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

FEB 27 2012

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) as Amended by HB 899 (Chapter 711 of the Acts of 2010) and HG § 15-135(g) – 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 Marie Grant, Director of Governmental Affairs at (410) 767-6480.

Sincerely,

Joshua M. Sharfstein, M.D.
Secretary

Enclosure

cc: Secretary Gloria Lawlah
Secretary Cathy Raggio
Chuck Milligan
Mark Leeds
Marie Grant

Money Follows the Individual Accountability Act Report
December 2011

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;
- 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. The Hospital Discharge Project continues to encounter shortages in community-based services to which to refer discharged patients.

In 2011, nurses in both jurisdictions continued to work with their respective hospitals and nursing facilities, assisting in the diversion of many people from permanent nursing facility residence. These efforts are similar to ongoing work to establish Aging and Disability Resource Centers (ADRCs) in jurisdictions across the State. During the latter months of CY 2011, the programs in Harford and Worcester Counties began meeting and sharing data with a stakeholders group advising a grant obtained by the Maryland Department of Aging to support a Person-Centered Hospital Discharge Planning effort in six additional counties. All of these efforts at diversion are working toward becoming ADRCs by the end of FY 2012

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 2011, 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, 1103 individuals have transitioned to the community from institutions, including 942 individuals from nursing facilities, 134 individuals from State Residential Centers (with 108 from Rosewood) and 27 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

[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.

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, 2009, the Department has conducted face-to-face outreach visits with more than 21,725 institutional residents, provided options counseling 5,580 times, and assisted 1,927 nursing facility residents in applying for home and community-based services.

Maryland Access Point (MAP). Funded and supported through a federal Aging and Disability Resource Center initiative of the Administration on Aging and the Centers for Medicare and Medicaid Services, the program operates and maintains a statewide public web-based resource directory that provides an extensive database with a user-friendly search capability, consumer needs assessment and personal folder secure data sharing among agencies, and e-form capability, among other functions. The website offers both virtual and actual single-points-of-entry for people seeking long-term care information, supports, and services. In addition to the statewide website, sixteen local MAP sites are serving individuals in nineteen of twenty-four Maryland jurisdictions covering 82% of Maryland's population. (Allegany, Anne Arundel, Baltimore, Caroline, Carroll, Charles, Dorchester, Frederick, Harford, Howard, Montgomery, Queen Anne's, Somerset, Talbot, Prince George's, Washington, Wicomico and Worcester Counties and Baltimore City) The Maryland Department of Aging intends to have statewide MAP coverage by the end of 2012 with funding and support from the MFP demonstration. Standards of operation and partnership development have been established and an assessment of all existing and potential MAP sites has been conducted. The MAP sites operate as conduits for new federal initiatives like self-directed community-based services, person-centered counseling and planning and options counseling, hospital and nursing home transition programs and other pilots the purpose of which is to create consistent standards across the MAP sites and develop programs that divert people from inappropriate and default transition to nursing homes.

Quality improvement efforts

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

Another component of the quality management process is the Waiver Quality Council which meets quarterly and has representatives from all of the home and community-based services waivers as well as other internal stakeholders. The council members share critical information, discuss best practices, analyze required reporting data, and address

identified areas of concern across all the waivers through various interventions including but not limited to training, regulation and policy changes. In July 2011, the Council implemented a revised the quarterly Reportable Events summary form used by the waivers to include more detailed and quantifiable quality indicators.

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

Reviews help the administering and operating state agencies ensure that participants' health, safety and welfare needs are addressed, and services are provided as specified in the participant's plan. Provider services must be based on acceptable standards of practice and in accordance with applicable regulations. Referrals are made to appropriate jurisdictional agencies when problems are identified (e.g. Office of Health Care Quality, Board of Nursing, and Office of Inspector General). The team is comprised of experienced registered nurses and social workers.

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

In 2010, the Autism Waiver instrument used to collect data during reviews was modified to better reflect the waiver quality assurances and performance measures. Currently, the new instrument is in the field testing phase and will be fully implemented sometime in 2012. A web-based Autism Waiver module for the QCR tracking system is under development. The QCR tracking system aids in the collection and analysis of data generated by the QCR Team during reviews.

New Initiatives

Increased Community Services (ICS) Program. In September 2009, the Centers for Medicare and Medicaid Services (CMS) approved DHMH's request to operate the Increased 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 30 individuals. Four individuals are now participating in the program.

In December 2011, the Department completed regulations and has submitted them for review to the Joint Committee on Administrative, Executive and Legislative Review (AELR).

Increasing Access to Housing. In February of 2011, in partnership with MFP, four Maryland public housing authorities applied for and were awarded a total of 112 category II vouchers for non-elderly disabled individuals transitioning from institutions. As of November, 75 vouchers have been awarded, allowing 46 individuals transition back to the community.

In September 2011, Maryland successfully applied for a Real Choice Systems Change Grant titled, Building Sustainable Partnerships for Housing. Maryland's proposal, Maryland Partnerships for Affordable Housing (MPAH), is a joint effort of Medicaid, the Department of Disabilities (MDOD), the Department of Housing and Community Development (DHCD), the Mental Hygiene Administration (MHA), the Developmental Disabilities Administration (DDA), Centers for Independent Living (CILs), disability advocates, consumers, and other community service providers. MPAH is a one year grant that will assist Maryland in developing strong relationships and a competitive application for funding through the Department of Housing and Urban Development's (HUD) revised 811 rental assistance program. It is anticipated that any new funds received will be dedicated to affordable and accessible housing for persons with disabilities and targeted to individuals who are institutionalized or at risk for institutionalization.

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 1, 2010 through December 15, 2011, the MFP demonstration has received and responded to 766 referrals including 348 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, 706 individuals have transitioned from nursing facilities to the community through the waiver.

The Older Adults Waiver closed to community applicants in May 2003. From FY 03 through FY 11, 2,470 individuals in a nursing facility within the previous three months, transitioned into the waiver.

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

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

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

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

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

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

Housing. 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 four (4) new Housing Specialists and a Housing Supervisor 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. MFP will continue to advocate for increased affordable, accessible housing for people with disabilities.

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.