STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

DEC 2 7 2010

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

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

RE: HB 113 (Ch. 371 of the Acts of 2009) and SB 761 (Ch. 308 of the Acts of 2009) – Department of Health and Mental Hygiene – Long-Term Care Supports and Services – Report

Dear President Miller and Speaker Busch:

In keeping with the requirements of SB 761 (Ch. 308 of the Acts of 2009) and HB 113 (Ch. 371 of the Acts of 2009) – *Department of Health and Mental Hygiene – Long-Term Care Supports and Services – Report*, the Department is submitting the enclosed report on the feasibility of creating a coordinated long-term care program to reform the provision of long-term care services under the Medicaid Assistance program.

Thank you for your consideration of this information. If you have questions or need more information about this report, please contact Ms. Wynee Hawk, Director of Governmental Affairs, at (410) 767-6481.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: John Folkemer
Susan Tucker
Mark Leeds
Tricia Roddy
Wynee Hawk
Sarah Albert, MSAR# 7896

INTRODUCTION

HB 113 from the 2009 legislative session requires that the Department of Health and Mental Hygiene (the Department) report on the feasibility of creating a coordinated care program to reform the provision of long-term care services under the Medical Assistance program in a manner that improves and integrates care for seniors and individuals with disabilities.

The Department convened a broad-based group of 38 stakeholders to tackle the question. Additionally, the Department broadened the question and asked stakeholders what their specific recommendations are for reforming long-term care in Maryland. The Workgroup met monthly starting in March 2010. The list of the stakeholders and meetings dates can be found in Appendix 1.

CURRENT STATE: MARYLAND'S MEDICAID LONG-TERM CARE SYSTEM

In FY 2009, Medicaid spent roughly $1.2 billion (total funds) on long-term care services.[1] Roughly $966 million (81 percent) funded 22,314 people for nursing home services and the remainder was devoted to those in the community (19 percent). Of those in the community, roughly $25 million funded 4,608 people for personal care services, $91 million funded 4,107 people for medical day care services, and $116 million funded 4,200 people in our Older Adults Waiver and Living at Home Waiver programs. There were 109,832 low-income adults and persons with disabilities enrolled in both Medicaid and Medicare for at least one month during the year.[2] Two-thirds (73,546) of these "dual eligibles" received full Medicaid benefits.

Despite Maryland's efforts in recent years to expand community long-term care services, the percentage of long-term care expenditures spent on institutional services remains well above the national average. Many services provided to the elderly and disabled populations remain uncoordinated and provided through a fee-for-service system. The home- and community-based services provided under the Older Adults and Living at Home waivers are coordinated through a case manager. Our waivers, however, do not manage the funds paid by Medicare for individuals who are enrolled in both Medicare and Medicaid ("dually eligible enrollees"). The federal government is moving towards demonstration models of care that are fully integrated. These demonstration models include the management of all funds for an individual and ensure that such funds are integrated and managed by one provider. The only program in Maryland where all of an individual's services are coordinated and integrated – even those paid by Medicare – is the Program of All-Inclusive Care for the Elderly (PACE) program. The PACE program can serve up to 150 individuals.

GUIDING PRINCIPLES

The workgroup members were asked to frame their recommendations for improving long-term care with the following principles.

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[1] This figure does not include services funded in the budgets of other agencies, such as the Developmental Disabilities Administration (DDA), the Mental Hygiene Administration (MHA), *etc.*

[2] This figure includes Qualified and Special Low-Income Medicare beneficiary individuals. These individuals only get assistance with Medicare premiums, copays, and deductibles. The amount of assistance varies by income levels.

1. Improve resources available in the community and serve people in the most integrated setting.

   Consumers want to make decisions about where they live and receive services. More community-based options need to be available to them. Our long-term care reform efforts must focus not only on adding services, but also on how to improve services currently offered in the community.

2. Provide consumers choice and allow them to direct their own care to the greatest extent possible.

   Any long-term care model needs to focus on and provide choices for consumers. Consumers need a central role in the decision-making process. Consumers would be allowed to make informed choices and be held accountable for their decisions.

3. Strive towards a better managed program.

   The current system lacks the management infrastructure to ensure services are being provided appropriately and in the most efficient manner. The different infrastructure components might include care plan development, disease and utilization management programs, and provider network development and management.

4. Build-up the long-term care infrastructure to coordinate and integrate individuals' care among providers, including Medicare providers.

   The program should be designed to ensure communication among providers and coordination of consumers' care across provider networks and settings.

5. Deliver high-quality services through an interdisciplinary care team.

   Typically consumers served under long-term care programs need more than a medical service model. Instead of consumers linking themselves with medical and community providers, our model would focus on a team-based approach that works with consumers to link them to services across all settings.

6. Resources are constrained and need to be prioritized.

   Our first priority and commitment are to consumers who already qualify for Medicaid either in the community or nursing homes.

7. Create a long-term care system that is financially sustainable and better aligns incentives across the system.

   Any long-term care reform effort cannot ignore the rising costs of long-term care services. Enhancements to the program need to be balanced with the programs'

financial health – both in the short- and long-term. Incentives need to be created that allow us to achieve our long-term care reform principles and goals.

WORKGROUP MEMBER RECOMMENDATIONS

Almost all of the workgroup members gave presentations to the group outlining their ideas for reforming long-term care in Maryland. There were 27 ideas presented, ranging from implementing a coordinated care program (the group referred to this option as an integrated care program) to improving Maryland's long-term care workforce. Attachment 2 includes a comprehensive list of the recommendations provided.

The workgroup spent more focused time discussing four recommendations. These are:

- Redesign the Medical Assistance Personal Care (MAPC) program to provide better access to personal care services
- Improve the Department's assessment and intervention methods, *e.g.*, better targeting of services and providing services earlier. The Department should develop a multidisciplinary assessment of care needs
- Implement an integrated care program
- Implement some of the new long-term care options detailed in the Affordable Care Act (ACA)

o *Redesign the Medical Assistance Personal Care program*

The workgroup discussed various options for reforming the personal care program. There was consensus around two recommendations to improve access to personal care providers. First, participants believe that the Department should begin to pay providers on an hourly basis rather than on a per diem basis. Second, participants believe that the Department should allow consumers to choose family members to be caregivers. Federal rules prohibit states from paying family members who are considered legally responsible for the consumer. A legally responsible family member is defined as a spouse or the parent of a dependent child. Under the Older Adults Waiver and Living at Home Waiver, Maryland permits payments to family members (other than a spouse). The Medical Assistance Personal Care (MAPC) program is more restrictive - the program prohibits payments to spouses, parents, children, siblings, in-laws or individuals with a step relationship. There was general agreement among participants to change the rules for MAPC to permit payments to family members with two exclusions – a spouse or the parent of a dependent child should remain ineligible for payments.

The conversation around quality reflected the challenges associated with allowing consumers to direct their own care while also ensuring oversight of the services. Some of these challenges include balancing the competing goals of crafting additional oversight and empowering individuals with the ability to evaluate their own services. At the end of the discussion,

participants agreed that all personal care providers should meet some minimal core competencies and training should be offered.

Lastly, the workgroup members noted their concerns about the Medical Assistance Personal Care (MAPC) payment rates being inadequate. The Long-Term Care Payment Advisory Committee (L-PAC), another stakeholder workgroup, already made recommendations to the Department and Legislature to increase the MAPC provider rates.

- ***Improve our intervention methods, e.g., better targeting services and providing services earlier. There should be a multidisciplinary assessment of care needs.***

One recommendation focuses on better targeting services to individuals. Clinical assessment tools may be one way to help Maryland achieve this goal. The Department asked Dr. Brant Fries, the founder of interRAI and a professor at the University of Michigan, to present interRAI's work regarding clinical assessment tools. interRAI has spent a great deal of time developing assessment tools to use across various care settings. These assessment tools were developed and validated by an international panel of experts and is being used, in some form, by 15 U.S. states and in over 30 countries.

During our discussion with Dr. Fries, the workgroup gleaned that the tools could be used to help develop plans of care and to help the Department prioritize those individuals waiting for community-based services.[3] Asking 20 to 30 questions concerning typical activities of daily living/instrumental activities of daily living, living arrangements, health status, cognition/behavior, and financial status, Maryland could identify those individuals who "look most like" other individuals receiving certain levels of care[4] and who could act as a trigger for whether or not individuals are offered an at-home assessment using the full interRAI tool. Moreover, the tools have the ability to identify individuals at most risk for nursing homes.

The advantage of interRAI compared to other available assessment tools is that interRAI has been validated through meticulous research. It would permit Maryland to compare our population against people in other states that use this model. interRAI also shares common data elements with the Minimum Data Set (MDS), which is the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This means there is consistency between nursing home assessments and community-based assessments, which would allow the Department to compare patient need across settings.

- ***Implementing Integrated Care Program or Managed Care System.***

In order to answer the question of whether or not it would be feasible to implement an integrated care program in Maryland, Maryland sought technical assistance from the Center for Health Care Strategies (CHCS). CHCS, a nonprofit health policy resource center, has been providing states

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[3] Maryland's home-and community-based waiver programs are capped enrollment programs, except for individuals who are leaving a nursing home. Once enrollment is capped, individuals who are living in the community and would like to request services, call and place their name on a registry list. Currently, the Department does not prioritize these registry lists.

[4] New Jersey uses five categories: 1—Information/Referral; 2—Homemaker; 3—Intermittent Personal Care; 4—Home Care; and 5—Nursing Facility.

technical assistance on how to best eliminate barriers to integrating Medicaid- and Medicare-covered services. Maryland was one of seven states selected for technical assistance. As part of this project, CHCS participated in our workgroup process. CHCS attended many of our meetings and gave two presentations. At the March 2010 meeting, Melanie Bella and Lindsay Palmer-Barnette presented the work CHCS has been doing in this area and gave an overview of what other states are doing to improve long-term services and supports.

CHCS advised that states are using various approaches to improve Medicaid long-term supports and services. Some are focusing on Medicaid home-and community-based services and institutional care, some are focusing on Medicaid acute care services and long-term supports and services, and some are integrating all Medicaid and Medicare services. Regardless of the approach, CHCS noted that improvement programs generally include:

- Robust system of assessment, determination of need, and care management outside of long-term care providers

- Capacity to collect/analyze data for performance measurement and to track utilization/program costs

- Commitment to continuous quality improvement that drives statewide approach for multiple populations

- Formal and informal bridges across medical care and long-term supports and services

- Consumer engagement in program design and quality monitoring

- Alignment of financial incentives that help keep consumers in the community

Alice Lind, from CHCS, facilitated the September 2010 meeting focusing on integrated care programs. She talked about the key decisions states need to make when designing an integrated care program and the various options that are available to them. Table 1 summarizes the key decisions and possible options for states that she addressed in her presentation.

Table 1 –Designing An Integrated Care Program: Key Decisions

Key Decisions	Options Discussed by CHCS
Populations Covered	- By aid category (aged, blind, and disabled) - Duals included or not - Spend-down, other sources of coverage, etc. - Special considerations: developmentally disabled, ventilator dependent, traumatic brain injury - Nursing home level of care only - Nursing home residents in or not
Services Covered	- Medicaid long-term care services and supports (state plan, waiver services, etc.) - Limit on days of nursing facility covered - Case management/care management - Behavioral health - Acute care services (consideration for duals: acute care services not included in Medicare)
Enrollment	- Mandatory - Voluntary - Automatic enrollment with opt-out
Geography	- Statewide (if so, phase in by part of state) - Pilots based on strength of provider networks - Other considerations
Procurement Decisions	- Medicare Advantage Special Needs Plan (MA SNPs) to provide integrated benefits - Contract for Medicaid covered benefits separately but limit to plans that are contracted with Medicare (side-by-side model) - Medicaid MCOs for Long-Term Services and Supports
Rate-setting	- What will motivate health plans to increase community settings of care? - Can you use rate-setting to reward plans for improved outcomes?
Role of Stakeholders	- How will stakeholder input be continued through program implementation? - Who needs to support for program success? - How to start/continue communication with key stakeholders, including legislature and Medicare?

From CHCS' perspective, the gold standard for integrated care programs is a broad program – one that targets a large population and percentage of the long-term care dollars, and one that focuses on coordinating services between Medicare and Medicaid. That said, each state has tailored its integrated care program differently to meet the unique needs and goals of its stakeholders.

The Department asked the workgroup members to submit written comments on the first four decision areas – populations covered, services covered, geography, and enrollment. We received

comments from 12 workgroup members. The comments are located in Attachment 3 and show that there is general consensus around two areas – the populations served and geographic area. Most felt that an integrated care program should serve as many of the elderly and disabled populations as possible and should be rolled-out across the entire state, in particular first to areas with the strongest provider networks. Most commentators believe also that an integrated program should be voluntary, not mandatory, or permit enrollees to opt-out.

The issue garnering the most disagreement among workgroup members concerns which services should fall under the management of an integrated care program. Some argue that the integrated care program should be responsible for managing all services for the individual. Others argue that mental health services, hospice services, and case management services should not be the responsibility of an integrated care program. For some, with regards to mental health services, only the specialty mental health services should be carved-out of the integrated care program's responsibility – not primary mental health services. A number of workgroup members are concerned that a service carve-out would lead to fewer services for individuals. Because a key tenet of any reform process is to design a program that best serves consumers with more – not fewer – services, the concept of a carve-out having the unintended consequence of reducing consumer welfare sparked significant debate. Those on both sides of the issue are approaching future discussions about any carve-outs approach with caution, and it seems the groups supporting and opposing the issue are far apart at this time.

Workgroup members also voiced concerns that certain geographic areas of the state lack strong community provider networks. The Department agrees with these concerns but recognizes that this will be a challenge facing any initiative aimed at serving more individuals in the community – it does not apply exclusively to integrated care programs.

Lastly, many of workgroup members are hesitant to move forward with an integrated program before understanding fully the new options available to states under the ACA.

- ***Implementing some of the new long-term care provisions in the Affordable Care Act (ACA).***

In an effort to better understand the new long-term provisions in the ACA, the Department invited Mary Sowers, the Director of the Division of Community and Institutional Services at the Centers for Medicare and Medicaid Services (CMS), to address our workgroup.

Ms. Sowers provided an overview of the new long-term care options. She recognized states are eager to receive federal regulations and guidance on these new provisions and assured us that everyone at CMS is working hard to roll this information out to states. CMS understands the uncertainties associated with a lack of federal guidance, although she was not able to provide an estimated timeframe for the new regulations and guidance. Three key provisions of interest for the workgroup are: the Community First Choice State Plan Option, the Rebalancing Incentives for States to Offer Home and Community-Based Services, and changes to the 1915i Option. Each are described below.

- *Community First Choice State Plan Option (effective date October 1, 2011)*

  The Community First Choice option creates a new means for providing home and community-based attendant services. It provides a 6 percentage point increase over a state's regular federal medical assistance percentage (FMAP) for attendant care services.

  CMS has not distributed regulations on the new provision. But the law details a number of new requirements for states that take up this option, including: (1) collaborate with a state-established Development and Implementation Council; (2) provide these services on a statewide basis and in the most integrated setting deemed appropriate to meet the needs of the individual; (3) maintain or exceed the preceding fiscal year's level of state Medicaid expenditures for individuals with disabilities or elderly individuals; and (4) establish and maintain a comprehensive, continuous quality assurance system.

  The law states also that services must be controlled, to the maximum extent possible, by the individual or representative – regardless of who may act as the employer of record. Also, the services must be provided by an individual who is qualified to provide such services, including family members.

- *Rebalancing Incentives for States to Offer Home and Community-Based Services (effective date October 1, 2011)*

  The Rebalancing option establishes a state balancing incentive payment program that allows states that currently spend less than 50 percent of their long-term care services on non-institutional care to receive additional federal matching funds for these benefits for federal fiscal years (FFY) 2012 through 2015. States would be required to meet certain target-spending percentages by the end of FFY 2015. For example, if the state's spending on home and community-based services in FFY 2009 is less than 25 percent, then its target spending percentage for home and community-based services would be 25 percent by October 1, 2015. For any other qualifying state, the target spending percentage would be 50 percent. States' FMAP would increase by five percentage points on "eligible medical assistance payments" for states meeting the 25 percent target; all other participating states' FMAP would be increased by two percentage points for eligible payments. Similar to the Community First Choice State Plan Option, CMS has not distributed federal regulations on the new provision. But the law details a number of new state requirements including the development of a "no wrong door – single entry point system" and the use of conflict-free case management services and core standardized assessment instruments. Although CMS has yet to issue regulations detailing what constitutes "the use of core standardized assessment instruments," CMS' representative advised that likely they will be more comprehensive than Maryland's current assessment tool used for nursing home services.

This option has the potential to be extremely helpful in rebalancing Maryland's long-term care system. The Department is urging CMS to not set the bar too high, however. Doing so risks preventing states from being able to implement this initiative. States are still grappling with tight budget issues and will be limited on the amount of money they can invest in the short-term. Regardless of the enhanced federal matching dollars, this option will require Maryland and other states to make investments. For instance, in FY 2009, Maryland spent 81 percent of its long-term care expenditures for seniors and individuals with disabilities on institutional care and only 19 percent on community-based services.[5] If Maryland were to achieve a 25 percent target for community-based services, it would need to spend roughly an additional $90 million (total funds) on community-based services. This spending would be partially offset by the enhanced federal matching rate but nevertheless would require a significant investment of State General Funds. We are encouraging the federal government to consider allowing states to achieve certain milestones rather than the absolute targets of 25 percent or 50 percent.

- *Changes to 1915(i) Option*

The ACA makes a number of changes to the authority granted under the 1915(i) of the Social Security Act. The 1915(i) option allows states to provide home- and community-based services to individuals who do not meet institutional level-of-care thresholds. The ACA made changes to allow states to cover individuals with incomes up to 300 percent of SSI, provide more community-based benefits, and target the provision of services to specific populations. At the same time, the ACA reduced the ability of states to pilot and limit enrollment – tools that would have helped states to implement this option during tough budget times. Individuals who qualify under this option would be entitled to all Medicaid state plan services, *e.g.*, hospital, physician services, as well as specified home- and community-based services. Entitling access to all Medicaid state plan services, however, may make it difficult for Maryland to provide this option to higher income individuals, *i.e.*, those with incomes between the Medicaid community-eligible level and 300 percent of SSI. Doing so would require that Maryland expand Medicaid services to a new eligibility group – those with higher incomes who do not meet institutional level of care. It is true that services provided to individuals who would otherwise have gone into a nursing home (thereby qualifying for Medicaid, anyway) would result in savings. And a key tenet of Maryland's reform efforts is to *prevent* nursing home placement. Most likely, though, there is little likelihood these individuals would have gone into a nursing and become Medicaid eligible, since those targeted under this option do not meet nursing level of care.

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[5] These numbers do not include long-term care expenditures spent on individuals with developmental disabilities. The Department is waiting for clarification from CMS on whether the expenditures for individuals with developmental disabilities are included in the target calculation. If they are, Maryland's targets would change significantly.

CONCLUSION AND RECOMMENDATIONS

Other states have successfully implemented integrated care programs. Workgroup members generally believe that such a program would work in Maryland as well. Maryland has significant experience with operating a managed care program for children, parents, and disabled individuals not on Medicare. Moreover, there are a number of managed care plans interested in operating a program focused on long-term supports and services in Maryland, but it would require additional resources in the short-term. Different management and infrastructure tools are required, and CHCS provided a preview of such changes.

Workgroup members expressed the need to have more discussions on the various options. But preliminary consensus among workgroup members is that a statewide, voluntary or an opt-out program for individuals with disabilities and seniors would work best. There is disagreement, however, concerning which services should fall outside the management of an integrated care organization. Appropriate quality standards also must be adopted.

The ACA establishes the Federal Coordinated Health Care Office (FCHCO). The FCHCO will work towards integrating benefits under Medicare and Medicaid and improving the coordination between the federal government and states. By doing so, it benefits those individuals eligible for Medicare and Medicaid services. The FCHCO will identify administrative, regulatory, and legislative policies to improve integrating care, and it will approve demonstrations aimed at improving integration of services. Maryland needs to position itself to take advantage of these changes when they become available. CHCS advised that any improvement in long-term care services and supports should include a robust system of assessment and determination of need.

The Department recognizes that workgroup members want to learn more about the ACA options, e.g., Community First Choice and Rebalancing Incentives, before moving forward with an integrated care program. The Department agrees and will work with the workgroup to further explore these options when more federal guidance becomes available. But the ACA options may not be the solution for better integrating Medicaid services with Medicare. The ACA provides states with additional incentives to provide more home- and community-based services.

In addition, the rebalancing provision in the ACA requires that states use core standardized assessment instruments to determine eligibility for non-institutionally-based long-term services and supports. Although CMS has yet to issue regulations detailing what constitutes "the use of core standardized assessment instruments," CMS' representative advised that likely they would have to be more comprehensive than Maryland's current assessment tool used for nursing home services. To better prepare, the Department should invest in assessment tools across its programs and settings of care. One option may be the interRAI assessment tools, although the benefits of better prioritizing and targeting limited community services to those who are at most risk for going into a nursing homes must be balanced against the costs of the assessment tools.

The ACA Community First Choice option requires states to allow family members to provide services. Maryland's current Medical Assistance Personal Care program is more restrictive. The program prohibits payments to spouses, parents, children, siblings, in-laws or individuals with a

step relationship. Knowing that this is an area of improvement, the Department recommends not waiting for federal guidance to begin allowing more family members to qualify for payments. The Department also recommends further analyzing the implications and costs associated with paying personal care providers on an hourly basis rather than on a per diem basis.

Furthermore, the Department is committed to developing a proposal for an integrated care program as well as evaluating the various ACA long-term care options. More time needs to be spent discussing these various design options for an integrated care program. Once these design options are discussed in greater detail, the Department will work with stakeholders to develop a work plan highlighting the timeframes, programmatic and fiscal impact, and resources required to implement a program. Because more time is need to fully examine these issues, workgroup members urged that the conclusions here be deemed interim until a final, more detailed analysis can occur.

APPENDIX 1

Workgroup List and Meeting Dates and Times

HB 113 Advisory Group List		
Representative	**Organization**	**Email**
Michele Douglas	Maryland Medicaid Advisory Committee and Alzheimer's Association	mdouglas@marylandadvocacy.com
Marie Ickrath	National Association of Social Workers	mickrath@mshsi.org
Nancy J. Bond	The Coordinating Center	nbond@coordinatingcenter.org
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Kelli Cummings	Maryland Department of Disabilities	kellic@mdod.state.md.us
Cathy Willis	Maryland Association of Area Agencies on Aging	cwillis@qac.org
Barbara Brookmeyer	Local Health Departments	bbrookmyer@fredco-md.net
Dave Ward	Maryland Disabilities Forum	cdavidward@aol.com

HB 113 Advisory Group List		
Representative	**Organization**	**Email**
Garret Falcone	Medical Home Model (Erickson)	garret.falcone@erickson.com
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James Chambers/Stefani O'Dea	Mental Hygiene Administration	jchambers@dhmh.state.md.us/sodea@dhmh.state.md.us
Carol Lienhard	Senior Citizen Action Network	carollienhard@earthlink.net
Nicholas Pannell	LAH consumer	mybernina@comcast.net
Naon Locast	OAW consumer	
Elizabeth Flury	The Johns Hopkins Health System	Eflury1@jhmi.edu

Meeting Dates and Times

- March 12, 2010 - Annapolis, House Office Building, Room 142, 12 noon to 2 pm
- April 21, 2010 - DHMH, 201 W. Preston, L-3, 1 pm to 3 pm
- May 25, 2010 - DHMH, 201 W. Preston, L-3, 1 pm to 3 pm
- June 22, 2010 -DHMH, 201 W. Preston, L-3, 1 pm to 3 pm
- July 20, 2010 - DHMH, 201 W. Preston, L-3, 1 pm to 3 pm
- September 8, 2010 – UMBC Tech Center, 2 pm and 4 pm
- September 20, 2010 - DHMH, 201 W. Preston, L-3, 1 pm to 3 pm
- October 20, 2010 - DHMH, 201 W. Preston, L-3, 1 pm to 3 pm
- November 17, 2010 – DHMH, 201 W. Preston, L-3 1:30 pm to 3:30 pm

APPENDIX 2

Summary of Workgroup Recommendations for Reforming LTC in Maryland

Here is a summary of the recommendations submitted to date. Please note that the document is a summary only and is not intended as an exhaustive dissertation of all comments.

Options
1. Integrated Care Program or Managed Care System *(Note: There are various options on how to implement an integrated care or managed care system, such as target population, covered benefits, enrollment options, etc. There are also different care management structures that can be used within a managed care system.)*
2. Leverage an interdisciplinary team model (similar to PACE)
3. Expand the number of individuals served under the current home-and community-based waivers
4. Provide community-based services to individuals who do not meet nursing home level of care (1915i waiver)
5. Redesign the state plan personal care program to provide better access to personal care services (includes maximizing the Community First Choice Option under PPACA)
6. Develop opportunities for individuals to self direct long-term care services, including hiring family members and controlling their own budgets
7. Enhance access to home health benefits
8. Expand on the hospice network model
9. Improve the housing options for seniors and individuals with disabilities. Potential options include: • Expand the Group Senior Assisted Living Subsidy amount and make it available regardless of the size of the assisted living establishment • Require all HUD Senior Housing buildings to participate in Congregate Housing Program • Funding for low-income continuing care at home • Merge funding streams, possibly including Medicaid and Medicare funds, to create "Type A" low-income CCRCs
10. Improve the long-term care workforce in Maryland (addressing both the number of caregivers and the quality of providers)
11. Improve our intervention methods, *e.g.*, better targeting services and providing services earlier. There should be a multidisciplinary assessment of care needs. One target population is individuals with Alzheimer's.
12. Increasing staffing for assessments and case management
13. Improve support for caregivers to prevent "caregiver burnout"
14. Streamline and modernize eligibility systems with the focus to improve the application processing time to find individuals Medicaid eligible. • Transfer nursing home eligibility functions from DHR to DHMH (policy and eligibility determination should be located under one agency)
15. Change eligibility rules for long-term care (do not have an asset test; only an income test)
16. Provide incentives for CLASS Act participation
17. Expand non-Medicaid covered services
18. Ensure that the Office of Health Care Quality has the tools and resources to monitor care provided in community-based settings; ensure individuals are safe in the community
19. Develop one long-term care resource database and allow all agencies and organizations to have access to database
20. Create a single, statewide, consumer-oriented point of entry (breakdown silos within Medicaid and among other senior programs)

Options
21. Provide options counseling for consumers prior to acute needs
22. Provide incentives for primary care providers to coordinate care and provide disincentives for non-primary care providers to stop performing services of a primary care provider
Additional Federal Funding Opportunities to Support Reform Efforts
23. Apply for additional federal funding under the Money Follows the Person Demonstration
24. Apply for a personal care state plan under Community First Choice Option
25. Provide more home-and community-based services through a higher matching rate from PPACA (state-balancing incentive payment). In order to qualify, states must reach certain spending targets and implement the following: • Establish a "single point of entry system" for individuals seeking access to all long-term services and supports • Through conflict-free case management services develop service plan and arrange for services and supports • Use of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports
26. Apply for the national pilot on payment bundling
27. Leverage other grant opportunities under PPACA

APPENDIX 3

Workgroup Comments on Integrated Programs

	Integrated Managed Care Key Decision Areas						
Stakeholder	**Populations Covered**	**Services Covered**	**Enrollment**	**Geography**	**Procurement Decisions**	**Rate Setting**	**Stakeholders Role**
Alzheimer's Association	Aged, blind and disabled category, including duals, NF residents, and spend down. No to DD served by DDA	Yes to all except limiting days of NFs, especially for individuals who choose this setting and for individuals for whom this is an appropriate placement based on medical condition and availability of necessary HCBS and family supports. Case management and behavioral health a must.	Automatic enrollment with opt-out	Statewide & rolling phase-in based on strength of provider networks in beginning phase while allowing for tailoring program as necessary based on initial phases	Open to whatever model provides best access and coordination of care If an MCO model is used, would expect a minimum of $.85 per dollar to be on care and independent care management provided	Would need to first determine minimum outcomes before addressing this	Suggest using model similar to the MAC specifically for LTC with some cross-over between groups. Will need support from the communities affected (individuals, advocates and providers to the greatest extent possible, knowing that not all will be in complete agreement) Am willing to help with brainstorming after key decisions and or consensus recommendations advanced – that will likely determine next steps
Amerigroup	We recommend that DHMH develop and submit to the Centers for Medicare and Medicaid Services a coordinated long-term care program for consideration that will serve individuals who are Medicaid eligible and meet one of the	We recommend Maryland's CLTC program include adult day health services, assisted living, adult family care and nursing home services. Further, the State should allow coordinated care	We recommend Maryland incorporate mandatory enrollment in its CLTC program. The pilot program must have mandatory enrollment to ensure that those who can benefit most from	We recommend the CLTC program is implemented statewide using a phased-in approach, selecting the most populous counties in which to initiate the program, resulting in more membership per plan, essential	Regardless of what the "entity" is today or ultimately called, a provider selected for participation in a CLTC program must, at a minimum, be a State-approved MCO and a federally approved Medicare-Advantage Plan to	We strongly support the development of program rates that are adjusted for risk. In addition, we encourage the State to maintain a transparent rate-setting	Our experience has taught us that a program rollout properly publicized and carefully coordinated with consumers, advocates/stakeholders and benchmarks for readiness along

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Amerigroup (continued)	following criteria: 1. Are 65 years of age or older 2. Dually eligible for Medicare and Medicaid 3. Meets nursing facility or chronic hospital level of care. CLTC is designed to make clinical and non-medical services available to seniors and people with disabilities in a home- or community-based setting while incorporating personal preference. A system of coordinated care can better address individuals with a history of multiple, chronic health needs. Based on our experience, a full integration of acute health care, LTC, and other supports and services as needed for all and Medicare services for dually eligible individuals is optimal. An integrated care model provides a single, one-stop, coordinated delivery system for all LTC services under both Medicaid and Medicare. An	organizations the flexibility to offer value-added benefits such as home modifications and telemonitoring. A comprehensive benefits package will allow coordinated care plans to better facilitate services and ensure adequate levels of service. We also recommend Maryland administer services for nursing home spend-down cases and long-term nursing home stays, as well as self-directed para-professional home care services. Other CLTC programs have successfully instituted a comprehensive benefits package that includes nursing facility services. Nursing homes are an important part of the LTC system for short-term stays, rehabilitation services and	coordinated care and services will enroll and to facilitate the maximum enrollment to produce cost savings and demonstrated program results. Mandatory enrollment promotes greater provider participation and allows for continuity of care during the transition from a FFS environment to a coordinated care model. While creating a mandatory program requires the additional step of obtaining federal approval of a waiver, it is more effective in achieving the program goals of streamlining care delivery and gaining cost savings. We also recommend that the State require enrollees to stay enrolled in the program for one year, similar to current HealthChoice recipients. However, a person should have the ability to	to accurately measure savings achieved and quality improvement of the program. Successful organizations understand the optimal way to care for and provide services to, a chronically ill population is to provide beneficiaries with the appropriate care and services in appropriate settings by appropriate providers. They recognize the most expensive care is the care that is ignored, delayed or not rendered at all. In order to maximize optimal member outcomes, states and their LTC partners make a significant up-front investment. The infrastructure necessary to deliver this care is expensive, but when costs are spread across a large population, it is much more attractive to coordinated care plans considered the best-in-class LTC providers, who have	ensure the delivery of fully integrated services. Although Maryland has chosen not to use the procurement process in the HealthChoice Program, if the State determines that a procurement process is preferred for the selection of coordinated care plans in the CLTC program, the State may wish to consider limiting the number of qualified organizations coordinating this program. Many states with successful LTC programs purposefully partner with a limited number of coordinated care plans. In New Mexico's LTC program, Coordination of Long Term Services (CoLTS), there are only two coordinated care plans. The Texas LTC program, STAR+PLUS, is administered by four coordinated care plans, with no more than three serving one service area. Tennessee has two coordinated LTC organizations for	process. With such an approach, all coordinated care plans can participate and discuss with the State the assumptions, population trends, and calculations for risk and contingency. Further, the coordinated care plans selected should have broad experience working with states and the complex needs of these populations and must understand the inherent risks of financing these services. For a pilot program's implementation, it is extremely important that contractors with extensive experience in both delivering and financing these services administer such a high-risk program.	the way is optimal and reduces start-up issues. It also increases opportunities for successful and seamless enrollment, on-going care, service coordination and member satisfaction. The State should involve stakeholders in decision-making and clearly communicate the transition process and program details to all affected providers and members as well as advocacy groups. Given that LTC providers and recipients are accustomed to receiving services under the FFS delivery model, they will need to be educated on a new coordinated care program to assure their understanding and its success.

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Stakeholder	**Populations Covered**	**Services Covered**	**Enrollment**	**Geography**	**Procurement Decisions**	**Rate Setting**	**Stakeholders Role**
Amerigroup (continued)	integrated model permits plans and providers to place a greater focus on care management and coordination of Medicare and Medicaid benefits and services, while expanding access to and options for services. The integration between Medicare and Medicaid funding aligns incentives to ensure the coordinated care model can deliver services across the full spectrum of needs most efficiently. Further, uniting the services under one program gives beneficiaries a one-stop shopping approach for all of their needs and facilitates care coordination holistically.	members who have complex needs that cannot safely be provided for at home, as well as people who might express a preference to live in a nursing home. The Family Care programs provide wellness and prevention services and supports to reduce the need for nursing home stays or reduce the amount of days per stay. Care coordination as well as person-centered case coordination is a key component to a successful, fully integrated CLTC program. As coordinated care organizations are considered to administer the Maryland LTSS program and provide similar services, the State will see correspondingly positive results.	opt out in accordance to the provisions currently available through HealthChoice. This recommendation provides for several benefits to members and providers: • Creates better opportunity to coordinate care • Provides for stronger provider-member relationships • Improves opportunity for continuity of care and services • Provides volume to support the development of HCBS • Results in a higher level of enrollment and increases the level of savings in a shorter period of time • Ensures that those who can benefit most from coordinated care and services will enroll.	expressed preferences to have maximum participation. Best-in-class LTC providers incur significant up-front expenses that are fixed costs, such as information technology platforms, claim centers, call centers and quality tools. A best-in-class LTC provider will suggest an optimal minimum population size is 5,000 members, or more. This would not preclude the State from considering gradual enrollment based on aid category or other factors in addition to geography to improve the transition of the program from FFS to CLTC.	each of its three regions. The benefits of setting programs up this way are to: • Lower administrative costs for the State (fewer payers for the State to manage) • Allow for cooperative exchange of information between payers and the State and the beneficiary and provider stakeholders • Minimize confusion among members and providers; comparison and choice are more easily made for members, and providers are not asked to contract with numerous payers • Increase quality both from an oversight perspective (small group to monitor) and also from a delivery perspective; few		

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Amerigroup (continued)					companies have the infrastructure, experience and know-how to deliver best-in-class LTC service coordination. It is important that the State identify and work with highly qualified plans with incentives aligned with the program goals • Attract the highest quality coordinated care plans with extensive experience, providing appropriate care for the chronically ill population.		
The Coordinating Center	Include all aged and disabled, by choice, allowing individuals to choose between LTC and waivers. ("Silos" are avoided if programs are appropriately administered) Include those with a nursing home level of care who are in "spend down". Include those with intensive needs (ventilator, etc.), comparing costs of	All HCBC with self direction Not limited to NF cost comparison for certain populations; rather compare with their actual cost in the NF (allows those with most intensive needs to access home care services) Housing support with care coordination Funding of	Voluntary	Pilots based on strength of provider networks other considerations	Consideration in procurement should be made in favor of accredited programs that demonstrate proficiency in evidence based practice as well as historical providers. Favorable consideration should also be extended to those that can demonstrate person centered planning and flexibility in service provision.	Reward health plans who demonstrate improved health outcomes as well as preventing and avoiding NF placements. Also reward those that work to decrease those currently residing in NFs especially those that have been there for an extended period of time (over 6	Ongoing meetings that include provision of data on performance measures of providers.

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The Coordinating Center (continued)	them individually with HCBS.	transition services Community based Occupational Therapy services beyond currently allowed assessment. Medication support in the community				mos.).	
Hopkins PACE Program*	Need a large population to spread the risk. Include aged, blind, disabled, duals. Do not limit to nursing home eligible. The goal is to provide services early enough to prevent or delay nursing home admission. Admission criteria should exclude individuals who are already in the nursing home and planning to remain there. When an individual in the program requires nursing home care, the individual should remain in the program long enough to have a financial impact on the program, i.e. long enough to matter to the program. PACE serves as such a model and ideally would remain and even be expanded for more	Include all Medicaid LTC services and supports currently in the state plan and in waiver programs (adult day care, assisted living, transportation, etc.) Limits on nursing facility covered: Repeat from above – When an individual in the program requires nursing home care, the individual should remain in the program long enough to have a financial impact on the program, i.e. long enough to matter to the program. Otherwise there is no incentive to delay or avoid nursing home admission. Case	Mandatory for individuals on Medicaid. Need a large pool to cover the risk. Auto enrollment with opt out is compromise option.	Recommend pilot program in limited geographic area; it is best to work out the issues with a smaller group before going statewide.	Best to coordinate with Medicare to provide integrated benefits.	Health plans will be motivated to increase community settings of care if they are on the "hook" for nursing home care for a "long enough" period of time. Otherwise there is no incentive to delay or avoid nursing home admission. Use rate-setting to reward and/or penalize plans AFTER there is more data and experience with the program. When setting rates, the state needs to take into consideration the market rates for medical adult day care, assisted living, etc. Payment to health plans must be sufficient for plans to utilize HCBS and to	Regularly scheduled meetings (quarterly) and communication between the health plans and the state are a must. The state must be open to the experience of the plans. (This sounds obvious, but it should be emphasized.) Require a DHMH report to the state legislature annually with a full report of progress, challenges, lessons learned after Year 3 or 4.

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Hopkins PACE Program (continued)	severely impaired such as those who have lost significant ADL function.	management/care management services are a must. Behavioral health services are a must. Individuals must have access to behavioral health specialists. This cost should be considered in rate-setting. Acute care services are a must. Overall comment about services covered: Any integrated/managed care program must include a care model that is person-centered, not just a financing system.				ensure that adult day care, assisted living providers, etc are sufficiently reimbursed to "stay in the game."	
Jamey George	It should apply to all people with disabilities of any age group who are at risk of nursing home placement or in nursing facilities. Services should be increased to be included in the hospital discharge plan or for individuals who reside in assisted living facilities so people can live in the least restrictive environment.	There should be several options available to allow consumers to choose when, how, and what their services should be. Consumer or self-directed services should be the basis to allow for services in the most integrated setting.	Voluntary. If it is mandatory, there should be available choices to encourage self directed services and nothing less.	Statewide	State procurement laws will suffice. Currently, bidders submit proposals and a contract is offered to the best and most qualified vendor. However, the procurement laws should be modified to include start up costs from the beginning rather than wait a month.	Rates should be set to encourage an increase in qualified care workers and to maintain a long list of available qualified and trained care workers. Care providers should also have good benefits. There should be options to allow consumers to	Continue stakeholder input on an ongoing basis. The stakeholders are the ones who truly understand the community and what will work in that community. There should be ongoing meetings with a consensus among the stakeholders.

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Jamey George (continued)	Currently, HCBS services are directed to nursing home residents. There is a need for services that will prevent nursing home placement and services that will allow transitions from assisted living facilities.					train their care workers.	
Jason Frank	All aged and disabled in all settings, to include 1915(i) State Plan Amendments for those who do not meet Nursing Facility Services Level of Care.	All possible services with self-direction as key. Primary emphasis on Medical Assistance funded Home and Community Based Services to ***prevent*** institutionalization to include current state only funded programs in MDOA and DHR.	Voluntary, if at all, if ever.	All services available to all Statewide.	All procurement should be per State law to the lowest responsive responsible bidder.	Pay them more if nursing home residence is prevented/avoided.	1) Ongoing committee meetings 2) Consensus among stakeholders Talk face to face.
Johns Hopkins Health System*	Need a large population to spread the risk. Include aged, blind, disabled, duals. Do not limit to nursing home eligible. The goal is to provide services early enough to prevent or delay nursing home admission. Admission criteria should exclude individuals who are already in the nursing home and planning to remain there.	Include all Medicaid LTC services and supports currently in the state plan and in waiver programs (adult day care, assisted living, transportation, etc.) Limits on nursing facility covered: Repeat from above – When an individual in the program requires nursing home care, the	Mandatory for individuals on Medicaid. Need a large pool to cover the risk. Auto enrollment with opt out is compromise option.	Recommend pilot program in limited geographic area; it is best to work out the issues with a smaller group before going statewide.	Best to coordinate with Medicare to provide integrated benefits.	Health plans will be motivated to increase community settings of care if they are on the "hook" for nursing home care for a "long enough" period of time. Otherwise there is no incentive to delay or avoid nursing home admission. Use rate-setting to reward and/or penalize plans AFTER there is	Regularly scheduled meetings (quarterly) and communication between the health plans and the state are a must. The state must be open to the experience of the plans. (This sounds obvious, but it should be emphasized.) Require a DHMH report to the state legislature annually with a full

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Johns Hopkins Health System (continued)	When an individual in the program requires nursing home care, the individual should remain in the program long enough to have a financial impact on the program, i.e. long enough to matter to the program. Exclude PACE.	individual should remain in the program long enough to have a financial impact on the program, i.e. long enough to matter to the program. Otherwise there is no incentive to delay or avoid nursing home admission. Case management/care management services are a must. Behavioral health services are a must. Individuals must have access to behavioral health specialists. This cost should be considered in rate-setting. Acute care services are a must. Overall comment about services covered: Any integrated/managed care program must include a care model that is person-centered, not just a financing system.				more data and experience with the program. When setting rates, the state needs to take into consideration the market rates for medical adult day care, assisted living, etc. Payment to health plans must be sufficient for plans to utilize HCBS and to ensure that adult day care, assisted living providers, etc are sufficiently reimbursed to "stay in the game."	report of progress, challenges, lessons learned after Year 3.

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Maryland Physicians Care	Include all Medicaid eligible enrollees meeting certain criteria such as; the dually eligible (Medicare and Medicaid), persons meeting nursing home level of care or chronic level of care in a facility and all aid categories. In addition recipients who are already in a nursing home but desire to be and meet criteria to be in a Home and Community Based Setting.	Acute care for non Medicare services should be included along with Case Management, care coordination, adult day care, nursing home services, assisted living services and hospice care. All services should be integrated without any carve out of services. A true integrated model does not require a recipient or their family members the need to coordinate with other agencies for the purpose of receiving covered services. Fragmentation of services is not in the best interest of the recipient or their family members.	Mandatory, if an opt out option is in place the option should be based on specific criteria similar to HealthChoice. Would recommend a lock in of 12 months to ensure recipients and family members allow for an appropriate time to use the system. This provides for a stronger continuity of care improved established relationships with providers and the opportunity to improve overall quality of care.	Statewide with a phase in plan over an extended period of time dependent on resource adequacy. Geographic area must be large enough to ensure a reasonable risk pool, population large enough to measure the success of the program both from a quality and cost perspective.	Do not recommend a SNP. The SNP authorization is only approved through 2013, very risky to use. The lead time to obtain a contract with CMS can be almost 2 years, MD has limited SNPs or Medicare Advantage options none on a statewide basis. Risky with the threat of decreased payments to Medicare advantage and SNP plans. What MD does have may exit as a result of financial viability. As the new office of the "duals" comes up with other models, state will have flexibility if have not committed to the SNP model. -Recommend MCO for LTCS. Should be all inclusive. Benefits should not be carved out to ensure a comprehensive case management program within the responsibility of a single organization. This is less costly to the State to manage and oversee and provides better coordination of services to recipients.	Not sure that rate setting should be tied to the development of HCBS. Health Plans can assist in the planning and coordinating of this but not sure it should be the financial vehicle. Outcomes should not only be medical but actually tied to reduction in placements in NH. Should establish a Value Based Purchasing program similar to what is established in Healthchoice all tied to improved quality of care. Not sure this is a part of the rate setting system rather a reward system for providing good quality and providing appropriate access to HCBS. Strongly encourage a transparent risk adjusted rate setting system similar to the current process for Healthchoice and the Primary	Would recommend a MLTC Advisory Committee very similar to the Medicaid Advisory Committee currently in existence. This committee includes all key stakeholders such as; consumers, providers, legislators, advocates, MCOs, DHMH

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Maryland Physicians Care (continued)					The result is improved quality, better system to navigate through for family members and recipient. A recipient should not have to be handed off to other organizations for carved out services. Single point of contact is very important for recipient satisfaction.	adult Care program.	
UnitedHealth Group	Generally speaking, we believe that the program should include the broadest set of beneficiaries as possible and believe that exception should be made only in the case of specialty care such as DD, TBI, etc. These populations may be included on a voluntary basis or phased in, but tend to be more complicated from our experience in initial implementation. We also firmly believe that nursing home residents must be included in a full risk model – which we think is the most effective – to ensure appropriate incentives and allow for a more meaningful rate design.	Similar to the comments above, we believe that the broadest set of benefits allows for the most effective program design. Excluding any set of benefits leads to fragmentation and can increase the likelihood that benefit shifting and duplication can occur. Model design should ensure a seamless approach to benefits to encourage a holistic approach to individual management. Care management can, therefore, provide a single navigator/care manager to each beneficiary who can easily identify needs and can	At a minimum, auto-in/opt-out should be deployed with the optimum model being mandatory. Voluntary enrollment has proven to be highly ineffective and can lead to poor participation by plans/partners and adverse member selection.	Pilots can be politically attractive, but if DHMH moves in a pilot direction, the geography must be significant and allow for sizeable population inclusion so as to demonstrate positive results. Our recommendation would be a phase-in to statewide approach with specific quality and performance targets before additional geographies are added. This allows for clear understanding of scale for possible plans/partners as well as alleviates any concerns as previously existed regarding targeting a single geography	Given the voluntary nature of Medicare enrollment – unless DHMH can get approval from CMS to passively enroll in a Medicare plan (SNP) – full integration is difficult. We would encourage DHMH to develop a model that encourages side-by-side, but does not mandate it. Procurement may be structured to give additional weighting to plans that offer a Medicare option or may require phasing in of Medicare to allow for mis-aligned timeframes of Medicare filing and Medicare expansion. Given the rural nature of certain parts of the state, though, mandating statewide side-by-	Rate setting can absolutely be utilized to both increase community placement as well as increase quality in other areas. We believe the most effective model to achieve both the shift from nursing homes as well as improved quality overall is a blended rate with an incentive corridor similar to ALTCS. By blending a rate, there is an automatic incentive for plans to seek community placement as often as possible and a disincentive to utilize nursing	We believe the most effective programs have stakeholder involvement on a continuous basis. This may include stakeholder councils facilitated by DHMH throughout planning and implementation, but we believe stakeholder engagement should be a consideration in procurement. Plans should be encouraged through some procurement mechanism to demonstrate a willingness and track record of stakeholder engagement. Given historic

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UnitedHealth Group (continued)		align appropriate benefits and services without limitation. In the case of dual eligibles, given the states' liabilities are largely limited to non-acute benefits, DHMH may consider incentives around benefit design to encourage individual enrollment into a Medicare program. Additionally, given the push at CMS for integration, we encourage the state to consider options of approaching CMS to share in savings achieved through comprehensive care management from appropriate CMS discretionary funds.		over another. In addition, phase in allows for development of networks and building of access to non-traditional and traditional services in areas that may be currently lacking.	side participation may be difficult as plans are not likely to universally want to participate in all counties in Maryland and therefore, DHMH may limit participation of plans that might otherwise be strong Medicaid partners. Another option for DHMH to consider is to leverage its existing Medicaid contractors to alleviate duplicative administrative oversight for the two programs. This might include a strong preference to existing relationships in procurement structure.	homes unnecessarily. In addition to the blended rate, an incentive corridor can be structured to ensure appropriate utilization and improved quality. If structured appropriately, the corridor can also decrease concerns about health plans underutilizing benefits as well.	reluctance in Maryland, early communication regarding the benefits of the program should be made very public. This will limit negative perceptions and win early support from a broad range of stakeholders – including legislators, providers, advocates, etc. Given the focus on integration and the current CMS leadership, Maryland should be well positioned to both receive guidance, but also approval for a well designed program with the focus on improved care for individuals while ensuring the sustainability of the LTC program.

* Other points:

1. Repeat comment: Need to develop a person-centered care model, not just a payment system.
2. The state needs to develop robust information systems for payment, quality monitoring, outcomes, participant satisfaction, plan evaluation, etc. There must be a robust program evaluation after Year 3.
3. Consider any/all options for capturing individual clinical information to ensure integrated care and to facilitate program evaluation.

Lori Doyle
Director of Public Policy
Baltimore Behavioral Health Association of Maryland

The Community Behavioral Health Association of Maryland wishes only to weigh in at this time on the issue of mental health services. Per HB 113, the legislation that created the long-term care workgroup, mental health services are to be carved out of any at-risk managed care system for the long-term care population, similar to the way the carve-out operates for HealthChoice. The public mental health system has a long, successful history of serving individuals who are part of the long-term care population, including dual eligibles. We look forward to working with the Department to ensure continued accessible and effective mental health services for the long-term care population, regardless of whether the state decides to go with at-risk managed care or another option.

Margaret Hadley, Clinical Representative
Christine Crabbs, Executive Director
Hospice and Palliative Care Network of Maryland

The Hospice and Palliative Care Network of Maryland (the Network) represents nearly all hospice care providers in the State of Maryland. The Network appreciates the efforts of the Committee and remains strongly supportive of the effort to promote home- and community-based care as an alternative to institutional care. We consider the Network to be in support of the goals of the Committee regarding the feasibility of creating a coordinated care program to reform the provision of long–term care services under the Medical Assistance program in a manner that improves and integrates the care of individuals, including health care services, designed to meet the differing needs of seniors and adults.

We reflect on the purpose of the program as identified in the legislation which directed the committee and study:

> *(1) deliver high–quality long–term care supports and services in a coordinated and integrated manner;*
> *(2) deliver long–term care supports and services in the most appropriate care setting to meet the needs and preferences of eligible individuals;*
> *(3) remove systemic and individual barriers to receiving care in home– and community–based settings, as preferred by the individual; and*
> *(4) ensure that, if the State plans to manage long–term care through at–risk contracts, the carve–out of mental health services and hospice services are implemented as required by Chapter 4 of the Acts of the General Assembly of the 2004 Special Session.*

To that end, we make the following statement for the permanent record and the final report:

Hospice provides care within a framework that exemplifies the Long Term Care goals and objectives outlined in SB 761 and HB 113; Hospice can improve resources available in the community and serve people in the most integrated setting; the majority of Hospice Care is provided in the patient's home; hospice care can also be delivered in any setting that the patient

calls home: long term care facility, CCRC, group home or assisted living facility; and hospice services are available anywhere the patient resides.

The Hospice Interdisciplinary team delivers the care with an holistic approach. Consistently, hospice care has been rated high on customer satisfaction surveys. Hospices have also been on the forefront of providing high quality symptom management in a culturally sensitive format.

Hospice includes an infrastructure which serves to coordinate and integrate individual's care among payers, including Medicare. The Hospice *Interdisciplinary Team* coordinates and integrates various providers internally and externally. For example, patients in nursing homes using Medicaid room and board may also be using their Medicare Hospice benefit.

Hospice works with the patient to provide consumers choice and allows the patient to direct their own care to the greatest extent possible. Hospice care is consumer directed and medically provided. Patients and family caregivers are actively involved in developing and implementing a plan of care.

- The Hospice system is financially sustainable and it aligns incentives across the system.
- The mechanism of payment to Hospices, although not perfect, has contained costs. It gives providers the incentive to manage a fixed amount of money per day, thereby restraining the use of unnecessary services across the system.
- Patients can move between care setting and different levels of care without disruption in services.
- The interdisciplinary team consisting of doctors, nurses, social workers, and other disciplines meet together on a regular basis to manage the plan of care.
- Services, supplies and medication are provided and monitored.
- Outcomes are assessed and changes to the plan or care are made if outcomes are not achieved.
- The interdisciplinary team in mandated.
- Resources are contained and prioritized.
- Providers would be paid an all-inclusive per diem rate for the services required for each patient.
- Providers are "at risk" for providing services within the constraints of a set reimbursement rate and are responsible for prioritizing and managing costs.

The Goal of the Hospice model is to provide high quality end of life support and services in a coordinated and integrated manner; across care settings to meet the needs and preferences of the patient; and remove systemic and individual barriers to receiving care in home and community – based settings. The model has been used since 1986 and it has stood the test of time. Hospice manages patients through multiple levels of care using an interdisciplinary medical team to coordinate those levels. The model is designed to manage costs across various levels of care as well as across different settings. The model minimizes unnecessary hospital admissions. Hospice care is patient/family centered having both high customer satisfaction and high quality outcomes.

We have learned many lessons from the Hospice Model and believe that it can serve as a model for managing patients with long term care needs. The Hospice model could be replicated by various home-based providers already licensed in the state including, Home Health Agencies and Residential Service Agencies. This model has the potential of creating incentives for care in

the community at a cost less than those found in more expensive settings or other managed care models.

To summarize,

(1) The current and existing hospice model already manages care to achieve the goals set out in the aforementioned introduction, so there is no need to incorporate hospice into another managed model. Any introduction of another model could jeopardize the finely tuned and sophisticated model that has worked well in Maryland and throughout the country. Hospice is already a Managed Care program.

(2) The hospice model could be replicated throughout the state using community based providers to provide long term services and supports in the communities they already serve.

We welcome any opportunity to find ways that any new model for long-term care delivery will honor and integrate the existing current hospice model so that we can achieve greater access to hospice care for all of our citizens in need.

Maryland Association of Community Health Officers

1. Voluntary Enrollment
2. Consumer choice/consumer advocacy
3. Case management component
4. Not instituted until a strong provider network established
5. Managed Care Organizations (due to financial interests) should not also be " gate keepers" of services.
6. Independent agency for assessment, care planning, outcome evaluation.
7. Local Health Departments continued involvement in any plan that evolves.