JAN 1 1 2011

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 President Miller and Speaker Busch:

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

If you have any questions or need more information, please do not hesitate to contact Wynee Hawk, Director of Governmental Affairs at (410) 767-6480.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: Secretary Gloria Lawlah
        Secretary Cathy Raggio
        John Folkemer
        Mark Leeds
        Wynee Hawk

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

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

This report is intended to satisfy these reporting requirements.

_____

BACKGROUND

The Medicaid Program has offered home and community-based services as an alternative to nursing facility placement for many years. However, the range of options increased dramatically in 2001 with the implementation of both the Older Adults Waiver (administered by the Department of Aging) and the Living at Home Waiver (administered by 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 efforts and partnered with other State agencies and community organizations to promote home and community-based services. Strategies implemented over the past several years to reach out to nursing facility residents include:

- ➢ Peer to peer outreach 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, DHMH announced a new "money follows the individual" policy. Under this policy, an individual who has been a nursing home resident, paid for by Medicaid, for at least 30 consecutive days, can apply for the Living at Home or Older Adults Waiver programs even if those waivers are closed to community applicants.

EFFORTS TO PROMOTE HOME AND COMMUNITY-BASED SERVICES

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

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

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

Nurses in both jurisdictions continued in 2010 to work with their respective hospitals and nursing facilities, assisting in the diversion of many people from permanent nursing facility residence. These efforts are similar to ongoing work to establish Aging and Disability Resource Centers (ADRCs) in jurisdictions across the State. The Hospital Discharge Project continues to encounter shortages in community-based services to which to refer discharged patients.

Information on Medicaid's community-based services. DHMH continues to offer a booklet that describes all of the long term care community-based services that are available through the Medicaid program. The booklet is designed to provide basic information for health care professionals, consumers, and families to assist them in making decisions about long term care services. DHMH will continue to update this

popular resource on a regular basis. The information is also available online at:
http://www.dhmh.state.md.us/mma/longtermcare/pdf/2009/2009_2010_HCBS_booklet.pdf

Enrolling individuals from the Waiver Services Registry. Since the Living at Home and Older Adults waivers initially closed to community applicants, DHMH has maintained a Waiver Services Registry. The Registry is a central clearinghouse that collects contact information on individuals interested in receiving waiver services. Throughout 2010, 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 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 outreach and 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 institution[1] for at least 90 days, have at least one day of Medical Assistance eligibility prior to transition, and move into a qualified community residence.[2]

The first MFP participant moved to a community residence on March 18, 2008. Since then, 746 individuals have transitioned to the community from institutions, including 611 individuals from nursing facilities, 119 individuals from State Residential Centers (with 108 from Rosewood) and 16 individuals from chronic hospitals, through the end of November 2010.

After receiving approval from CMS in March 2008, DHMH 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. Several other efforts for nursing facility residents have been implemented, including peer outreach, program education, application assistance, and enhanced transitional case management that includes housing assistance. These enhanced transitional services will provide support to nursing facility residents in understanding their options, completing waiver applications, navigating community resources, identifying affordable and accessible housing options, applying for housing subsidies, and successfully moving from the facility to a community residence. Since July

---

[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.

1, 2009, the Department has conducted face-to-face outreach visits with more than 14,000 institutional residents including 13,750 nursing facility residents, provided options counseling 2,873 times, and assisted 868 nursing facility residents in applying for home and community-based services.

In August 2010, Maryland was awarded an additional $397,560 in federal funds through Funding Opportunity C, Nursing Home Transition and Diversion Programs within the larger funding opportunity titled *Implementing the Affordable Care Act: Making it easier for Individuals to Navigate their Health and Long-Term Care through Person-Centered Systems of Information, Counseling, and Access* offered by the Centers for Medicare and Medicaid Services and the Administration on Aging. Through this funding, Maryland Money Follows the Person (MFP) peer outreach and peer mentoring contractors will work with three local Aging and Disability Resource Centers, locally known as Maryland Access Point (MAP) sites, to develop a set of best practices for integrating peer supports and services into the MAP service structure (see next section for more information on MAPs). This integration will include standardizing models of peer support, identifying roles and responsibilities for peers in the MAPs including responding to Minimum Data Set (MDS) 3.0 Section Q referrals, developing a peer and volunteer network and developing a peer support manual for all Maryland MAPs to use.

Through this funding opportunity, the Maryland Department of Aging also secured additional federal funds to implement two new initiatives through the MAP sites. MDoA will implement a pilot of the Guided Care model, which provides comprehensive health care by physician-nurse teams for people with several chronic health conditions, specifically focusing on the 25% of Medicare patients at highest risk for using health services heavily. Scientific studies have shown that Guided Care improves the quality of care and suggests that it reduces overall health care costs. MDoA will also develop standards and requirements for ADRC Options Counseling (OC) for the MAP sites, which are an integral component of Maryland's rebalancing initiative including the Money Follows the Person (MFP) Demonstration, the Community Living Program (CLP) and the Person Centered Hospital Discharge Program (PCHDP). MDoA will create an OC workgroup under the state MAP Advisory Board that will develop protocols to guide OC during the initial intake, assessment and care planning, and case management. These protocols will assist individuals make informed choices about long term care and other benefits and address the participant-directed option that will soon be implemented as part of the CLP and the Veterans Self Directed Integrated Care Program.

Maryland Access Point (MAP). Funded under a federal Aging and Disability Resource Center grant, the program has developed a web-based information system that provides 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 website offers both virtual and actual single-points-of-entry for people seeking long-term care information, supports, and services. The MAP website launched on December 1, 2010. Current MAP sites are in operation in Howard, Worcester, Anne Arundel, Washington, Prince George's counties and Baltimore City. Sites in Wicomico, Somerset, Dorchester, Carroll, St. Mary's, and

Montgomery counties have been funded and are in the beginning stages of operation. Baltimore County has also received funding and will begin operations in early 2011. The Maryland Department of Aging intends to have statewide MAP coverage by the end of 2012 with funding and support from the MFP demonstration.

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 DHMH and other home and community-based services 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 overall operations.

To that end, DHMH 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, two subcommittees of the Waiver Quality Council have been working on addressing provider barrier issues as well as the reporting system for complaints and incidents. The Department of Health and Mental Hygiene Reportable Event Policy was revised and changes were implemented on April 2010. The Council reviews quarterly waiver reports in an effort to track and trend reportable incidents/events across waivers. The Council revised the quarterly Reportable Events forms to include more detailed, quantifiable quality indicators. As of December 15, 2010, the revised forms are in final draft format and will be implemented in early 2011. Lastly, the Council meets on a quarterly basis to share waiver information/issues in an effort to continually improve processes and services across all the waiver programs.

Quality Care Review Team. DHMH has a Quality Care Review (QCR) Team which is responsible for monitoring the various waiver programs. The QCR Team conducts annual reviews of a random sample of waiver participants. The review process includes on-site visits, clinical record reviews, observations, and interviews. The team conducts participant interviews to evaluate satisfaction and/or dissatisfaction with provider services and to identify any compliance issues. Reviews are conducted to ensure that participants' health, safety and welfare needs are addressed, and services are provided as specified in the participant's plan. Provider services must be based on acceptable standards of practice and in accordance with applicable regulations. Referrals are made to appropriate jurisdictional agencies when problems are identified (e.g. Office of Health Care Quality, Board of Nursing, and Office of Inspector General). The team is comprised of experienced registered nurses and social workers.

Additionally, the team generates findings and needed actions 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.

In 2010, the Autism Waiver instrument used to collect data during reviews was modified to better reflect the waiver quality assurances and performance measures. The new instrument is in final draft form and will be implemented in early 2011. A web-based Autism Waiver module will be added to the QCR tracking system. It is in the final stages of development and will be completed early in 2011. The QCR tracking system aids in the collection and analysis of data generated by the QCR Team during reviews.

New Initiatives

Increasing Community Services (ICS) Program – In September 2009, the Centers for Medicare and Medicaid Services (CMS) approved DHMH's request to operate the Increasing Community Services (ICS) Program. This innovative program strips away the barrier that now prevents individuals from moving into the community. Specifically, the ICS program allows individuals in institutions with incomes above 300 percent of Supplemental Security Income (SSI) to move into the community while also permitting them to keep income up to 300 percent of SSI. The ICS program is an expansion population and is currently capped at 10 individuals. Three individuals are now participating in the program.

Collaboration with other State Agencies

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

DHMH 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. MDS assessments conducted at admission and annually ask whether the resident has expressed a preference to return to the community. A resident is defined as any person staying within the nursing facility, regardless of their expected duration of stay or if they maintain another official residence elsewhere.

The Centers for Medicare and Medicaid Services (CMS) implemented a new Minimum Data Set (MDS) assessment on October 1, 2010. As part of the revised MDS assessment instrument, there is a new requirement that states must create a Local Contact Agency (LCA) responsible for responding to requests for information about community living based on the responses to the MDS 3.0 Section Q. To respond to this new requirement, the MFP demonstration was designated as the LCA for Maryland. The MFP demonstration responds to Section Q referrals by providing program education to all interested nursing facility residents, regardless of Medicaid eligibility or payment source. Since its implementation on October 1st through December 15, 2010, the MFP demonstration has received and responded to 163 referrals including 95 referrals for individuals who are not eligible for Medicaid.

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

Since the Living at Home Waiver closed to community applicants in December 2002, 566 individuals have transitioned from nursing facilities to the community through the waiver.

Since the Older Adults Waiver closed to community applicants in May 2003, 2,458 individuals have transitioned from nursing facilities to the community through the waiver.

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

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

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

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

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

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

Housing. The Money Follows the Person Demonstration provides housing assistance to nursing facility residents who seek independent housing through enhanced transitional case management services. Nursing facility residents 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. In addition to the case management supports, the MFP demonstration received additional federal funding for five (5) new Housing Specialists who will provide assistance in advocating for additional housing resources, overcoming individual barriers such as criminal backgrounds and poor credit history, and linkages with existing housing resources.

Transportation. Information is available, through DHMH, regarding options available to Medical Assistance enrollees for Medicaid-covered healthcare services. The information includes contact phone numbers, how to schedule transportation, and how to report complaints. It includes non-Medical Assistance transportation information in local areas as well. DHMH 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, outreach, education, and peer support are available to individuals in nursing facilities.