, including what to do in case of emergency and how to access back-up systems. This information is provided at the time the initial plan of service is developed. This process will not change during the MFP Demonstration as the waiver case manager will be actively involved in revising the plan of service with the participant just prior to the transition to the community.

Transportation

There is currently not one universal back-up system for transportation available to waiver participants as local transportation options are varied. DHMH developed a comprehensive list of transportation options available to Medical Assistance enrollees. The list includes Medicaid transportation information including contact phone numbers, how to schedule transportation, and how to report complaints. It includes non-MA transportation information in local areas as well. This list will be made available to participants of all waivers through waiver case managers in the future so that demonstration participants will be assured access to this information.

For individuals with developmental disabilities in the Community Pathways waiver, community-based service providers are responsible for transportation necessary to implement the Individuals Plan. The mode of transportation to a day program or supported employment is delineated in a person's Individual Plan and in some instances individuals use public transportation or Mobility/Paratransit should these services be available in their region.

Direct Service Workers

For current participants of the HCBS waivers, back-up plans for direct care workers are included in the plans of service or plans of care. An alternate provider is identified as an emergency back-up at the time that the initial plans are written with the case manager. Individuals with developmental disabilities choosing to self-direct their services through the New Directions waiver are required to have a two-level back-up system as part of their approved plan of care. For individuals transitioning to group homes, alternative living units, or assisted living facilities of four persons or less, the emergency back-up plans are explained to the individual as part of the intake process and are contained in the administrative policies and procedures of the service provider.

Provider Registry

The Maryland Personal Assistant Services Advisory Committee (PASAC), provider unions, Centers for Independent Living, waiver advisory committees, and various other stakeholder groups have advocated for an online, searchable database of providers of HCBS. This type of registry, similar to registries that already exist in other states, would allow participants to search

for qualified, pre-screened providers and increase ease of access to support. The Maryland Department of Aging is working with the interested parties and will include a provider registry on the Maryland Access Point website as part of the next phase of development in 2014. The development of the provider registry may improve access to emergency back-up providers.

Repair or replacement of durable medical and other equipment

For the current HCBS waivers, persons in need of durable medical and other equipment are provided with information about their choices for providers in their area during the development of their plan of care or plan of service. This information is disseminated by the case manager during coordination efforts. The participant is given the contact information for the equipment provider and at least one alternate provider in their area. The case manager is responsible for assisting participants in locating and accessing repair to or replacement of medical equipment as needed. Again, lists of available providers may be given to the participant and case manager assistance in coordinating the repair may be provided.

Access to medical care

When waiver participants become eligible for community MA through a waiver program they also become eligible for State Plan services. These State Plan services include access to routine medical care such as physician visits and specialists. Some individuals access these services through managed care organizations (MCOs). The MCOs are responsible for maintaining an adequate number of qualified providers for participants in their regions of service. The participants in the waivers choose an MCO and are sent an informational packet that includes information about accessing medical care through their chosen MCO including the appointment scheduling and referral process. In addition, information about contacting the MCO and any back-up systems that are in place are provided to the participant by the MCO at the time of enrollment.

All others access the State Plan services through fee for service, including dual-eligibles and participants in the REM program. DHMH is responsible for maintaining an adequate number of providers and communicating relevant information about back-up and complaint systems to these participants.

Demonstration Support Services
The only MFP demonstration service available to MFP participants is peer mentoring. Peer mentoring services will be provided both pre and post transition. All peer mentoring services will be subject to the Reportable Events policy. For services provided to MFP participants in the community, the peer mentoring service will be included on the individual's plan of care or plan of service and therefore be subject to the existing waiver quality management process as described below in Section 8.1 Quality, including the Quality of Care Review Team process.

Supplemental Support Services

The only supplemental services available to demonstration participants are the one time only funds available to assist in the process of transitioning to a qualified community residence. These funds may be used for a food card, transportation funds, and other transition related items. These services are provided by the transitional case manager prior to and during transition and are not

ongoing. Information about accessing these services will be provided by the transitional case manager during the development of the plan of care or plan of service.

New Emergency Back-up Systems

The Department is currently pursuing other options for improving emergency back-up services and enhancing monitoring of emergency needs for waiver participants. A new Complaints and Surveillance Unit at the Department has been proposed to triage calls for emergency back-up. This proposed unit would consist of three staff, including one nurse. The staff would rotate on-call hours in order to be available 24 hours per day when the first and second emergency back-up options (a back-up provider on the plan of care and the case manager) fail to resolve the crisis. MFP will support the cost of some of the new staffing, phone lines, and associated technology needs. Some of the staffing for this unit will be funded through other State general funds.

Also proposed is a statewide contract for emergency personal care services. The Department proposes to procure a contractor that will be responsible for maintaining a pool of qualified personal service providers who will be available to waiver participants in emergency situations. The provider would be required to maintain plans for emergency situations such as severe weather and a sudden loss of provider. The contractor would be funded through an administrative contract to retain qualified providers, develop and maintain emergency procedures, and respond within 24 hours to requests for emergency assistance. The actual services rendered would be reimbursed through normal Medicaid service payments and only the administrative cost of maintaining a system of supports would be funded administratively using MFP rebalancing funds. The State will work with the Board of Nursing to determine feasibility of such a contract while adhering to existing regulations.

6.2 Complaint Resolution Process and Remediation

The HCBS waivers have implemented Reportable Events and Reportable Incidents policies as described in Section B.2.1, that serve as the mechanism for reporting complaints and incidents, including failure of back-up systems in place and other issues related to waiver services and supports. Waiver case managers will utilize the Reportable Events policy for complaint reporting and remediation. Critical incidents involving residents of institutions who are waiver applicants will follow the institutional incident reporting and remediation policies.

7.   Self-Direction

The three HCBS waivers that MFP participants will use to access community-based services offer a variety of self-direction opportunities that vary with each waiver. The Traumatic Brain Injury Waiver has the fewest opportunities for self-direction, incorporating the consumer in the care planning process but not offering additional self-direction options. By merging the two DD waivers, individuals will receive additional self-direction opportunities. Home and Community Based Options Waiver participants that receive Community First Choice services will have access to participant centered planning, the consumer employed model of attendant care, optional self-delegated care, self-direction training, and a flexible budget for certain services.

Community First Choice

The Community First Choice program offers various levels of self-direction for attendant care. The first is the consumer-employed model in which the consumer hires and trains the personal assistance provider. Consumer-employed model means the delivery of personal assistance services when: (a) A participant chooses the provider who will render services; (b) The provider is a self-employed Medicaid provider; and (c) The participant utilizes services of a fiscal intermediary. This type of personal assistance provider has a nurse monitor that creates provider instructions and is responsible for training the provider to provide appropriate care to the consumer.

The second option for self-direction offered through CFC is the consumer-employed and self-directed model in which the consumer hires and trains the personal assistance provider and waives the nurse monitoring of the provider. In this model, the consumer develops their own provider instructions and is responsible for monitoring their care. In this model, the participant may also set rates for the personal assistance provider within the program's guidelines. Both models of care require the use of a fiscal intermediary that is responsible for reviewing the time sheets of the attendant, withholding taxes, and arranging payment for the services provided. CFC provides fiscal intermediary services through a statewide contract and there is no cost to the consumer for fiscal intermediary services. Individuals choosing self-delegated care through CFC can begin, discontinue or resume self-delegation at any time.

For CFC participants choosing to self-delegate care, involuntary termination from self-delegation may be pursued by the State. If there is a concern that the participant's health and safety is in jeopardy, a meeting will be held with the participant, supports planner, DHMH clinical staff, and provider to discuss concerns and options. If the strategies are determined not to meet the participant's health and safety needs, the CFC Division will review the information provided by the supports planner and, if necessary, complete the reduction/denial of services form to discontinue self-delegation of personal assistance services. The form and appeal rights will be forwarded to the participant. The participant may appeal any decision regarding his/her ability to self-delegate personal assistance services under the program. The current Policy for Self-Delegated Care is attached as Appendix D.

The Community First Choice supports planner monitors service utilization and issues relating to health and safety through monthly contacts and quarterly visits with the participant. The supports planner helps to facilitate resolution if there are issues between the consumer-directed personal assistance provider and the participant.

DDA Waivers

Individuals transitioning from a State Residential Center will work with their resource coordinator to develop their Individual Plan using a person centered methodology described in Section B.1. MFP participants with developmental disabilities will receive services from the Community Pathways waiver, Self-directed services under the Community Pathways waiver include: support brokerage, supported employment, community supported living arrangements (personal supports), assistive technology, environmental accessibility adaptations, transportation, behavioral support services, and transition services.

Any individual self-directing their services through the Community Pathways waiver can elect to change to provider-directed services at any time. A participant shall be disenrolled from self-directed services when either: the participant voluntarily elects to disenroll or the Developmental

Disabilities Administration determines that: a) the individual no longer meets eligibility criteria for self-directed services; b) the health and safety of the participant may be threatened; c) a significant amount of the services outlined in the approved Individual Plan and Budget are not being provided to the individual; d) the Individual Plan and Budget is not being implemented as approved; e) the participant's expenditures or attempts to expend funds are inconsistent with the approved Individual Plan and Budget; f) there is mismanagement of funds; g) funds have been used fraudulently or for illegal purposes or; h) the individual has been without a certified Support Broker for more than 30 days.

Under the self-directed model of Community Pathways, a Support Broker is hired by and works for the participant. Along with the Resource Coordinator, they assist the individual to develop the individual plan, coordinate supports and services to implement the plan, develop and manage the participant's budget, develop an emergency back-up plan, and help an individual to recruit, hire and supervise staff. Support Brokers and Resource Coordinators may also help to locate data about who provides services, their location and 'fair market" costs, etc.; and/or technical assistance with implementation of contractual agreements with service providers; adjusting for changing needs including exceptional circumstances; conflict resolution and mediation; monitoring of service arrangements; identifying alternative services and supports, or stimulating the development of new options; and ensuring that mechanisms are in place for financial administration of individualized funding. The primary aim of these supports is to assist the participant and their family to capably use funding to get the best services or supports to meet individual needs. The process is intended to increase personal confidence and competencies, resulting in real participation in the community, in ways that are meaningful to the individual. The participant can hire and train the person that they choose to be their Support Broker. It can be a member of their family, although only certain members can be paid, a trusted friend, or anyone that is trusted who meets the requirements.

Each staff member hired by Community Pathways participants must undergo a Criminal Background Check and complete First Aide/CPR training. Support Brokers are required to attend the Policy on Reportable Incidents training, as well as, when necessary, Medication Technician training along with training individualized to the waiver participant (i.e. positive behavior supports, managing seizures, etc.)

Having a Fiscal Management Service (FMS) is a requirement for individuals that are self directing services under the Community Pathways waiver. The State has two FMS that manage funds for Community Pathways participants that assist individuals/families to fulfill employer responsibilities by setting up employment forms and deductions, paying taxes, unemployment, workman's comp, etc. on behalf of the individual/family. The FMS pays employees and vendors for Community Pathways participants, produces and disseminates a budget statement each (DDA receives quarterly) month (which is sent to the individual, the Support Broker, the Resource Coordinator), verifies provider qualifications, and secures criminal background checks on providers. The FMS provides no other services to the Community Pathways participant.

MFP participants who decide to self-direct their services through the Community Pathways waiver will be provided with information and training about self-directed services, including information about the role of the FMS and available FMS providers. Information about FMS providers is also available at each DDA Regional office and on the DDA website. DDA recommends that individuals/families meet with each of the FMS providers to find the best "fit".

It is then up to the individual/family, with any desired assistance from the Resource Coordinator and Support Broker, to make the choice. The individual/family will notify the FMS of their choice and plan for that expense during the development of the New Directions Individual Plan & Budget. Upon receipt of that letter the FMS works with the individual/family to set up all the necessary paperwork, provide any necessary/desired education and begin managing funds on the participant's behalf. Each individual transitioning to community services, whether in traditional or self-directed services, is assigned a Resource Coordinator. The role of the Resource Coordinator includes: coordinating the planning and budgeting process, assisting the individual/family to interview & choose a support broker, assisting the individual/family to chose a Fiscal Management Service (FMS), if applicable, assisting in the development of the Individual Plan and ensuring that it includes all essential elements (i.e., services to ensure health and safety, emergency back-up plans), monitoring individual health, safety, and satisfaction, monitoring monthly budget statements, and monitoring Emergency Back-Up usage.

MFP

Through the MFP demonstration, opportunities for self-direction will continue. Transitional case managers and Resource Coordinators will use person-centered planning as it is used to develop initial plans of care/service for the HCBO, CP, and TBI waivers and CFC. The MFP demonstration has provided training on person-centered planning and continues to advocate that case managers utilize a person-centered service plan development process for all participants who receive transitional case management services. The participant or a chosen representative may direct the components of the Plan of Care, including the choice to reduce services to meet cost neutrality, as long as health and safety assurances are met. Transition coordinators will also apply principles of self-direction to the use of supplemental and waiver transition funds, allowing the participant to spend funds on qualified expenditures of their choosing. Additional person-centered planning training will be offered through the MFP demonstration as well as one-on-one consultation with transition teams to enhance the application of a person-centered philosophy to the waiver process.

8.   Quality

Maryland is offering MFP demonstration participants services through three existing HCBS waivers and the CFC program. On the day of transition to the community, an individual will use a slot in one of the existing waivers or directly through the state plan if they meet community Medicaid eligibility standards and transition using Community First Choice. Each waiver has a comprehensive quality management system which includes emergency back-up systems and incident reporting and management strategies. Maryland's Community Pathways waiver recently revised its quality plans with technical assistance from CMS's contractor, Human Services Research Institute (HSRI), in 2012. Maryland's Living at Home waiver received technical assistance from Thomson Medstat for submission of its waiver renewal on April 1, 2009. The combined HCBO Waiver will follow the LAH quality management strategies. The State assures that all MFP demonstration participants will receive the same level of quality assurance and improvement activities described in the existing 1915(c) HCBS waiver applications during the 12 month demonstration and throughout their participation in the waiver.

8.1 Existing Programs

Each of the 3 HCBS waivers that MFP participants may access for community-based care currently have comprehensive quality plans in place. These plans include the details of the quality assurances developed and implemented by the State, including the policy and process in place to ensure quality of individual plans of care and participant's health and welfare. The Home and Community Based Options Waiver, Community Pathways, and Traumatic Brain Injury Waivers have approved quality strategies under 1915(c) Appendix H.

Quality Care Review (QCR) Team

A Quality Care Review (QCR) Team contracted by the State also audits the plans of service and reviews a random sample of waiver plans each year. The QCR team is responsible for auditing the files for any participant who has died or been discharged in the past year as well. The QCR team performs a record review, interviews the case manager and provider, observes the participant, compares the plan to the AERS nurse recommendations, determines if the case manager/supports planner visits regularly as scheduled, reviews plan of care/service revisions for appropriateness, and administers a participant survey. The QCR Team then compiles results from these activities, drafts a report, and submits the report to the Division of Waiver Programs. Remediation of issues identified by the QCR team can include corrective action plans, provider sanctions, or other actions as deemed appropriate by the DWP.

8.2 MFP Quality Strategies

Additional quality assurances and improvement activities will be developed for peer mentoring and supplemental services as described below. The State is moving toward a more comprehensive quality management system across all HCBS programs using the CMS Quality Framework articulated in the revised Appendix H of the 1915(c) HCBS waiver application. This effort is designed to create a consistent and uniform strategy to measure and enhance performance across all community long-term care programs and services. The goals of this effort are to: (a) create a more evidenced-based quality management system, (b) improve the ability of the State and HCBS administering agencies and case managers to monitor service provision, (c) improve the capacity of the State to monitor and improve the quality of service from providers, (d) monitor the quality of care and life at the individual consumer level, (e) develop better quantifiable indicators of quality, (f) improve infrastructure to collect and distribute data on quality indicators, and (g) create more comprehensive and standardized quality reports for improving program operations.

To that end, DHMH has reestablished the Waiver Quality Council with representatives from each waiver administering agency, the Office of Healthcare Quality, and Medicaid, who will work towards these goals over the next year. The Waiver Quality Council brings together these groups to discuss waiver quality management policies and procedures, the aggregate data analysis from the Division of Waiver Programs, and consumer experiences in an effort to develop recommendations for improving data collection and remediation processes. The council is currently working towards improving data collection across waivers to capture meaningful and uniform information on reports so that data analysis can be more efficient and useful to improving quality of care.

In order to enhance quality monitoring and oversight of personal assistance services, rebalancing funds were used to create an electronic system to monitor the provision of home and community-based services. This In-home Supports Assurance System (ISAS) is a way to increase the monitoring of services and remove the burden on consumers to monitor time sheets and report attendance issues of their providers. ISAS requires personal assistance providers to call-in to an automated system from the home of the participant when arriving and departing each day and to log some details of the services provided. The electronic system includes voice recognition and other technology to verify the identity and location of the provider. The system matches the provider's calls with the participant's approved plan of service to verify that the provider is qualified to provide that service and that the service duration and scope match the participant's needs in the plan of care. The system can then create electronic billing and eliminate the need for paper time sheets. Participants, providers, and case managers will have access to real-time reports on attendance via a website. Case managers will be required to use the attendance reports to identify quality issues and to review the reports with participants. In 2013, the ISAS system began to be phased-in, starting with personal care services in the Older Adults Waiver and Living at Home Waiver. In 2014, additional service providers will be phased in, including MAPC and CFC personal assistance providers. Other programs and additional in-home supports will be added each year after the initial system is established. Costs to be covered in the first two years include procuring a vendor, software, technology upgrades, and training to all key stakeholders (participants, providers, case managers, and administrators).

As noted above on page 53 in Section 6.1 *Back Up Systems*, in order to enhance the quality monitoring beyond what is currently in place for the existing HCBS waivers, MFP proposes to create a new Complaints and Surveillance Unit to triage and respond to emergency backup calls. Staff will work with the Board of Nursing to determine if a statewide personal care back up agency could be a complementary initiative that the triaged calls for emergency backup could access. MFP will support the cost of the new staffing, phone lines, and associated technology needs.

As DDA works to rebalance its service delivery system to decrease institutional placements and increase community supports and services there is an increased focus on quality improvement in community-based services tied to the six HCBS waiver assurances required by the Centers for Medicare and Medicaid Services (CMS). As part of a comprehensive quality assurance system there is a need for an information and data system that is transparent to individuals, families, and providers that tracks activities related to quality of care and outcomes in community-based services. The availability of such a system will provide information to drive quality improvement in community-based services and assist individuals and families in making choices about community-based care and supports. It may also increase the comfort level of those in institutions and their families that quality support systems in community-based services can address their health and safety needs in the most integrated setting.

In order to make the community a viable alternative for individuals currently residing in institutions whose families are resistant to change, quality systems must tie directly to their loved one's Individual Plan (Plan of Care) and the services and programming for that individual. As part of MFP rebalancing activities, the DDA will collaborate on a quality information and data system tied to Individual Plans and individual outcomes as part of the larger LTSS Tracking

System. The enhancements to the system will drive quality improvement activities at the individual, provider, regional, and state levels.

As DDA develops its Strategic Plan to rebalance its service delivery systems, it is expected that consultant services may be required to address specific issues related to services for individuals dually diagnosed with developmental disabilities and mental illness, individuals with developmental disabilities with forensic charges, individual employment services, services for medically fragile individuals, services for aging individuals with developmental disabilities, developing community capacity, and enhancing self-direction for individuals with significant disabilities. The DDA projects to use consultants to assist it in its efforts to reform and rebalance its service systems and underlying infrastructure to improve quality.

The State may seek assistance from the MFP Quality Technical Assistance contractor in addressing improvement areas noted above. Any new quality assurances and improvement strategies will be implemented for all waiver participants, including MFP demonstration participants.

MFP Demonstration Services

Peer Mentoring. Peer mentoring quality assurances and improvement strategies will be tracked in the LTSSMaryland Tracking System, described below. The identified providers will also be required to participate in quality activities as developed and required by CMS and the Quality Technical Assistance Contractor.

Supplemental Services. As noted in section B.5.4, Maryland's MFP demonstration participants will be able to access food cards, transportation, and flexible funds, as supplemental services to support their transition to the community. For HCBO, CFC, MAPC MFP participants, hese onetime only supplemental services will be administered by a Fiscal Intermediary with the support of the transitional case managers/supports planners. DDA and TBI waiver participants may access flex funds through the designated provider network. MFP participants will have the ability to submit complaints related to these services and will participate in waiver quality processes as described above.

LTSS Tracking System. As noted on page 12 in the Project Introduction, Maryland has developed a web-based tracking system in collaboration with a contractor to assist in fulfilling CMS reporting requirements and evaluation. The current system tracks activities and performance of MAP partners, service providers, and contractors, including the number of peer outreach and peer support contacts, the number of referrals to options counseling, including application assistance, transitional case management (previous MFP service), and peer mentoring, as well as the services each potential participant receives. The Department will continue its work on a unified long-term care tracking system that has consolidated previous systems including the MFP and waiver tracking systems. Current efforts will add quality monitoring components such as reportable events, and expand to include other waivers and community-based supports. It will also include data from MMIS, the MDS 3.0, and other data sources.

MAP Information Technology. The local MAP sites currently each use a unique system for tracking their efforts and incoming inquiries about long term supports and services. A single, statewide database is necessary to monitor inquiries about long-term supports and services and

standardize data collection and reporting. Such a unified system could share data with the Medicaid long-term care tracking system, facilitating referrals for support and generating vital data on service demand. MFP will support the development and implementation of a statewide system that is compatible with the Medicaid LTSS tracking system by using MFP rebalancing funds for contractor and software costs, training for all users, and the connection to the Medicaid tracking system.

9.   Housing

<u>9.1 Defining and Documenting Qualified Residences</u>

There are three types of qualified residences in which MFP participants can choose to reside:

1. A home owned or leased by the individual or the individual's family member;
2. 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.
3. A residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

The Code of Maryland Regulations defines five residential settings that may serve small groups of unrelated individuals:

Alternative Living Unit – Code of Maryland Regulations 10.22.01.01 B(2)
(1) "Alternative living unit" means a residence that:
(a) Provides residential services for individuals who, because of developmental disabilities, require specialized living arrangements;
(b) Admits not more than 3 individuals; and
(c) Provides 10 or more hours of supervision per unit per week.
Regulated by the Department of Health and Mental Hygiene, Developmental Disabilities Administration and the Office of Health Care Quality

Group Home - Code of Maryland Regulations 10.09.26.01 B(10)
"Group home" means a residence that:
(a) Provides residential services for individuals who, because of developmental disability, require specialized living arrangements;
(b) Admits at least 4 but not more than 8 individuals; and
(c) Provides 10 or more hours of supervision per home, per week.
Regulated by the Department of Health and Mental Hygiene, Developmental Disabilities Administration, and the Office of Health Care Quality

Adult Foster Care Home - Code of Maryland Regulations 07.02.17.02 B(1)
"Adult Foster Care" means a program that provides a family setting in the community for an aged adult or an adult with disabilities who requires:
(a) Protective oversight;
(b) Assistance with the activities of daily living; and
(c) Room and board.

Regulated by Department of Human Resources

CARE Homes – Code of Maryland Regulations 07.02.19.02 B(3)
"CARE home" means a certified adult residential environment home that provides a resident with a supportive housing arrangement, help in reaching community resources, and protective oversight; and is licensed or has an application pending for licensure and has not been denied a license as an assisted living program under COMAR 10.07.14. A CARE home includes a:
(a) Private home which is the provider's residence and serves a maximum of four residents;
(b) Supervised home which is not the provider's residence but may have live-in staff and serves not more than four residents; or
(c) Group home which may be the provider's residence, has live-in staff, and serves four to eight residents.

Assisted Living Facility - Code of Maryland Regulations 10.07.14.02 B(11)
"Assisted living program" means a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination of these services to meet the needs of residents who are unable to perform, or who need assistance in performing, the activities of daily living or instrumental activities of daily living, in a way that promotes optimum dignity and independence for the residents.
Regulated by the Department of Health and Mental Hygiene, Office of Health Care Quality

Each of these types of residences as defined in the regulations has the potential to serve as a qualified residence for an MFP eligible individual provided that the residence serves no more than 4 unrelated individuals. For example, an assisted living facility that is licensed to serve 4 or fewer individuals may be chosen by an MFP participant and would meet the standards for a qualified residence. The supports planners/case managers and the community placement specialists will document the type of qualified residence where each MFP participant chooses to live. Staff will verify that homes or apartments meet the statutory definitions under MFP. Verifications may be based on a visit to the residence, a report of the consumer or representative, information obtained from the property manager or landlord, licensure information, or information from a local housing authority. For community-based settings serving four or fewer individuals, the transitional case manager will document the type of setting based on the definitions in the Code of Maryland Regulations. For assisted living facilities, this means verifying with the Office of Health Care Quality that the facility is licensed to serve four or fewer individuals. For Alternative Living Units, the staff need only verify the type of setting, since by definition this residence serves 3 or fewer individuals. Maryland expects that few MFP participants will choose to live in a Group Home or Adult Foster Care Home. Information about the community residence chosen by each participant will be documented in the LTSSMaryland tracking system and reported to the State in periodic required reports.

Due to difficulty in generating consolidated reports on housing type for MFP participants, the Department will work with the IT contractor to add housing type as a data field in the LTSS

system. This data field will then be required for all LTSS recipients and reports can be generated more easily to track when housing type changes and to compare non-MFP participants to MFP participants.

9.2 Strategies to Meet the Projected Housing Need

The lack of affordable and accessible housing is a major barrier to community transition. The MFP demonstration will employ a variety of strategies to address this barrier. These strategies coordinate to assure an adequate supply of quality housing for Marylanders.

Housing Assistance. One of the major components of transitional case management is the provision of housing assistance. Supports planners/case managers provide information about types of housing options, the availability of housing, and the housing subsidy systems. They will also provide intensive support to complete applications, acquire needed documentation, and secure housing. It may also include opportunities for MFP participants to visit different housing options using their supplemental service funds (Section B.5.4). Housing assistance will be available to residents of SRCs who indicate a preference for independent community housing instead of an Alternative Living Unit and will be provided by their Service Coordinators. Through MFP, the Department maintains four (4) Housing Staff who accept referrals from transitional case managers and provided enhanced housing assistance when the case manager is unable to secure community housing. These staff are also tasked with participating in statewide housing policy development, establishing and maintaining relationships with local housing authorities to advocate for additional resources, and providing training to MFP partners.

Assisted Living Provider Incentives

MFP allows congregate settings in the community if each individual has lockable access and their own private sleeping, bathing, and cooking areas. Maryland generally does not offer this type of congregate setting, forcing individuals who would like to live in assisted living to choose less independent options. Creating congregate settings with more independence could serve a group of individuals who remain institutionalized due to the lack of housing or due to lack of natural supports in the community. Start-up costs for providers to establish residences that meet the MFP criteria and newly proposed CMS definition of a community residence could increase options for people in need of long-term supports. Maryland's MFP demonstration will solicit proposals from providers to establish this type of residence and fund any proposals that meet the goals of the demonstration by increasing MFP-qualified community-based options. Proposals may include requests for funding for accessibility modifications, renovations to establish individual cooking, sleeping, and bathing areas or lockable egress and access, and funds for securing a new residence that meets these criteria.

As this model of smaller congregate setting with enhanced features and independence is not currently offered, the waiver rate structure for congregate settings may not adequately fund the support. If a new waiver or service is needed to adequately fund the supports, then State budget approval would be necessary as MFP could not cover the ongoing State cost. However, if a new service structure is identified, MFP could fund a pilot project or supplemental service to test its efficacy. If such a model is proposed, stakeholder input will be used to evaluate the model and develop a new MFP service.

Behavioral Health Group Homes

The MFP Behavioral Health Workgroup recommended the development of Behavioral health group homes that utilized current providers of assisted living and mental health residential rehab services to collaborate in small residential settings that meet the needs of individuals with significant behavioral health and somatic support needs. However, the collaboration has not yet been successful as most providers maintain larger group home sizes and are not willing to cross-license in both the behavioral and somatic service systems. In order to facilitate the development of these group homes, Maryland's MFP demonstration will solicit proposals from providers to establish this type of residence and fund proposals that meet the goals of the demonstration by increasing MFP-qualified community-based options for people with co-occurring somatic and behavioral health support needs. Proposals may include requests for funding for consultation services, accessibility modifications to existing group homes, renovations existing homes to meet MFP criteria, enhanced staff training, administrative staffing or consultation to develop a model, etc.

If a new waiver or service is needed to adequately fund the combined supports provided in the newly established residences, then this initiative could require budgetary authorization from the Department of Budget and Management because of the ongoing state cost that can not be covered by MFP.

The Bridge Subsidy. The Bridge Subsidy Demonstration Program provides State-funded short-term rental assistance (up to three years) for individuals with disabilities while they await permanent housing assistance. Participants are selected based on specified criteria by the State's Developmental Disabilities Administration, Mental Hygiene Administration and private non-profit signatories to the Memorandum of Understanding (MOU). All Public Housing Authorities (PHAs) received an invitation to participate in the Demonstration and those who elected to sign the MOU agreed to administer the bridge subsidy payments to the landlords, accept a participant on their waiting list, and provide a preference for a participant under their Annual Plan if the participant did not otherwise reach the top of the waiting list within their three-year term on the Demonstration Program. Participants are required to abide by certain standards to remain in the Program, including receiving tenant and financial training and participating in a service plan. MFP will expand support for this program if more subsidies become available.

DDA currently funds 20 Bridge Subsidies to support capacity for individuals moving out of institutions. Currently, all subsidies have been used and the ongoing annual funding supports a person already in a voucher slot. Only one of the DDA Bridge Subsidies went to a person moving out of an institution. The remaining subsidies created capacity in community living settings by allowing a person in a congregate setting to access these housing options. The DDA intends to continue the current level of funding through MFP rebalancing funds so that an additional 20 individuals can receive a voucher in the MFP extension period. Priority for new vouchers will be given to MFP participants transitioning out of institutions.

MHA proposes to fund 14 Bridge subsidies to support 14 individuals transitioning to the TBI waiver for the 5 year period that it takes to obtain a permanent housing choice voucher. Individuals transitioning from institutions will be prioritized for the Bridge Subsidy Program, to include chronic hospitals, nursing home facilities and state psychiatric facilities. Another priority group for the MFP Demonstration and funded with the Bridge Subsidy Program would be individuals moving from an Alternative Living Unit (ALU) or Residential Rehabilitation Program (RRP). These individuals would move into independent housing and create capacity in

the congregate setting for an individual moving from an institution as most individuals transitioning to the TBI waiver choose a congregate setting as a step-down from institutional care.

The Office of Health Services proposes to fund 50 Bridge subsidies to support 50 individuals transitioning out of nursing facilities for the 5 year period that it takes to obtain a permanent housing choice voucher. Each of the 50 subsidies will be awarded to MFP participants leaving institutions.

While these MFP initiatives focus on maximizing available housing and subsidies, additional support is needed to develop additional housing units. Using rebalancing funds, the Maryland Department of Disabilities (MDOD) hired a Staff Specialist to work on housing. The individual in this role serves as the Maryland Partnership for Affordable Housing Program Administrator by providing technical assistance to case managers and landlords throughout the HUD Section 811 Project Rental Assistance Demonstration. This Specialist also maintains waitlists, manages preferences and selections process, and provides ongoing support.

In addition to the Staff Specialist position, MDOD also created an Interagency Housing Liaison position. This position is responsible for coordination between MDOD and the Maryland Department of Housing and Community Development (DHCD) on special projects related to the implementation of the MFP Housing Initiatives. These projects include Bridge Subsidy Program, transit-oriented development, and sustainable community planning initiatives for the purpose of creating affordable and accessible housing for people with disabilities transitioning out of nursing facilities. The individual is also responsible for developing and maintaining key relationships across affordable housing systems including public housing authorities, developers, and local municipalities.

9.3 Relationship between MFP Program and State/Local Housing Authorities

The State recognizes that working in partnership with housing professionals is essential to assuring a supply of accessible and affordable housing options. The Director of Multifamily Housing from the Department of Housing and Community Development (DHCD) and the President of the Maryland Association of Housing and Redevelopment Agencies (MAHRA) reaffirmed the importance of these partnerships at the 2008 MFP Housing Day. With leaders in the housing sector supportive of the MFP program, the next step is to target the local level. Building on the supportive efforts at the Federal level, the MFP program will work in partnership with the local MAP sites and stakeholders to promote MFP goals through changes in housing policy at the local level.

As noted in the Project Introduction on page 9, Maryland successfully applied for a Real Choice Systems Change Grant titled, Building Sustainable Partnerships for Housing. Maryland's proposal, Maryland Partnerships for Affordable Housing (MPAH), is a joint effort of Medicaid, the Department of Disabilities, the Department of Housing and Community Development, the Mental Hygiene Administration, DDA, Centers for Independent Living, disability advocates, consumers, and other community service providers. MPAH was a one year grant, with a one year extension, that assisted Maryland in developing strong relationships and a competitive application for funding through the U.S. Department of Housing and Urban Development's revised section 811 rental assistance program demonstration. In February 2013, DHCD, in

partnership with DHMH and MDOD was awarded the Section 811 Project Rental Assistance Demonstration (PRA Demo) program. The program will serve 150 persons with disabilities and is targeted to individuals who are institutionalized between the ages of 18-62 (non-elderly disabled) utilizing $10 million in funding. The Section 811 PRA Demo will consist of 70% one bedroom units and 30% two bedroom units in the Baltimore/Washington metropolitan area. DHCD and local public housing authorities have also committed to provide local preference for 102 Housing Choice Vouchers (HCV) or public housing units to support non-elderly disabled (NED) individuals. The commitments do not include HCV already reserved for this population as part of a PHA's NED baseline.

Also noted in the Project Introduction on page 11, Maryland was awarded 112 category II vouchers for non-elderly disabled individuals transitioning from institutions. The Coordinating Center, the case management provider for the Living at Home waiver that serves individuals under age 65, took the lead role in assisting eligible MFP applicants in accessing these vouchers. DHMH MFP staff worked directly with individuals that met the voucher criteria, but were served through other HCBS programs, including the Waiver for Older Adults and the DDA waiver programs. As of September 2012, all 112 vouchers have been awarded. These vouchers have been used successfully because of the partnerships between the MFP demonstration, MFP housing staff, local housing authorities, and the case management providers.

Maryland will continue to pursue any options created by the Federal partnerships between the U.S. Departments of Health and Human Services and Housing and Urban Development.

Continuity of Care Post the Demonstration

Participants in the Maryland Money Follows the Person Demonstration will receive home and community based services through the existing and ongoing 1915(c) waivers and State Plan HCBS programs, including Community First Choice, that are currently in place. Any additional services received through participation in the MFP Demonstration are one-time only and not ongoing services. Therefore, participants will continue to receive services without interruption or modification at the end of their participation in the demonstration via the HCBS waiver and/or State Plan program in which they are enrolled. Participants of the HCBS waivers are re-evaluated annually for medical, financial, and technical eligibility. Redeterminations for waiver services will likely coincide with expiration of MFP demonstration eligibility as the time periods are the same. MFP participation and eligibility will not affect the redetermination process.

As noted in the Project Introduction; Increasing Use of HCBS on page 6, Maryland has developed a policy in accordance with the Money Follows the Individual Act. This policy allows any individual who has been an institutional resident, paid for by Medicaid, for at least 30 consecutive days to apply for the waiver programs even if those waivers are "closed".

In Maryland, waivers have higher income and asset limits than other eligibility categories. Though the State anticipates that most individuals transitioning under MFP will utilize waiver programs, an individual who would be eligible for Medicaid in the community could transition under MFP and receive State Plan services such as Community First Choice, Medical Assistance Personal Care, DMS/DME, PRP or Home Health. Similarly, if an individual was no longer eligible for a waiver, but did meet community eligibility for Medicaid, that individual could access State Plan services after leaving a waiver.

The central goal of the MFP program is to serve people in the community rather than in institutional settings. In 2008, Maryland Medicaid recipients in nursing facilities were unable to transition to the community despite a strong desire to do so because their income was a few dollars over the 300% SSI income limit for our waiver programs. Maryland's MFP program allowed these individuals to transition to the community using the MFP demonstration authority. During the MFP demonstration year, the State pursued an amendment to its existing 1115 waiver to create a permanent authority to serve these individuals. This new option was approved by CMS in 2009 to serve 10 participants and was titled the Increased Community Services (ICS) program. Since the initial approval, the 1115 was amended to allow 30 individuals to be served under this authority due to expanded interest.

C   Organization and Administration

Organizational Structure

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- GOVERNOR
  - Department of Health and Mental Hygiene
  - Department of Disabilities
  - Department of Human Resources
  - Department of Aging
  - Department of Housing and Community Development
    - Bridge Subsidy Program

Peer Outreach and Support

- Centers for Independent Living
  - Peer Mentoring Provider
- Maryland Access Points (Aging and Disability Resource Center Network)
  - Options Counseling
- Area Agencies on Aging

- Office of Health Services
  - Long-Term Care and Community Support Services Administration
    - Money Follows the Person
    - Community First Choice
    - Home and Community Based Options Waiver
      - Supports Planning
- Mental Hygiene Administration
  - Traumatic Brain Injury Waiver
    - Case Management
- Office of Health Care Quality
- Office of Eligibility
  - Division of Eligibility and Waiver Services
- Developmental Disabilities Administration
  - Regional Offices
    - Community Pathways Waiver
      - Resource Coordination

1.   Staffing Plan

There are thirteen dedicated positions for the MFP Demonstration that are paid for by the grant, the MFP Project Director, MFP Associate Project Director, Data Specialist, MFP Policy Analyst, Housing Supervisor, three Housing Specialists, Finance Specialist, MAP Specialist, Statewide (DDA) Transition Coordinator, and two Community Placement Specialists. They are full time positions in the Office of Health Services, Long Term Care and Community Support Services Administration. 100% of these positions are dedicated to the MFP Demonstration.

The primary role and responsibility of the Project Directors is to direct or assist the activities for Maryland's Money Follows the Person demonstration. This will include: reviewing and developing policies; serving as liaisons with interested groups, individuals, agencies, and the legislature concerning the demonstration; developing and implementing rules, regulations, standards, and controls for carrying out and completing the demonstration; preparing the budget for the assigned programs; completing required federal reporting; supervision of staff; and performing other related duties. The Project Director also manages the Balancing Incentive Program in conjunction with the BIP Coordinator. The current Project Director was appointed as of 10/5/11. The Associate Project Director was appointed 6/13/12. The Associate Project Director supervises the MFP Policy Analyst, MAP Specialist, and Data Specialist.

The primary role of the Data Specialist is to assist the reporting and quality activities for the demonstration. This includes developing relationships with and gathering data from MFP partners, contractors, staff, and providers to monitor the efforts and outcomes in order to complete required State and Federal reporting. This position will also maintain accountability to the MFP stakeholders by generating monthly reports and responding to data requests.

The primary role of the MFP Policy Analyst is to identify opportunities to improve Maryland's behavioral health support system; develop relationships with and gather input from behavioral health providers, advocates, and consumers; provide training and consultation to MFP contractors on coordinating behavioral health services and supports for MFP participants; and to provide direct support in coordinating these services as issues arise during the transition process. The MFP Policy Analyst also assists with other rebalancing related programs such as Community First Choice.

The MAP Specialist assists with the Maryland Access Point (MAP) initiative. This includes reviewing and developing policies related to the expansion of MAP sites including, integrating MFP activities such as options counseling within the MAP site functions, assisting with sustainability planning, and developing template agreements to be used by the various agencies that make up the MAP site which include protocols for data sharing, cross referrals, and co-location

The Housing Supervisor's main duties are to supervise three (3) housing specialists and direct policy development related to affordable and accessible housing for MFP participants. This includes direct training and support of the housing specialists and MFP partners such as staff of Maryland Access Point sites, Area Agencies on Aging, public housing authorities, and other stakeholders; clarifying policy and customer service issues, and identifying opportunities to increase collaboration and develop additional housing resources.

The primary role for the Housing Specialist positions is to provide direct housing assistance to MFP applicants including locating and securing community-based affordable housing and providing time-limited case management support as needed for NED category II voucher recipients that are not eligible for other case management services. The specialists will also provide training and support to MFP partners and case managers.

The Finance Specialist's role is to manage all of the finances for the demonstration. The finance specialist will monitor the accrual and expenditure of MFP service dollars and administrative funds; prepare the budget and grant funding requests; complete MFP adjustments & accruals, act as a liaison with the Budget and Management Office and General Accounting; compile rebalancing spreadsheets to account for total MFP funds; develop a report on the budget and rebalancing funds and present reports to the MFP Stakeholder Advisory Group; compile budget reports and benchmark data for the required CMS Semi-annual Report; prepare and submit the quarterly MFP expenditure report to CMS; complete quarterly grant payment memos for the grantees; complete quarterly MBE reports on all contracts; review and adjust expenditure and revenue ledgers; monitor Federal grant award account for undrawn award balances; reconcile draws to Federal Fund share of Department-wide MFP expenditures; review and approve MFP-related invoices; respond to inquiries from contractors regarding payments; review and sign-off on MFP staff and partner requests for funds for conferences, training, and travel; and respond to legislative and CMS requests for MFP budget information.

The primary role of the Statewide DDA Transition Coordinator is to coordinate all aspects of the demonstration related to individuals with intellectual disabilities who qualify for funding from the DDA. The Transition Coordinator develops strategies for the smooth transition of individuals out of institutions, identifies individual candidates for transition to home and community-based services, monitors contracts and grants related to the MFP project, and supervises the work of the community placement specialists.

The primary role of the two Community Placement Specialist positions is to work with identified individuals in State Residential Centers and nursing facilities to assist in their transition to community-based services through MFP. Direct services include conducting outreach in nursing facilities including providing outreach to individuals with PASRR indicators for developmental or intellectual disabilities, providing consumer education and options counseling on community-based services options, assisting the transition teams in identifying and overcoming barriers to transition, utilizing the MFP web-based tracking system to document activities and consumer progress, documenting all transition-related activities and completing all required Federal and state reporting for the MFP demonstration acting as a liaison between DDA regional offices and the transition team.

There are many other positions within DHMH that are providing in-kind support to the project but that are not directly paid for by the MFP Demonstration grant. These positions were existing prior to the demonstration are fully staffed. The positions providing support are outlined in the chart below.

Positions Providing In-Kind Support

Name	Title	Roles and Responsibilities

Susan Tucker	Executive Director, Office of Health Services	Discuss program implementation activities, report and discuss evaluation data
Mark Leeds	Director of Long Term Care and Community Support Services Administration	Discuss program implementation activities, report and discuss evaluation data
Marlana Hutchinson	Deputy Director of Nursing and Waiver Programs	Discuss program implementation activities, report and discuss evaluation data
Susan Panek	Deputy Director of Nursing Home and Community Long Term Care	Discuss program implementation activities, discuss evaluation
Lorraine Nawara	Deputy Director of Community Integration Programs	Directly supervise the MFP Project Director; ascertain relevant information about the impact of program, budget, and services on other programs and Medicaid in general; discuss implementation activities
Stephanie Hull	Chief of Long-term Supports and Services, Maryland Department of Aging	Ascertain information about impact of program, budget, and services on other programs; discuss and plan for implementation activities; liaison for the MAP initiative
Kelli Cummings	Director of Community Living Policy, Maryland Department of Disabilities	Ascertain information about impact of program, budget, and services on other programs; discuss and plan for implementation activities; liaison for the MAP initiative

MFP-Dedicated Positions

Most MFP staff and those that are providing in-kind support are currently in place. The MFP-dedicated positions are listed below, all positions are currently filled.

Name	Position
Devon Mayer	Project Director
Christin Whitaker	Associate Project Director
Onika Constant	Data Specialist
April Ostrowski	MFP Policy Analyst
Rebecca Oliver	MAP Specialist
Kimberley Ausby	Finance Specialist

Jennifer Miles	Housing Supervisor
Michelle Haile Adenike' Dobson Janeille Shorts	Housing Specialists
Wayne Reed	DDA Statewide Housing and Transition Coordinator
Rick Mason Catharine Dawson	DDA Community Placement Specialists

Performance Assessment

The Department of Health and Mental Hygiene will be responsible for evaluating the performance of staff related to the demonstration. The MFP Project Director will be responsible for evaluating the performance of contractual staff.

2.   Billing and Reimbursement

MFP Billing

All new services offered under MFP will comply with the Department's existing guidelines to prevent duplication of services, fraud, and abuse. The State plans to operate the MFP demonstration within current guidelines and procedures, and to monitor and pay for all new services through the MMIS claims system. In addition to submitting claims through this State's MMIS claims system, the fiscal intermediary will be required to validate the supplemental flexible funds with receipts.

Fraud Control Provisions and Monitoring

Maryland Medicaid programs have several layers of protection from fraud and abuse including internal programmatic audits, oversight by the Office of the Inspector General, and accountability to the Department of Legislative Services Office of Legislative Audits. The mission of the Office of the Inspector General (OIG) is to protect the integrity of the Department of Health and Mental Hygiene (DHMH) and promote standards that benefit the citizens of Maryland and program beneficiaries. The OIG has a responsibility to report to both the Secretary and Program Managers any problems and make recommendations. The OIG's duties are carried out primarily through audits, reviews, investigations, and trainings. The OIG is comprised of six divisions: Corporate Compliance, Privacy Office, Internal Audits, Institutional Review Board, Program Integrity, and Ethics. The OIG supports a toll-free hotline through which to report fraud, waste and abuse.

The Office of Legislative Audits (OLA) is part of the Maryland General Assembly's Department of Legislative Services. Their mission is to serve the General Assembly and the citizens of Maryland by providing independent, objective, and non-partisan audits and evaluations of State government agencies. OLA operates under the authority of the State Government Article, Sections 2-1217 through 2-1227 of the Annotated Code of Maryland and reports to the General Assembly's Joint Audit Committee. OLA is responsible for performing fiscal compliance audits of State agencies to evaluate fiscal operations and determine compliance with laws and regulations conducting performance audits to evaluate whether a State agency or program is operating in an economic, efficient and effective manner, operating a fraud hotline for reporting

fraud, waste, and abuse of State resources, monitoring the financial reporting practices and financial condition of local governments, and conducting special reviews and investigations requested by the Joint Audit Committee.

OLA's audits are conducted in accordance with Generally Accepted Government Auditing Standards issued by the United States Government Accountability Office.

D.   **Final Budget**

A considerable amount is included in the budget to enhance the transition process. Specifically, over the 5 year extension, we estimate more than $17 million will be spent on peer supports and options counseling. These initiatives are designed to address two areas of particular concern for the stakeholder group. The details and specific duties of the peer support staff and options counselors may be found throughout the protocol.

A detailed description of the personnel and contractual costs follows. The total estimated administrative budget for CY14 is $1,183,584. In addition to administrative costs, peer mentoring will incorporate MFP demonstration service dollars estimated at $181,783 in CY14.

Personnel

The total budget for salaries, fringe and indirect costs for the five year extension period is $5,591,368. Full-time staff supporting the implementation of the demonstration include:

- *Project Director and Associate Project Director*– The Project Directors will oversee the day to day operation of the demonstration. The project director will be responsible for CMS reporting, MFP contract management, and overseeing the stakeholder process.
  - *   The total cost for CY 2014 is $180,831.
  - *   The total cost over the 5 year extension period is $979,438.

- *Housing Staff, Policy Analyst, MAP, Data, and Finance Specialists*-One housing supervisor and three housing specialists work directly with MFP applicants and advocate for affordable, accessible housing. The policy analyst provides direct support to MFP participants and liaises on behalf of the MFP demonstration, in addition to providing support to other rebalancing initiatives such as Community First Choice. The MAP specialist assists with the Maryland Access Point (MAP) initiative, including, integrating MFP activities such as options counseling within the MAP site functions. The data specialist and finance specialist provide administrative support for the demonstration.
  - *   The total cost for CY 2014 is $560,578.
  - *   The total cost over the 5 year extension period is $3,036,276.

- *Developmental Disabilities Administration Transition Staff* – Three additional staff are necessary to work with families during the transition from State Residential Centers and nursing facilities to the community. One individual will work centrally to coordinate transitions. The other two staff will provide direct assistance to consumers during the transition process.
  - *   The total cost for CY 2014 is $210,969.
  - *   The total cost over the 5 year extension period is $1,142,678.

- The State has negotiated a 33.81 percent indirect cost rate for salaries effective July 1, 2013.
  - *   The total cost for CY 2014 is $231,305.
  - *   The total cost over the 5 year extension period is $1,252,281.

Contracts

Memorandums of Understanding

- *Bridge Subsidy Rental Assistance Program* – Additional funding to create availability of rental assistance through the Bridge Subsidy program for MFP participants.
    * The total cost over the life of 5 year extension period is $5,300,000.
        - $2,500,000 for 41 DDA participants,
        - $300,000 for 5 TBI participants,
    * $2,500,000 for 41 MFP participants transitioning from nursing facilities

- *State Residential Center Peer Support* – Additional funds will be provided to enhance the existing peer mentoring efforts for individuals residing in State Residential Centers. This support will expand the availability of peer supports to all SRC residents.
    * The total cost in CY 2014 is $76,106.

- *The Hilltop Institute* – The Department will utilize an MOU with the Hilltop Institute for two separate activities, both of which include data management and analysis. During the initial years of MFP implementation, Hilltop built a web-based tracking system for MFP in order to track services and administrative activities related to potential and enrolled MFP participants. Ongoing IT support for data management and analysis will be necessary to complete all mandatory reporting requirements.
    * The total cost for CY 2014 is $257,999.
    * The total cost over the 5 year extension period is $1,080,000.

    During the extension period, a contractor will continue development of a new unified LTSS tracking system that will consolidate the existing MFP and waiver tracking systems, add quality monitoring components such as reportable events, and expand to include Community First Choice, other waivers and community-based supports. It will also include data from MMIS, the MDS 3.0, and other data sources.
    * The total cost for CY 2014 is $10,000,000.

- *TBI Waiver Tracking System* – creation of a web-based tracking system to reduce delays in eligibility determination and increase quality monitoring abilities. This system will be integrated into the LTSS tracking system.
    * The total cost over the 5 year extension period is $50,000

- *TBI Staff Development* – As MHA continues to expand the community based options available to support individuals with TBI, it is critical that TBI waiver staff that are involved with the MFP Demonstration have the opportunity to expand their knowledge of federal policies and funding opportunities, state programs and resources, and national best practices. MHA intends to use a portion of re-balancing funds to support MFP/ TBI waiver staff development through attendance at National and local meetings.
    * The total cost over the 5 year extension period is $30,000

Maryland Department of Aging – The Department will utilize an MOU with the Department of Aging to provide options counseling to nursing facility residents. This agreement will also provide funding for ADRC development through CY2014. MDoA provides ongoing administrative support to the demonstration through monitoring of services, billing, and technical assistance. The MOU includes funding to help support these administrative functions.
- ∗ The total cost for CY 2014 is $4,768,841.
- ∗ The total cost over the 5 year extension period is $15,768,841.

- *Maryland Department of Disabilities* – The Department will utilize an MOU with the Department of Disabilities to funds the peer support activities for nursing facility residents. The MOU includes funding for MDOD's administrative costs related to the implementation of the peer supports program.
  - ∗ The total cost for CY 2014 is $700,000
  - ∗ The total cost estimated cost over the 5 year extension period is $4,025,517.

- *Maryland Department of Disabilities*- The Department will utilize an MOU with the Department of Disabilities to fund housing development. MDOD will hire two (2) housing developers to focus on transit-oriented development and partnerships with developers to increase available affordable and accessible housing units.
  - ∗ The total cost for CY 2014 is $215,228
  - ∗ The total cost over the 5 year extension period is $1,076,140.

- *Schaefer Center for Public Policy*-The Department will utilize an MOU with the Schaefer Center for Public Policy in order to administer the Quality of Life Survey. The Schaefer Center will administer QoL surveys to MFP participants at baseline in the institution and again one and two years after their transition and provide relevant data to the State regarding survey results and follow-up needs.
  - * The total cost for CY 2014 is $363,097.
  - * The total cost over the 5 year extension period is $2,448,125.

- *Complaints and Surveillance Unit* - MFP requires enhanced quality monitoring beyond what is currently in place for the existing HCBS waivers. A new Complaints and Surveillance Unit is proposed to triage and respond to emergency backup calls. The unit would be responsible for establishing a call-in number for emergencies, 24 hours per day. Three staff would be needed to answer calls and respond to or triage the emergency situation.
  - * The total cost for CY 2014 is $230,000.
  - * The total cost over the 5 year extension period is $1,245,753.

Contracts – Requests for Proposals

- *Provider Training* – this contractor will host trainings for community personal care providers in areas identified by stakeholders as important to improving quality of services and ensuring successful implementation of the MFP demonstration. The contract will include Mental Health and Substance Abuse Training as well as training on quality.
  - * The total estimated cost for CY 2014 is $125,000

* The total estimated cost over the 5 year extension period is $625,000

- *Partner Training* – this contractor will host outreach and in-service trainings for MFP partners, including discharge planners, MAP staff, and ombudsmen on topics such as quality requirements, opportunities, and supports available in the community. The contract will also include person centered planning in order to increase self-direction.
    * The total estimated cost for CY 2014 is $125,000
    * The total estimated cost over the 5 year extension period is $625,000

- *Training for Direct Support Staff* – Cost to purchase the license and training support for direct support staff in the DDA service system.
    * The total cost over the 5 year extension period is $1,482,000

- *Rebalancing Budget Allocations* –DDA pilot of the Supports Intensity Scale with SRC residents to develop individualized budgets.
    * The total cost over the 5 year extension period is $750,000.

- *Person Centered Planning* – intensive person-centered planning process for SRC residents transitioning to the community through MFP.
    * The total cost over the 5 year extension period is $750,000

- *DDA Data Management* – improved information technology systems to increase quality monitoring capabilities and drive quality improvement activities. Any new system will be integrated with the LTSS tracking system.
    * The total cost over the 5 year extension period is $300,000

- *TBI Provider Incentives* – to increase the availability of providers for the TBI waiver and increase choice of providers for participants.
    * The total cost over the 5 year extension period is $200,000

- *TBI Resource Coordination* – outreach, application assistance, and transitional case management for chronic hospital and TBI waiver eligible nursing facility residents.
    * The total cost over the 5 year extension period is $750,000

- *TBI Waiver Clubhouse Model* – establish a consumer-driven alternative to day programs for TBI waiver participants.
    * The total cost over the 5 year extension period is $100,000

- *Single Standardized Assessment* – cost of the instrument, software, technology, and initial training for the users.
    * The total cost for CY2014 is $2,000,000
    * The total cost over the 5 year extension period is $3,000,000

- *In–home Supports Assurance System* – cost of procuring a vendor, software, technology upgrades, and user training for key stakeholders, including participants, providers, case managers, and administrators.

* The total cost for CY2014 is $1,000,000
* The total cost over the 5 year extension period is $2,000,000

- *Personal Care Back-up Agency* – cost of procuring a vendor, and paying a retainer fee, this agency would respond to emergency back up calls from the Complaints and Surveillance unit.
  * The total cost for CY2014 is $200,000
  * The total cost over the 5 year extension period is $1,000,000

- *MAP Information Technology* – The local MAP sites currently each use a unique system for tracking their efforts and incoming inquiries about long term supports and services. A single, statewide database is necessary to monitor inquiries about long-term supports and services and standardize data collection and reporting. Such a unified system could share data with the Medicaid long-term care tracking system, facilitating referrals for support and generating vital data on service demand. Costs include the procurement of a vendor and software, training to all users, and the connection to the Medicaid tracking system.
  * The total cost for CY2014 is $250,000
  * The total cost over the 5 year extension period is $1,250,000

- *Maryland Hospital Diversion Model* – After an evaluation of current diversion efforts and national models, Maryland could create its own model of nursing home diversion that could be implemented statewide. A unique program would allow Maryland to continue and expand the efforts at lower costs in order to be viable after the MFP demonstration period.
  * The total cost for CY2014 is $75,000
  * The total cost over the 5 year extension period is $175,000

- *Hospital Outreach* – An expansion of the NF peer outreach model to hospitals in order to provide training for hospital discharge planners on available community options.
  * The total cost for CY2014 is $200,000
  * The total cost over the 5 year extension period is $1,000,000

- *Prioritize the Waiver Registries* – Assess all individuals on the Living at Home and Older Adults waiver registries using the new evidence-based standardized assessment instrument and prioritize based on need rather than date of application.
  * The total cost over the 5 year extension period is $4,000,000

- *Provider Registry* – Creation of an online, searchable database of providers of HCBS. This type of registry would allow participants to search for qualified, pre-screened providers and increase ease of access to support.
  * The total cost over the 5 year extension period is $500,000

- *Community First Choice Implementation* – If the state pursues this ACA option, MFP would fund the start-up administrative costs such as staffing, technology, training, and outreach.
  * The total cost over the 5 year extension period is $500,000

- *Assisted Living Provider Incentives* – Start-up costs for providers to establish residences that meet the MFP qualified residence and newly proposed CMS definition of a community residence
    * The total cost over the life of the 5 year extension period is $1,000,000

- *Behavioral Health Group Homes*– Incentivize current providers of assisted living and mental health residential rehab services to collaborate on the development of small residential settings that can meet the needs of individuals with significant behavioral health and somatic support needs.
    * The total cost over the life of the 5 year extension period is $200,000

- *Pilot HCBS Services*–Programs to be explored include, but are not limited to, the Living Well Program (Chronic Disease Self Management Program), PEARLS, and a modified bundle of existing services such as occupational therapy, environmental modifications, and assistive technology.
    * The total cost over the 5 year extension period is $1,000,000

- *Nursing Facility Expansion to HCBS* –Pilot projects that encourage institutional providers to expand their business model to include home and community-based services can increase consumer choice and expand the pool of HCBS providers, especially in rural areas. Working with institutions to change their business models is an important part of transitions and rebalancing efforts and increasing those efforts is crucial to meeting the goals of MFP. Examples include training and outreach to NF providers, Continuity of Care Pilot, or Bed Restructuring Incentives
    * The total cost over the 5 year extension period is $2,000,000

- *Bed Closure Incentives* – Provide incentive payments to nursing facilities for the permanent, voluntary closure of unused beds.
    * The total cost over the 5 year extension period is $1,000,000

Consent Form for Waiver Services

❑ **I freely choose to <u>accept</u> home and community-based services under the Living at Home Waiver Program Home and Community Based Services Waiver for Adults with Physical Disabilities.** **I understand that there are alternative services for which I am eligible, including services in a nursing facility. The waiver will offer me home and community based services as an alternative to a nursing facility.**

1. I have been informed that if I am eligible for the waiver, I will have my choice of selecting one of two service options for managing the delivery of my attendant services: consumer-employed or agency-employed. Also, I will participate fully as a co-planner in developing my plan of services. I understand and considered my options, which have been explained to me. It is my wish to receive home and community-based services under the Living at Home Waiver Program Home and Community-Based Services Waiver for Adults with Physical Disabilities.

2. I further understand that in order to continue to receive home and community-based services, I must meet all of the eligibility criteria of the Maryland Medical Assistance program and the Waiver. I also understand that I can change my mind about my choice of options at any time simply by contacting my case manager.

❑ **I choose to receive services in a nursing facility.**

❑ **I choose neither of these service options. Explanation:**

My signature below indicates that I have been informed of the various options available for my choice and that any questions that I may have about my options have been answered.

Printed Name: _____Social Security #: _____

Signature: _____ Date: _____

HOME AND COMMUNITY-BASED SERVICES WAIVER FOR OLDER ADULTS
MARYLAND MEDICAL ASSISTANCE PROGRAM
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Participant Consent Form

_____ I choose to receive home and community-based services under the Maryland Medical Assistance Programs Home and Community-Based Services Waiver for Older Adults, as an alternative to long-term care institutional services in a nursing facility. I understand and have considered my options, which have been explained to me. I further understand that in order to qualify, and continue to qualify, for the waiver program, I must meet all the eligibility criteria of the Maryland Medicaid Program and the Waiver.

_____ I choose to receive long-term care institutional services in a nursing facility, rather than services in the Maryland Medical Assistance Programs Home and Community-Based Services Waiver for Older Adults. I understand and have considered my options, which have been explained to me. I further understand that in order to qualify, and continue to qualify, for Medicaid coverage in the nursing facility, I must meet all the eligibility criteria for the Maryland Medicaid Program and for the nursing facility services.

_____ I choose neither of these service options.
Explanation:

Individual's Name:_____

Signature: _____
                                             Individual
          or   _____
                          Legally Authorized Representative

Date Signed: _____

MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER
FOR ADULTS WITH TRAUMATIC BRAIN INJURY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Consent Form for TBI Waiver Services

_____ I choose to receive home and community-based services under the Medicaid Waiver for Adults with Traumatic Brain Injury, as an alternative to long-term care institutional services in a hospital or nursing facility. I understand and have considered my options, which have been explained to me. I further understand that in order to qualify, and continue to qualify, for the waiver program, I must meet all the eligibility criteria of the Maryland Medicaid Program and the Waiver.

_____ I choose to receive long-term care institutional services in a hospital or nursing facility, rather than services in the Medicaid Waiver for Adults with Traumatic Brain Injury. I understand and have considered my options, which have been explained to me. I further understand that in order to qualify, and continue to qualify, for Medicaid coverage in the institution, I must meet all the eligibility criteria for the Maryland Medicaid Program and for the institutional services.

_____ I choose neither of these service options.   Explanation:

Individual's Name: _____

Individual's Signature: _____

or
Legally Authorized Representative: _____

Date Signed: _____

Appendix A-4: Community Pathways / New Directions Waiver Consent Form

INTERPRETIVE INTERVIEW: COMMUNITY PATHWAYS WAIVER

Individual Name: _____

1. Assessment results and individual needs have been discussed with the Individual and/or family on (date) _____ by (name and title)

2. Alternative plans for meeting individual needs have been discussed and a choice of services, ICF/ID or community waiver services has been presented to the individual and/or family on (date) _____ by (name and title)

3. Individual and/or family has chosen:

   ____   Waiver Services   ____   ICF/ID Institution

4. The Individual Plan has been developed prior to placement date.

5. The signature below indicates approval of the services identified based on assessment results which will be developed into an Individual Plan.

Check only one of the boxes and complete:

_____   _____
Capable Individual   Date   Witness to Individual's Signature   Date

                                          _____
                                              Relationship to Individual

_____   _____
**   Guardian/Parent of   Date   Witness to Guardian/Parent   Date**
   under 18 Yr. Old Individual

____   I was present

____   I could not be present but I have been involved in the interpretive interview process and fully understand the results of my choice on the Individual's behalf.

_____   _____
Individual for Incapable Person   Witness   Date

Relationship _____

____   I was present

____   I could not be present but I have been involved in the interpretive interview process and fully understand the results of my choice on the Individual's behalf.

All other parties present at this Interpretive Interview should sign here:

_____   _____
Resource/Service Coordinator/Case Manager   Date   Other/Relationship   Date

WC-3B Return to: Terri Elliott, DDA, 201 W. Preston St., 4th Floor, Baltimore, MD 21201
Revised: 8/04

Appendix B: DHMH Reportable Events Policy and DDA Policy on Reportable Incidents and Investigations

DHMH Reportable Events Policy:

https://mmcp.dhmh.maryland.gov/docs/RE-POLICY-FINAL-VERSION-OHS.pdf

DDA Policy on Reportable Incidents and Investigations:

http://dda.dhmh.maryland.gov/SitePages/ReportableInc/Sept%202013/10220201%20FINAL%20PORII.pdf

Appendix C: Blue Book – Outreach Materials

See attached PDF file:

Appendix C Blue Book.pdf

https://mmcp.dhmh.maryland.gov/longtermcare/SiteAssets/SitePages/Home/2012-2013%20HCBS%20Booklet.pdf

Policy for Participants to Self-Delegate Care

Participants in the Living at Home Waiver (LAH), may if cognitively capable, choose to direct the independent attendant care provider to assist the participant with routine care and self-administration of medication. The Board of Nursing regulations (COMAR 10.07.11.01D) support this policy.

Process:

- The Service Coordinator will share a self-delegation packet with the participant/applicant during their quarterly/initial meeting. These documents will assist the participant/applicant in making an informed decision regarding the direction of his/her care. The packet will include:

    - ✓ A booklet called "Attendant Care Services and You: Partners in Community Living" which describes the models of attendant care services and other useful information
    - ✓ Self-Delegation Fact Sheet

- After reviewing these documents, the Service Coordinator will ask the participant/applicant if they are interested in directing their own attendant care without the standard oversight of a nurse monitor or requesting the oversight of a nurse monitor for a specified period of time before beginning to self-delegate.

- The participant and the Service Coordinator (if requested) will identify the tasks that will be self-delegated.

- The participant and the Service Coordinator (if requested) will develop a job description and back-up plan for the attendant(s).

- The participant and the Service Coordinator (if requested) will discuss and develop a plan for hiring, screening, interviewing, and training the attendant(s).

- Once a potential attendant has been identified, the participant will direct him/her to the Living at Home Waiver Division to complete the provider enrollment process (if necessary).

- If the participant and Service Coordinator agree that they are ready to move forward, a Self-Delegation of Attendant Care Agreement will be provided to the participant for signature.

- ✓ The Agreement will state that the participant will be responsible for the direction and oversight of the attendant(s) and that the Plan of Service (POS) supports the participant's needs while receiving LAH waiver services in the community.
- ✓ *The Agreement should only be signed when the participant is ready for total self-delegation.*
- ✓ *The Agreement will include the time frame for review of the agreement, but minimally, the participant and the Service Coordinator will review it on an annual basis at redetermination.*
- ✓ *Details of the independent delegation agreement will be indicated on the waiver participant's POS.*
- ✓ Attendant care service tasks shall be noted on the Caregiver Service Plan.

- The Agreement, POS and Caregiver Service Plan can be modified at any time.

- If the Service Coordinator determines that the participant's health is in jeopardy, a meeting will be held with the participant, Service Coordinator, LAH RN Clinical Supervisor and provider to discuss concerns and options. Strategies to address concerns will be developed. Strategies may include, but are not limited to: consumer training, education provided by a nurse monitor, follow-up training by the nurse monitor, temporary nurse monitoring and/or identification of a new attendant care provider.

- If the strategies are determined not to meet the participant's health and safety needs, the Service Coordinator will inform the participant that the Living at Home Waiver Division will be notified. Once notified, the LAH Waiver Division will review the information provided by the Service Coordinator and, if necessary, complete the reduction/denial of services form to discontinue self-delegation of attendant care services. The form and appeal rights will be forwarded to the participant. The participant may appeal any decision regarding his/her ability to self-delegate attendant care services under the waiver.

Appendix E: Guardianship Resources

Guardianship Resources

The Guardianship Handbook

http://www.peoples-law.org/health/disability/adult-guardian/toc.htm

Code of Maryland Regulations (COMAR)

07.02.16.11 Guardianship Procedures

http://www.dsd.state.md.us/comar/getfile.aspx?file=07.02.16.11.htm

Annotated Code of Maryland

Estates and Trusts Article §§ 13-704 through 13-710

Maryland Rules of Procedure

Title 10 Guardians and Other Fiduciaries

Appendix G: Behavioral Health Workgroup Recommendations

Appendix F-1: Peer Mentoring Demonstration Service

The Peer Mentoring for Nursing Facility Residents program is designed to support individuals who are transitioning to homes in the community and will support inclusion and connections in the local community.

The goals of the program are to:

- Promote socialization, community inclusion, and the development of community roles;
- Promote self-advocacy, defined as an individual's ability to make informed, independent choices, ask questions, and voice opinions;
- Assist in the development of natural, unpaid supports and social support networks;
- Aid in the development of community-living skills;
- Increase awareness of community activities and opportunities;
- Support vocational choices; and
- Promote effective use of service delivery systems and natural resources in the community.

Peer mentoring will include an assessment of support needs, a person-centered, individualized goal plan with regular goal review, and will incorporate individual interaction in the community, drop-in centers, telephone support, and group training and activities. Peer mentoring will begin two to three months prior to an individual's transition with assessment and goal development. Active work on goal attainment will occur after goal planning and may be provided in the community as long as the individual remains in the MFP demonstration.

From training and through life experiences, all peer mentors will have sufficient knowledge and skills to use community resources necessary for independent living, the ability to teach independent living skills to others, knowledge and skills to engage in problem solving and conflict resolution strategies, experience in utilizing community-based supports such as personal care, accessible transportation, and support groups.

Peer mentoring will be provided as an MFP demonstration service and may be added to the Living at Home and Older Adults waivers as a waiver service if it proves to be cost-effective and successful in fostering community inclusion. Peer mentoring will be provided by the Centers for Independent Living across the State. Peer mentors will be reimbursed for mentoring provided to MFP participants at a rate of $31.11 per hour or $7.78 per 15 minute billable unit. This rate was developed based on the same rate setting methodology used to develop Maryland's transitional case management rate. Please see the attached rate setting methodology. Peer mentoring providers will also be reimbursed a flat rate of $100 for the initial assessment and goal plan. Peer mentoring services will capped at 48 hours (192 units) per person, plus the assessment cost. It is estimated that peer mentoring will be utilized by approximately 500 MFP participants who transition from nursing facilities throughout the demonstration at a maximum cost of $1,593 per person.

Appendix G: Behavioral Health Workgroup Recommendations

To the Aging in Place Task Force

Develop a residential model of integrated somatic and behavioral health supports

Present this model as a pilot in assisted living facilities through the Older Adults Waiver

Enhance Residential Rehabilitation Program (RRP) rates for programs that incorporate this integrated model of care

Increase transitional case management for individuals leaving IMDs

Increase behavioral health training opportunities for somatic care providers including attendant care, assisted living, and medical day care providers

Add peer supports as a Public Mental Health System (PMHS) service

Ensure Psychiatric Rehabilitation Program (PRP) services are provided to OAW and LAH waiver participants as needed

Increase utilization of PMHS short-term intensive support services

Enhance caregiver and staff supports

Develop in-home respite care services

Encourage RRPs to become licensed as Assisted Living Facilities (ALFs)

Collect Data on consumers with brain injury

Enhance access to assistive technology

Advocate for changes in Medical Assistance Personal Care (MAPC) to allow services in RRPs >3

Develop increased options for nurse delegation

To the Brain Injury Advisory Board

Add a behavioral consultation service to the current TBI waiver

Enhance Assistive technology available to waiver participants

Add a short-term intensive support service that includes specialized staffing

Provide education and support to families and representatives of consumers

Increase outreach into the chronic hospitals

Monitor brain injury data collection efforts in the MFP demonstration

Expand eligibility for the TBI waiver to include all brain injury and all institutional settings

If the waiver is expanded consider the following:

> *Add financial management or rep payee service*
>
> *Add peer support service*
>
> *Add in-home respite care*
>
> *Add specialized training for consumer-directed attendants*
>
> *Move to aggregate cost neutrality*

To the Living at Home Advisory Committee

Behavioral Consultation Services

Residential or Supportive Housing Option

Enhanced attendant care rates for attendants with specialized behavioral health training

Short-term intensive support by a behavioral health professional

Financial representatives to assist with money management

Peer support services

Increase availability of behavioral health training for attendant care providers

Enhance access to assistive technology

Collect data on LAH applicants with a history of brain injury

Move to aggregate cost neutrality

To the Older Adult Advisory Committee

Enhanced rates for assisted living providers with specialized behavioral health training

Enhanced attendant care rates for attendants with specialized behavioral health training

Short-term intensive support by a behavioral health professional

Financial representatives to assist with money management

Peer support services

Increase availability of behavioral health training for attendant care providers

Enhance access to assistive technology

Collect data on OAW applicants with a history of brain injury

Move to aggregate cost neutrality