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 0 8 2008

The Honorable Martin O'Malley
Governor
100 State Circle
Annapolis, MD 21401-1925

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
H-101 State House
Annapolis, MD 21401-1991

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

Dear Governor O'Malley, 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 Mr. Mark Leeds, Director of Long Term Care and Community Support Services, at (410) 767-6770.

Sincerely,

John M. Colmers
Secretary

Enclosure

cc: Secretary Gloria Lawlah
Secretary Catherine A. Raggio
Mr. John Folkemer
Mr. Mark A. Leeds
Ms. Anne Hubbard

Money Follows the Individual Accountability Act Report
December 2007

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;
(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 confronted 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 efforts and partnered with other State Departments 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 Moving To Community resource guide;
- Distribution of community options fact sheets to nursing facility residents, social workers, and administrators;
- Development and distribution of a booklet, *Maryland Medicaid Home and Community-Based Long-Term Care Services*; and
- Options Counseling – utilization control agent nurses discuss community options with residents that express a preference to move to the community.

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, interest has far exceeded the capacity of each waiver. As a result, the Living at Home Waiver closed in December 2002 and the Older Adults waiver closed in May 2003 to applicants from the community. Since that time, both waivers have only enrolled a limited number of applicants from the community.

As the Living at Home Waiver approached its enrollment cap in November 2002, the Department announced a new "money follows the individual" policy for the Living at Home Waiver and Waiver for Older Adults programs. Under this policy, Medicaid recipients leaving nursing facilities who meet the waiver eligibility requirements can enroll in the Waiver for Older Adults or Living at Home Waiver even if, due to budget constraints, the waivers have reached their enrollment limit for individuals living in the community.

Efforts to Promote Home and Community-based Services

This section presents some of the Department's most significant efforts to promote home and community-based services. These efforts fall into four main categories: linking consumers with community supports, improving access to community supports, quality improvement, and systems reform.

Linking consumers with and improving access to community supports

Options Counseling. DHMH contracts with a Utilization Control Agent (UCA) to perform several utilization review functions in nursing facilities, including quarterly on-site reviews for Medicaid recipients at each Medicaid participating nursing facility. In response to HB 946/SB 620, we enacted a provision in the UCA's contract to expand the role they play at their quarterly reviews.

Now, nurses from the UCA identify residents that have expressed a preference to move to the community, and the nurses discuss home and community-based options with those nursing facility residents. If a resident so desires, the UCA nurse will make a referral to the agency that administers a Medicaid waiver program appropriate to the resident's needs. The UCA nurses saw their first clients in September 2004 and have since made more than 486 referrals to either the Waiver for Older Adults or the Living at Home Waiver.

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 exists 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 that they would need when they return home.

Continuing education for social workers and nurses. Consumer advisory groups have expressed concern that hospital and nursing facility employees do not fully understand the long-term care services that are available in the community. Since many individuals are in hospitals for a short period of time, it is especially important that those responsible for discharge planning be fully informed about the services available to assist individuals when they are discharged to the community. In 2006, DHMH hosted two workshops (in Baltimore County and Anne Arundel County) for social workers and nurse case managers about the community-based services available in Maryland.

The workshops were financed through the federally-funded Real Choice Systems Change Grant and a partnership with Johns Hopkins. The Department planned to hold additional workshops during 2007, however due to staffing shortages the workshops were not held. The goal of the workshops is to give practical, user-friendly information about programs and services in the community that are available to assist low-income older adults and people with disabilities. Attendees received continuing education credit for completing the day-long workshop. Six regional workshops are planned for FY09 as part of Maryland's Money Follows the Person Demonstration.

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. In 2005 and 2006, the Real Choice Systems Change Grant covered the printing and distribution costs for this project, and the Department sent copies to nursing facilities, hospitals, local government agencies, advocacy groups, and State legislators. The Department will continue to produce this popular resource on an annual basis.

Rate increases for personal care providers. This year payment rates were increased under the State Plan personal care program. The Department implemented regulatory changes to include provisions to allow an annual increase in personal care services per diem rates by the percentage

of annual increase in the March Consumer Price Index. This resulted in a 4.1% rate increase for FY 2008.

Rate increases for DDA providers. FY07 was the 5th and final year of the direct care wage initiative and a total of $80,991,172 was budgeted for the initiative.

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 2007, DHMH enrolled individuals from the Registry into the Waiver for Older Adults on a first-come, first-served basis to take the place of individuals who have left the program.

MFP. The Money Follows the Person Rebalancing Demonstration (MFP), offered through the Centers for Medicare and Medicaid Services (CMS), was created as part of the Deficit Reduction Act of 2005 passed by the U.S. Congress. CMS awarded Maryland an MFP grant with the goal of assisting the State in providing a greater proportion of long-term care services in the community. The MFP demonstration will promote transitions to the community by offering additional outreach and resources to individuals in nursing facilities.

Pending the approval of the MFP operational protocol, expected February 1, 2008, the State will implement the following initiatives:

- Peer mentoring for nursing facility residents where peer mentors will provide outreach, education, and peer support. Peer support will be available for institutional residents and their families. Peer mentors may also provide ongoing support during and after the transition.
- A Transition Center to provide program education, application assistance, housing assistance, and transition services to nursing facility residents interested in transitioning to the community.
- Flexible funding under the MFP demonstration authority will allow individuals who transition to access $700 for expenses related to their transition.

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. Pilot Sites are in operation in Howard and Worcester counties, and funding has been approved to support additional sites in Anne Arundel and Washington counties.

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 Framework articulated in the revised Appendix H of the 1915(c) HCBS waiver application. This effort is designed to create a consistent and uniform strategy to measure and enhance performance across all community long-

term care programs and services. The goals of this effort are to: (a) create a more evidenced-based quality management system, (b) improve the ability of the State and HCBS administering agencies and case managers to monitor service provision, (c) improve the capacity of the State to monitor and improve the quality of service from providers, (d) monitor the quality of care and life at the individual consumer level, (e) develop better quantifiable indicators of quality, (f) improve infrastructure to collect and distribute data on quality indicators, and (g) create more comprehensive and standardized quality reports for improving program operations.

To that end, DHMH has established a Waiver Quality Council consisting of representatives from each waiver administering agency, the Office of Health Care Quality, and Medicaid, who will work towards these goals over the next year. The State may seek assistance from the MFP Quality Technical Assistance contractor in addressing improvement areas noted above. Any new quality assurances and improvement strategies will be implemented for all waiver participants, including MFP demonstration participants.

Systems Reform

In August 2005, the Department submitted an application to the federal government for permission to implement the CommunityChoice program, a capitated, managed long-term care program to be piloted in two areas in Maryland. The proposal called for a fundamental change in Medicaid financing, with the intent of promoting community-based long-term care services, reducing avoidable hospitalizations and nursing facility placements, improving outcomes, and reducing the rate of cost growth in the Medicaid program. The Department held multiple stakeholder meetings regarding CommunityChoice, and selected pilot areas and a preliminary framework for implementation. On March 16, 2007, the Department informed the members of the Medicaid and CommunityChoice Advisory Committees of the decision to no longer pursue CommunityChoice. This decision arose after the Centers for Medicare and Medicaid Services (CMS) indicated that the Department would receive a denial of the Medicaid §1115 waiver application for CommunityChoice. The denial created an opportunity for the Department to reevaluate its strategy for long-term care reform. The Department is continuing to consider options for long-term care reform.

Collaboration with other State Agencies

The Department has collaborated with various State Agencies on initiatives to promote home and community based services including the Department of Human Resources' *Nursing Facility Transition Grant*, Maryland Department of Aging's *Maryland Access Point* and *Nursing Home Diversion Modernization Grant*, Department of Housing and Community Development's *Bridge Subsidy Demonstration*. The Department collaborated with each of these agencies and the Maryland Department of Disabilities on the *Money Follows the Person Demonstration.*

The Department currently serves on various committees and workgroups including:

- Maryland Commission on Disabilities;
- Personal Assistance Services Advisory Committee;
- Coordinating Committee for Human Services Transportation;
- Maryland Access Point (Aging and Disability Resource Center);

- Bridge Subsidy Demonstration Program;
- Home and Community-Based Services Waiver advisory committees (Traumatic Brain Injury, Older Adults, and Living at Home); and
- Money Follows the Person Stakeholder Advisory Group.

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

The Minimum Data Set (MDS) 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 2006.[1]

The Department's analysis indicates that 5,596 out of 24,454 total (23%) 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 less likely to express a desire to leave a nursing facility when compared to non-Medicaid residents during similar types of stays. Of the 24,454 total residents, 17,209 were identified as Medicaid recipients. The percentage of Medicaid recipients wishing to return to the community was slightly higher in 2006 compared to the previous year, while all other rates remained steady. The 2006 results are categorized in the table below.

Respondents expressing a preference to return to the community

Resident Type	Type of Stay: Medicare covered (Post-acute)	Other Long-Term Care	Total
Medicaid	**41%** (782 / 1,925)	**12%** (1,910 / 15,284)	**16%** (2,692 / 17,209)
Non-Medicaid	**72%** (1,966 / 2,723)	**21%** (938 / 4,522)	**40%** (2,904 / 7,245)
Total	**59%** (2,748 / 4,648)	**14%** (2,848 / 19,806)	**23%** (5,596 / 24,454)

MDS survey results March, 2006

[1] 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 2006).

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, 242 individuals have transitioned from nursing facilities to the community through the waiver.

Since the Waiver for Older Adults closed to community applicants in May 2003, approximately 1,754 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 housing that includes modifications and/or adaptive equipment.

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 explore housing options. 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-Medicaid 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. We consistently hear anecdotes about nursing facility employees who do not think any of their residents can move into the community. Likewise, many consumers and family members are unaware 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. A housing commission was established to develop solutions and strategies to address the shortage of affordable and accessible housing in Maryland, including funding options for housing for people whose income is at SSI levels. In its final report, several of the commission's recommendations address concerns of the disability community, including the development of the Bridge Subsidy Demonstration Program. DHMH will continue to collaborate with the Department of Housing and Community Development and other agencies to identify housing resources for older adults and people with disabilities. The Money Follows the Person

Demonstration will provide housing assistance to all nursing facility residents who seek independent housing.

Transportation. DHMH developed a comprehensive list of transportation options available to Medical Assistance (MA) enrollees. The list includes Medicaid transportation information including contact phone numbers, how to schedule transportation, and how to report complaints. It includes non-MA transportation information in local areas as well. This list is available to participants of all waivers. 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, Money Follows the Person Demonstration peer mentors 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 the operational protocol for Maryland's Money Follow the Person Demonstration for Fiscal Year 09 and annually as requested.

Systems Reform

The Department believes that to fully realize the intent of the Money Follows the Individual Accountability Act will require system-wide changes across Medicaid long-term care. This reform effort is a top priority of the Department and will include the key goals of improving access to home- and community-based services, offering more consumer choice, promoting high-quality services, and balancing fiscal challenges. In the coming months, the Department will continue to work with stakeholders, other State agencies, and the Legislature to further define our mutual goals for long-term care reform.