



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

JAN 13 2009

The Honorable Martin O'Malley
Governor
State of Maryland
Annapolis, MD 21401-1991

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

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

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

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

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

If you have any questions or need more information, please do not hesitate to contact Anne Hubbard, Director of Governmental Affairs at (410) 767-6481.

Sincerely,



John M. Colmers
Secretary

Enclosure

cc: Secretary Gloria Lawlah
Secretary Catherine Raggio
John Folkemer
Mark A. Leeds
Anne Hubbard
Sarah Albert, MSAR# 2522

Money Follows the Individual Accountability Act Report December 2008

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

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

This report is intended to satisfy these reporting requirements.

BACKGROUND

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

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

- Peer to peer outreach services;
- Outreach worker training;
- Continuing education courses targeted to social workers and discharge planners about Medicaid home and community-based services;
- Development of a *Moving To Community* resource guide;
- Distribution of community options fact sheets to nursing facility residents, social workers, and administrators; and
- Development and distribution of a booklet which describes Maryland Medicaid Home and Community-Based Long Term Care Services.

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

Living at Home Waiver in December 2002 and the Older Adults waiver in May 2003 closed to applicants from the community. Since that time, enrollment of applicants from the community has been limited.

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

EFFORTS TO PROMOTE HOME AND COMMUNITY-BASED SERVICES

This section presents some of the Department’s most recent efforts to promote home and community-based services.

Linking Consumers With Community Supports

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

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

Information on Medicaid’s community-based services. DHMH continues to offer a booklet that describes all of the long term care community-based services that are available through the Medicaid program. The booklet is designed to provide basic information for health care professionals, consumers, and families to assist them in making decisions about long term care services. The Department will continue to produce this popular resource on an annual basis. The information is also available online. (http://dhmh.state.md.us/mma/pdf/resourcebooklet_2007.pdf)

Enrolling individuals from the Waiver Services Registry. Since the Living at Home and Older Adults waivers initially closed to community applicants, DHMH has maintained the Waiver Services Registry. The Registry is a central clearinghouse that collects contact

information on individuals interested in receiving waiver services. Throughout 2008, DHMH enrolled individuals from the Registry into the Waiver for Older Adults on a first come, first served basis to fill openings created by individuals who leave the program.

Money Follows the Person Demonstration. The Centers for Medicare and Medicaid Services (CMS) awarded Maryland a demonstration grant to improve the transition process and increase the number of transitions to the community. The Department received formal approval of the State's Money Follows the Person (MFP) Operational Protocol on March 6, 2008 with an effective date of February 6, 2008. The goal of the MFP demonstration is to offer additional resources to individuals in nursing facilities by increasing outreach efforts and decreasing barriers to transition. New services under MFP include peer mentoring, enhanced transition assistance, housing assistance, flexible transition funds, and the addition of waiver services to existing waivers. In order to be eligible for MFP, a person must have resided in an institution¹ for at least 6 months, have at least one month of Medical Assistance eligibility prior to transition, and move into a qualified community residence.²

The first MFP participant moved to a community residence on March 18, 2008. Since then, 99 individuals have transitioned to the community from nursing facilities, 31 individuals have moved from State Residential Centers, primarily Rosewood, and two (2) individuals have moved from chronic hospitals, through the end of November 2008.

After receiving approval from CMS in March, the Department has worked to implement the plans outlined in the approved Operational Protocol. The MFP Grant brought with it significant reporting requirements that required changes to the MMIS system, modifications to several Medicaid waiver tracking systems, and the development of an MFP web-based tracking system. The Department has added services to the Living at Home and Older Adults waivers in order to improve the package of services available to those transitioning out of nursing facilities.

Several other efforts for nursing facility residents will be implemented in 2009, including peer outreach, program education, enhanced transitional case management, and housing assistance. The Department is currently reviewing proposals for a peer outreach contractor who will begin providing information about the demonstration and available home and community-based service options to nursing facility residents, their families, and facility staff by February 2009. Enhanced transitional case managers will begin providing program education, application assistance, and housing assistance in late spring of 2009. These enhanced transitional services will provide support to nursing facility residents in understanding their options, completing waiver applications, navigating

¹ Qualifying institutions include nursing facilities, State Residential Centers (ICF/MRs), State Psychiatric Hospitals (IMDs), and chronic hospitals.

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

community resources, identifying affordable and accessible housing options, applying for housing subsidies, and successfully moving from the facility to a community residence.

Maryland Access Point (MAP). Funded under a federal Aging and Disability Resource Center grant, the program has developed specifications for proposals for a web-based information system that will provide an extensive resource database with a user-friendly search capability, consumer needs assessment and personal folder, secure data sharing among agencies, and e-form capability, among other functions. In addition, the project is developing both virtual and actual single-points-of-entry for people seeking long-term care information, supports, and services. MAP sites are in operation in Howard, Worcester, Anne Arundel and Washington counties. Sites in Baltimore City and Prince George's county have been approved but are not yet in operation.

Quality Improvement Efforts

The State is moving toward a more comprehensive quality management system across all home and community-based service programs using the CMS Quality Improvement Strategy. This effort is designed to develop 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 evidence-based quality management system, (b) improve the ability of the Department and other 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 quality indicators, (f) improve infrastructure to collect and distribute the data, and (g) create more comprehensive and standardized quality reports in an effort to improve program performance as well as overall operations.

To that end, the Department has established a Waiver Quality Council consisting of representatives from each waiver administering agency, the Office of Health Care Quality, and Medicaid, who continually work towards these goals. Currently, subgroups of the Waiver Quality Council have been working on addressing issues regarding the reporting system for complaints incidents.

Quality Care Review Team. The Department has a Quality Care Review (QCR) Team which is responsible for monitoring the various waiver programs. The QCR Team does on-site visits and interviews to determine if the participant is receiving appropriate care and services based on assessed needs and as specified in the plan of care. The team conducts participant interviews to evaluate satisfaction and identify other issues with the services they are receiving. The QCR review includes: a participant record review, a participant in-person interview in their home (or assisted living facility), and completion of a participant survey.

Referrals are made to appropriate agencies when significant problems are identified by the team. Additionally, the team generates review reports that may require a provider to submit a corrective and preventive action plan. Providers and vendors must submit

acceptable plans which are reviewed by Department staff. The reports are also used to monitor case managers and provide on-going guidance, training, and technical assistance.

New Initiatives

New Medical Eligibility Standard. On July 1, 2008, the Department changed its nursing facility level of care criteria to allow nursing facility, medical day care, and waiver services to be covered for a broader range of individuals who have cognitive, functional, and behavioral needs.

Medical Day Care Services Waiver. The Department implemented the Medical Day Care Services Waiver on July 1, 2008. The program provides medical day care services to individuals in the community and has the capacity to serve 1,000 more individuals than had been receiving services under the previous State Plan program. Since medical day care is no longer a State Plan option, the Department also added it as a waiver service to the Living at Home, Older Adults, and other waiver programs so that all individuals in these waivers could access medical day care.

Collaboration With Other State Agencies

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

The Department currently serves on various committees and workgroups including:

- Maryland Commission on Disabilities;
- Coordinating Committee for Human Services Transportation;
- Maryland Access Point (Aging and Disability Resource Center);
- Home and Community-Based Services Waiver advisory committees (Traumatic Brain Injury, Older Adults, and Living at Home);
- Money Follows the Person Demonstration stakeholder advisory group;
- Employed Individuals with Disabilities; and
- Inter-Agency Committee on Aging Services

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

The Minimum Data Set is a federal assessment for all nursing facility residents. The MDS assessments conducted at admission and annually ask whether or not the resident has expressed a preference to return to the community. A resident is defined as any person staying within the nursing facility, regardless of their expected duration of stay or if they maintain another official residence elsewhere. To determine the number of

individuals expressing a preference to return to the community, the Department analyzed the records for residents who were in nursing facilities at the end of March 2008.³

The Department's analysis indicates that 6,045 out of 24,145 total (25%) residents expressed a preference to return to the community. The numbers differ markedly when grouped by Medicare payer status. Medicare-covered stays are typically short term and associated with an acute hospital stay. Non-Medicare-covered stays can be more commonly defined as long-term care. Medicaid covered residents are also significantly less likely to express a desire to leave a nursing facility when compared to non-Medicaid residents during similar types of stays. Among the Medicaid-covered long-term care recipients, 13% indicated a preference to return to the community.

Respondents expressing a preference to return to the community (2008)			
<u>Resident Type</u>	<u>Type of Stay</u>		Total
	Medicare covered (Post-acute)	Other Long-Term Care	
Medicaid	35% (341 / 963)	13% (1,975 / 15,048)	14% (2,316 / 16,011)
Non-Medicaid	82% (2,612 / 3,193)	23% (1,117 / 4,941)	46% (3,729 / 8,134)
Total	71% (2,953 / 4,156)	15% (3,092 / 19,989)	25% (6,045 / 24,145)

**MDS survey results
March, 2008**

From 2000 to 2008, the proportion of respondents who express a preference to return to the community has generally increased.

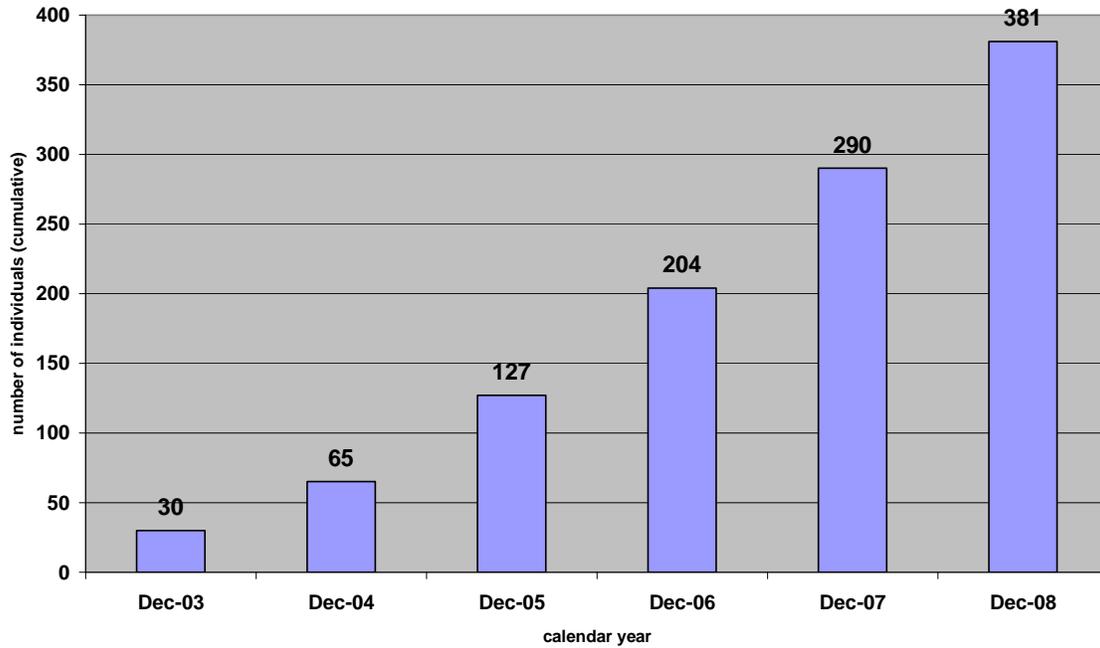
Respondents expressing a preference to return to the community (2000-2008)									
<u>Resident Type</u>	2000	2001	2002	2003	2004	2005	2006	2007	2008
Medicare covered (Post Acute Care)									
Medicaid	33%	34%	38%	38%	44%	41%	42%	41%	35%
Non-Medicaid	72%	72%	75%	75%	77%	76%	80%	80%	82%
<i>Total</i>	61%	63%	66%	66%	68%	68%	70%	70%	71%
Other Long-Term Care									
Medicaid	10%	10%	11%	12%	13%	13%	13%	14%	13%
Private Pay	19%	19%	20%	20%	19%	20%	21%	22%	23%
<i>Total</i>	13%	13%	14%	14%	14%	15%	15%	16%	15%

³ Our approach largely replicates the approach that CMS uses for public reporting of these results on their website, using MDS assessments for currently active residents but looking back to the last assessment with a response for MDS question Q1a (even if that assessment was well before the first quarter of CY 2008).

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

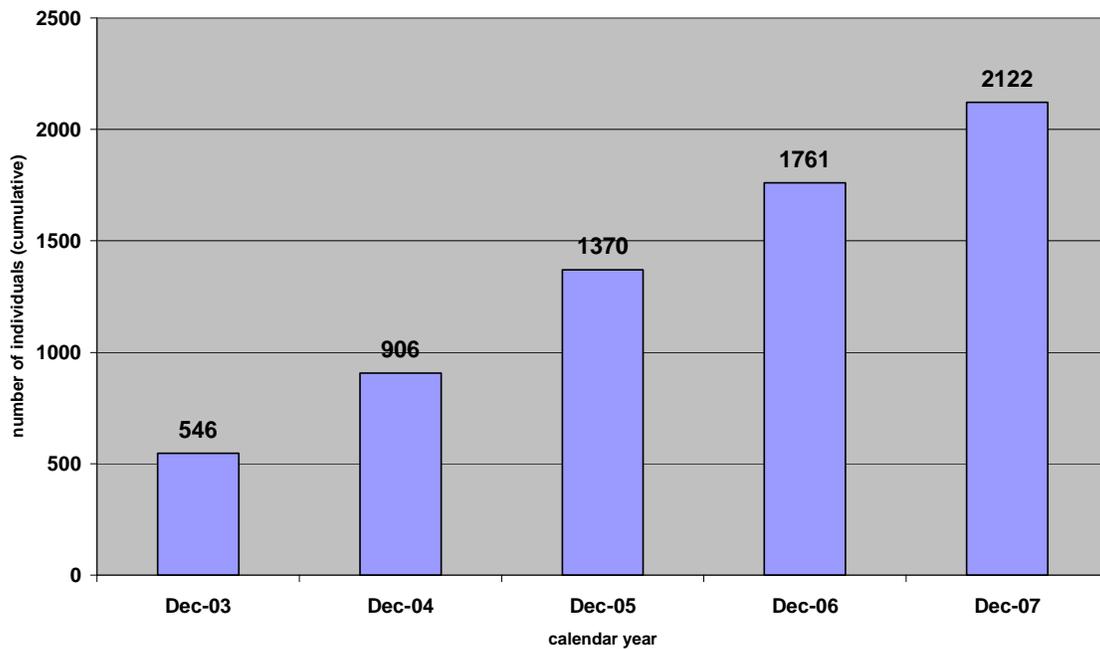
Since the Living at Home Waiver closed to community applicants in December 2002, 381 individuals have transitioned from nursing facilities to the community through the waiver. See Figure 1 below.

Figure1. Number of Individuals Who Transitioned from Nursing Facilities to the Living at Home Waiver (2003-2008)



Since the Waiver for Older Adults closed to community applicants in May 2003, 2,122 individuals have transitioned from nursing facilities to the community through the waiver. See Figure 2 below.

Figure 2. Number of Individuals Who Transitioned from Nursing Facilities to the Older Adults Waiver (2003-2007)



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

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

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

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

Information and communication. Many health care professionals do not fully appreciate the range of services and supports that are available to help people with disabilities living in the community. It is often reported anecdotally that nursing facility employees do not

think any of their residents can move into the community. Likewise, many consumers and family members are unaware of the full range of community options.

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

Housing. The Money Follows the Person Demonstration will provide housing assistance to nursing facility residents who seek independent housing through enhanced transitional case management services. Nursing facility residents will receive assistance in identifying affordable and accessible housing options in their local communities, completing applications for housing subsidies and housing opportunities, and in overcoming barriers to obtaining community housing. Living at Home Waiver recipients currently receive some assistance in accessing housing resources through waiver case managers.

Transportation. The Department developed a comprehensive list of transportation options available to Medical Assistance enrollees for Medicaid-covered healthcare services. The list includes Medicaid transportation information including contact phone numbers, how to schedule transportation, and how to report complaints. It includes non-Medical Assistance transportation information in local areas as well. The Department will continue to collaborate with the Maryland Department of Transportation and other agencies that fund human services transportation through participation on the Maryland Coordinating Committee for Human Services Transportation.

Information and communication. As noted above, through the Money Follows the Person Demonstration, peers will provide outreach, education, and peer support to individuals in nursing facilities. The State will continue to offer continuing education courses for nurses and social workers to learn about community support services. Six regional workshops have been included in Maryland's Money Follow the Person operational protocol for FY10.